

A WORLD BANK STUDY



# Assessment of the Private Health Sector in the Republic of Congo



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# Foreword

The Republic of Congo has engaged in a process of economic and social reforms since the mid-1980s. These reforms focus on restructuring and promoting the private sector. Private health sector facilities include clinics, health centers, and medical practices. One of the guidelines of the National Health Policy states that the government must adjust its role in the health sector by opening the health sector to other institutional private and voluntary actors. This reallocation of responsibility will allow the state to meet its public service obligations for quality health care and poverty reduction. The existence of public and private nonprofit health facilities is also an expression of national solidarity to eradicate disease and improve health.

In addition, the state is committed to organizing and promoting the private nonprofit sector represented by faith-based organizations and not-for-profits, as well as the private for-profit sector of business owners and companies. The promotion of private health care through streamlined startup and regulatory mechanisms is a key national health policy challenge.

The report of the Ministry of Health and Population, with the support of the Results for Development Institute (R4D), Health Research for Action (HERA), and International Finance Corporation (IFC) of the World Bank Group, indicates that integrating the private health sector into global public policy requires the following actions: (i) improve the private sector's ability to provide services by encouraging the public sector and donors to work more closely with it; (ii) modify policies and local regulations to support and mobilize the private sector, reducing red tape, liberalizing regulations on human resources, and reducing taxes and other barriers to a clear strategy; and (iii) develop a series of recommendations for the government to improve cooperation between the public and private sectors and to generate an increased interest from participating insurers, investors, and businesses from Africa and beyond.

The private sector is able to make a significant contribution towards diversifying the supply of care in general and improving the health of the Congolese people in particular.

Professor Georges Moyon  
Minister of Health and Population  
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# Preface

The private sector did not begin to play a role in health care in the Republic of Congo until 1988, when its contribution was officially recognized. Since then, the role of private health providers has grown considerably. The goods and services supplied by the private sector are significant, both in urban areas (essentially through providers, pharmacies and for-profit laboratories) and in rural regions (through faith-based organizations). However, very little information is available regarding the role of the private sector. The implementation of the 2005 health mapping exercise provided a “snapshot” of public and private providers, but updates to the data since that time have been irregular and incomplete. At the same time, policy statements from the Ministry of Health have indicated an interest in closer cooperation and coordination between the public and private sectors. Despite these statements, very little has been accomplished. More broadly, we have seen openness in other sectors to greater participation from the private sector in the Congolese economy. Although the Republic of Congo is fortunate enough to have petroleum resources, a factor that has bumped it into the lower ranks of middle-income countries, its health care indicators are more in line with those of its low-income neighbors.

With funding from the Health in Africa initiative—a joint initiative of the International Finance Corporation (IFC) and the World Bank—the Congolese government recruited a research team to conduct an assessment of the private health sector. The Results for Development Institute (R4D), the organization largely responsible for this assessment, worked closely with Health Research for Action (HERA) and a team of consultants from the Republic of Congo led by Mr. Guy-Patrick Gondzia to complete the work. Determining the role currently played by the private health sector was among the project’s objectives. This work included diagnosing the nature and effectiveness of the interface between the public and private sectors, establishing a dialogue on policy with stakeholders, and making recommendations for reform that would bolster public and private involvement.

## Methodology

The research team used a supply-and-demand approach to identify market, policy, and institutional barriers, as well as options for reducing these barriers by changing policies and initiatives. The information pertaining to demand revealed how users perceive private providers and their potential. The information pertaining to supply gave us a better understanding of the role that private providers play and the challenges that they encounter. The institutional information showed how the Republic of Congo’s institutions have facilitated or hampered private participation.

The study methodology included the following aspects:

- Presentation of the general context of the private health sector in the Republic of Congo
- Multidimensional analysis of demand
- Multidimensional analysis of supply
- Analysis of the institutional context

Three stakeholder workshops were held to share observations and conclusions, to discuss concerns and to reach a consensus on the development of a three-year action plan. A steering committee with representatives from the public sector, the private sector, and development partners provided guidance through the process of conducting the assessment.

