



# DEMOCRATIC REPUBLIC OF CONGO

## Maternal & Newborn Health Country Profile



## OVERVIEW

The Democratic Republic of Congo (DRC) is the largest country in Sub-Saharan Africa and has a wealth of natural resources. Despite this, it is one of the poorest nations in the world, largely driven by decades of conflict and political instability.

The humanitarian crisis has become increasingly complex and exacerbated by recurrent disease outbreaks including COVID-19, cholera, measles, and Ebola. DRC's [2023 Humanitarian Response Plan](#) estimates that 26.4 million people are in need of humanitarian assistance and protection with 5.4 million people internally displaced.<sup>1</sup>

Eastern Congo – including in North and South Kivu provinces – has experienced decades of instability with regular armed conflict often linked to the illegal exploitation of resources. Disease outbreaks, food insecurity, and a growing presence of displaced persons have further strained the already weak health system.



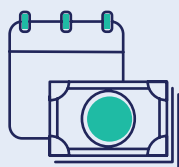
# DRC'S HEALTH SECTOR

The socio-political context, coupled with funding and human resource shortages, has resulted in a weak public health system unable to meet the needs of the population.



## HEALTH SYSTEM STRUCTURE

DRC's health system is decentralized with the central level – based in the capital, Kinshasa – responsible for developing policies, setting national priorities, and managing tertiary hospitals; the provincial level offices provide technical support, administrative management, and implementation supervision; and the health zones operationalize the national health plan, define, monitor and evaluate primary health care activities, and interact with operational partners. Faith-based institutions, nonprofit organizations, and for-profit actors like private pharmacies and health facilities, also play an important role.



## FINANCING

Government spending on health remains low with only [8.5% of the country's total budget](#) allocated to health in 2018 – an increase from previous years.<sup>2</sup> As a result, limited funding is available to strengthen the workforce, health infrastructure, and/or equipment. Patients typically pay user fees to cover the cost of care, which is a significant burden on households given that [64% of people](#) lived on less than \$2.15 a day in 2021.<sup>3</sup> Funding gaps are largely filled by external actors – including donors and INGOs – which has led to donor dependency and donor driven priorities.



## HEALTH WORKFORCE

In 2018, DRC had only [~1 doctor, nurse and midwife per 1,000 people](#), far below the [WHO recommended threshold](#) of 4.45 doctors, nurses and midwives per 1,000 people.<sup>4,5</sup> Among the existing providers, inadequate and unreliable compensation leads to demotivation, lower quality of care, and poor retention rates. Funding shortages also impact ongoing training and supervision to strengthen the capacity of health workers.



## HEALTH FACILITIES

Physical distance, road conditions, and insecurity inhibit access to health facilities for many. On average, people are expected to live within 5 to 10 kilometers of a health facility, however, there are many remote areas with difficult geographic accessibility. Strengthening community health systems is a [key strategy](#) among many health partners for bringing services closer to communities through community health workers and mobile clinics.<sup>6</sup>

All of these factors have a compounding effect on the quality of care available – especially for women and newborns before, during, and after pregnancy.

# MATERNAL AND NEWBORN HEALTH IN THE DRC

Maternal and newborn health (MNH) services are part of the DRC Essential Health Package and offered through primary health care facilities, community health workers, and at hospitals. The minimum package includes family planning, antenatal- and postnatal care, obstetric care (for normal deliveries), newborn care, child vaccination, integrated management of childhood illness (IMCI), and treatment of severe acute malnutrition.<sup>7</sup> The complementary package (available at hospitals) also covers internal medicine, hospitalization, intensive and emergency care (including emergency obstetric and newborn care), surgery, gynecology, as well as preventive and promotional activities, and managerial functions. The implementation of these packages – and on overall access to facilities providing basic and emergency obstetric care – varies depending on the presence of technical and/or financial partners like INGOs.

While progress has been made with up to 85% of all deliveries assisted by skilled health personnel as of 2018, other indicators (per below) for improving MNH outcomes remain low: <sup>8,9</sup>

- 43% of women attend at least four antenatal care (ANC) visits during pregnancy (2018)
- 50% of women (15-49) receive postnatal care within two days of giving birth (2018)
- 57% of newborns have postnatal contact with a skilled provider within two days of delivery (2018)<sup>10</sup>

The state of MNH in the DRC is an indication of the weak health system. DRC ranks 4<sup>th</sup> among eight countries – behind India, Nigeria, and Pakistan – that account for more than 50% of all maternal deaths worldwide.