## Results

The information below summarizes the study findings and the recommendations to improve the contribution of the private sector in attaining the broader national health care objectives in the Republic of Congo. The main points are as follows:

### Multidimensional Analysis of Demand

An analysis of the quantitative data from the 2005 Demographic and Health Care Survey (EDS) and the Congolese Household Survey (ECOM), also conducted in 2005, with the results of the focus groups, yielded an overview of demand for health care and services offered by private for-profit, nonprofit, informal, and traditional providers. The main results were as follows:

- The private sector is an important source of health care. The use of private sources of health care accounts for between one third and one half of the total use of modern medicine, and it may continue to increase if the quality of the care improves.
- According to the ECOM, the public sector addresses 44 percent of the health care demand and the private sector addresses 56 percent (which includes 31 percent by private for-profit health care providers, 10 percent by pharmacies, 9 percent by practitioners of traditional medicine, 4 percent by the nonprofit sector, and 2 percent by other private sources).
- The sector is focused more on outpatient care than on hospitalization, and therefore it plays an important role in providing primary health care. This pertains both to the for-profit and nonprofit subsectors.

### Multidimensional Analysis of Supply

The purpose of the supply analysis, based on a survey and interviews, was to confirm and supplement the available data (from the health mapping exercise and censuses) to gain additional information on the characteristics of the private providers and the services offered. The main results were as follows:

- The 2005 health mapping exercise documented 1,712 private facilities distributed over the entire country. Most of the facilities in the Republic of Congo are private (59 percent) and most of those are for-profit organizations (88 percent) located in urban and semi-urban areas.
- According to the data from the Ministry of Health and Population (MSP) in 2005, there were 2,849 individual providers operating exclusively in the private health sector throughout the country (26 percent of all providers in the Republic of Congo). Many public sector workers also work part-time in the private sector, but this phenomenon could not be quantified.

- Although pharmaceutical prices are standardized throughout the country (except for shipping costs), the pricing of health care, laboratory tests and medical imaging varies (sometimes greatly) depending on different types of facilities, and even between facilities of the same type. This price variation is greater for less expensive care than for more expensive care.
- The poorest populations face barriers to financial access. The lack of demand-side financing and national health insurance limits access to health care products and services, especially for the poorest populations. However, private providers often treat the poorest individuals by offering more flexible payment terms and timeframes or even by offering free services (but this sometimes poses problems for the financial stability of these private facilities).
- The onerous financial and administrative fees collected by several ministries (trade, finance, labor) can raise the prices of private health care products and services.
- The poor financial management capacities of private providers are an obstacle to the efficient operation of the facilities and their ability to mobilize investments to expand their activities.

### **Analysis of the Institutional Framework**

Interviews with key informants and a review of the legal documents and legislation were used to analyze the institutional framework for the organizations involved in the private health sector. The main results were as follows:

- The private health sector is not extensively regulated. The weaknesses in the current regulations, the lack of knowledge of the regulations on the part of private-sector organizations and the failure to enforce the law, result in illegal competition, the emergence of illegal circuits, and a mediocre service quality at private facilities.
- The procedure for creating and registering private facilities is laborious, and many facilities operate only under provisional authorizations beyond their first year of practice. This ineffective procedure runs the risk of promoting an illegal circuit and noncompliance with regulations in an environment perceived as “lax.”
- The private health sector is poorly organized and does not have a voice at the national level. The lack of organization into associations/professional organizations for most groups of private providers (except for pharmacists and soon for practitioners of traditional medicine) and the lack of a representative organization uniquely for the private health sector pose problems in interacting with the public sector and in promoting private sectorwide interests.
- The lack of coordination between the various ministries with regard to the private health sector prevents more effective management of the activities of the private sector.
- The private for-profit and nonprofit sectors are treated as commercial sectors, which increases the price of the services offered (since taxes are additional costs for the facilities) and reduces their financial accessibility.
- The private health sector receives minimal support from the public sector, and is underused in helping to meet the national health care objectives. There are no contracts or strategic agreements between the public sector and private provid-

ers (except for a few ad hoc agreements with private facilities as part of national health care programs). Government authorities also do not have policies in place to enlist the help of the private sector in treating poor populations through financing strategies or subsidies that compensate this sector accordingly.

- The difficulty or lack of access to bank loans to provide startup capital or to finance the expansion of activities decreases the willingness of health care professionals to invest in the development of the private sector and/or to take the risk of setting up their practice in a rural area.