**MATERNAL MORTALITY RATIO**

547 deaths per 100,000 live births (2020)<sup>11</sup>



**NEONATAL MORTALITY RATE**

26 deaths per 1,000 live births (2021)<sup>12</sup>



**STILLBIRTH RATE**

28 deaths per 1,000 live births (2021) <sup>13</sup>

This far exceeds the targets set by the SDGs which aim to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030; to reduce neonatal mortality to as low as 12 deaths per 1000 live births;<sup>14</sup> and the stillbirth target set in the Every Newborn Action Plan (ENAP) to reduce stillbirths to less than 12 per 1000 total births by 2035.<sup>15</sup>

## LEADING CAUSES OF MATERNAL AND NEONATAL MORTALITY IN THE DRC

The greatest direct drivers of maternal mortality in the DRC include hemorrhage, hypertension, and sepsis while the majority of newborn deaths are caused by preterm birth complications, intrapartum related events, pneumonia, and infections.<sup>16, 17</sup>

# MATERNAL AND NEWBORN HEALTH IN THE DRC

## THE IMPACT OF DISEASE OUTBREAKS ON MNH IN THE DRC

- **EBOLA:** During the Ebola epidemic in West Africa in 2014–2016, and the subsequent epidemic in the DRC starting in 2018, use of MNH services declined as women refused going to facilities for fear of infection or were declined care if they were suspected of having Ebola. As a result, the maternal and neonatal deaths and stillbirths indirectly caused by the epidemic were reported to out number direct Ebola-related deaths.<sup>18</sup>
- **COVID-19:** During the COVID-19 pandemic, access to MNH care was negatively impacted as restrictions were made on travel and gatherings. Health facilities were poorly equipped to manage the pandemic with limited infection prevention supplies and practices. Evidence from several contexts reveals this led to a decrease in health service utilization, especially ANC visits.<sup>19</sup>



# POLITICAL WILL FOR MNH IN THE DRC

The government of DRC has made the reduction of maternal mortality a top health concern along with Universal Health Coverage (UHC).<sup>20</sup> This commitment is further demonstrated by the revised roadmap towards UHC which includes MNH and the commitment to the Global Strategy for Women's and Children's Health to strengthen the health system, to increase the proportion of deliveries assisted by skilled personnel to 80%, and to increase access to emergency obstetric care.<sup>21</sup>

## MNH TARGETS / INDICATORS IN DRC

### Sustainable Development Goals <sup>22</sup>

- Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- Target 3.2: By 2030, reduce neonatal mortality to at least as low as 12 per 1,000 live births.

### National Health Development Plan Targets (2019-2022) <sup>23</sup>

- By the end of 2022, help reduce maternal deaths from 846 to 548 per 100,000 live births.
- By the end of 2022, help reduce neonatal mortality from 28 to 14 per 1,000 live births.



## POLICIES AND PLANNING

DRC's MNH priorities are outlined in several national strategies and plans including but not limited to the following:

- National Health Development Plan (2019-2022)<sup>24</sup>
- Plan Stratégique National de la Santé et du Bien-être des Adolescents et Jeunes (2016-2020)<sup>25</sup>
- Plan National de Développement Sanitaire: Vers la Couverture Sanitaire Universelle (2018-2022)<sup>26</sup>
- Integrated Strategic Plan for Reproductive, Maternal, Newborn, child, adolescent health and nutrition (2019-2022)<sup>27</sup>
- National List of Essential Medicines (2020)<sup>28</sup>
- Integrated Management of Childhood Illness (IMNCI) National Strategic Plan (2018-2022)<sup>29</sup>
- National Community Health Strategic Plan/Roadmap (2019-2022)<sup>30</sup>

# MNH COORDINATION

With so many partners – including the government and external actors – working to strengthen the health system and to reduce preventable maternal and newborn deaths in the DRC, a variety of coordination mechanisms and technical groups have been established at national and provincial levels.

## National level groups:

- **National Health Sector Coordinating Committee (CNP-SS):** A multi-sector forum responsible for setting policy and strategic direction of the health sector.
- **Technical Coordination Committee:** The operational arm of the CNP-SS responsible for coordinating interventions.
- **National RMNCH Task Force:** A multi-stakeholder forum for coordinating RMNCAH partners and interventions.

## Provincial level groups:

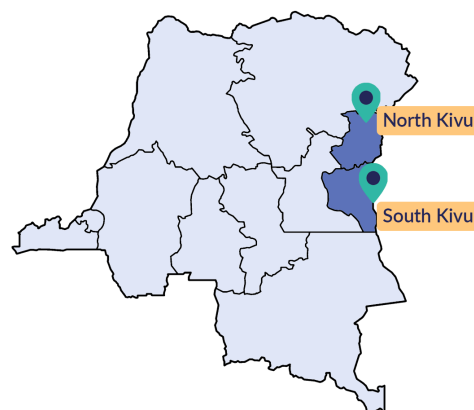
- Provincial RMNCH task force
- Maternal and Perinatal Death Surveillance (MPDSR) working groups



## EQUAL'S RESEARCH IN THE DRC

The EQUAL research consortium will conduct research in North and South Kivu including:

- **Political economy analysis:** A qualitative study to understand how political and economic dynamics at the national and subnational levels affect how MNH policies, strategies, and services are prioritized and how this changes over time – including during periods of increased insecurity.
- **Maternal and Perinatal Death Surveillance:** A study to assess the feasibility, acceptability, and effectiveness of community-based maternal and perinatal death surveillance (reporting and review of maternal and perinatal deaths that occur within communities) and response in conflict-affected settings.
- **Facility-based quality of care:** Assessments to evaluate the readiness of facilities to provide routine and emergency obstetric and newborn care services, the provision of services around the day of delivery, and the experiences of women during childbirth at health facilities.



# EQUAL PARTNERS IN DRC



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