### Options for Action

The details of this study were presented in a series of three stakeholder workshops for actors in the health sector. The purpose of these workshops was to encourage the parties involved in the public and private health sectors to agree on reforms to better guide the private sector, and to ensure quality in order to effectively contribute to attaining the national health objectives. At the end of the final workshop held in December 2010, the participants decided on the actions to be taken based on the assessment and on the discussions that took place during the second workshop, in October 2010. The participants in the final workshop identified the key action items below, most of which should be incorporated in the working programs of the *Programme de développement des services de santé* (PDSS) [Health System Development Project] for the years 2011–2013.

### Policy and Governance Initiatives

- Create a formal platform for ongoing dialogue between the public and private sectors (by also establishing relations with the High Council for Public-Private Dialogue).
- Increase the participation of the private health sector in the bodies of the PDSS and on the technical committees established by the ministry (for example, with regard to free Cesarean sections, Emergency Obstetric and Neonatal Care (EmONC), the revision of legislation and more).
- Strengthen the structure of the private health sector by creating a private health sector alliance (*Alliance du secteur privé de la santé, Alliance SPS*).
- Develop a strategic framework for the private health sector within the context of the national health care policy. This should include a strategic memo to accompany the action plan, as well as creating and regularly updating a directory of private-sector facilities and providers.

### Regulatory Initiatives

- Collect, update and implement all legislation and regulations that govern the private health sector. This involves creating a joint public-private sector committee to review all legislation and regulations.
- Improve the efficiency of the regulatory framework by: (a) increasing the institutional capacities of the MSP to enforce regulations; (b) developing and increasing the private sector's self-regulation capacities; and (c) strengthening the mechanisms for detecting illegal activities and products, as well as implementing a penalty system.

## Incentive Initiatives

- Increase access to bank financing/guarantee funds by (a) creating a guarantee fund for the private health sector; (b) creating a fund for the government to support private initiatives in the health sector; (c) increasing the capacities of private providers to design projects that are appealing to potential funders, and (d) encouraging banks to grant loans to the private health sector.
- Provide tax relief, including: (a) decrease or eliminate taxes for private providers in rural areas; (b) eliminate taxes on generic products, resources and raw materials intended for local pharmaceutical production; and (c) establish an agreement that allows for a startup tax credit (see investment law).
- Increase the management and oversight capacities of the private health sector.

## Concrete Measures for Public-Private Partnerships (PPP) in the Health Sector

- Establish a public/private technical committee on the operationalization and oversight of PPPs (ad hoc committee reporting to the Public-Private Dialogue Platform) and develop a mechanism for implementing and overseeing the PPPs.
- Make the PPPs operational for subsidized public health care programs (for example, existing programs on HIV/AIDS, malaria and vaccinations).
- Develop PPPs on EmONC, and specifically, develop the EmONC improvement plan by defining PPPs and implementing the improvement plan; define the terms for free Caesarean sections through public and private networks and implement the free service plan.
- Develop PPPs for training and continuing education. This would mean that students of public institutions could do their internships at private facilities; that private providers could be invited to teach at public education facilities and to participate in continuing education programs organized by the public sector (creation of a private technical committee on continuing education as a subcommittee of the Alliance SPS).
- Develop demand-side subsidy strategies in the public and private sectors after analyzing the possibility and feasibility of introducing or improving strategies such as health insurance, mutual health insurance companies, health care vouchers and other mechanisms. This would be part of more comprehensive development of financing strategies for the public and private sectors.

This country assessment is part of a set of studies planned in order to provide a better understanding of how to improve the business environment in which the private health sector operates in the Republic of Congo and other African countries. The assessment was conducted in order to establish a baseline of information, to help with political decision-making and to provide market information.

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# Acronyms

ASPHAC	<i>Association des pharmaciens du Congo</i> [Pharmacists Association of the Republic of Congo]
BCH	<i>Banque Congolaise de l'Habitat</i> [Congolese Housing Bank]
CFA franc	African Financial Community franc
CFE	<i>Centre de formalité des entreprises</i> [Business Registration Center]
CMS	<i>Centre médico-social</i> [Medical and Social Services Center]
COMEG	<i>Congolaise de médicaments essentiels et génériques</i> [Congolese Agency for Essential Generic Medications]
COSA	<i>Comité de santé</i> [Health Care Committee]
CSS	<i>Circonscription socio-sanitaire</i> [Health District]
DDS	<i>Direction départementale de la santé</i> [Regional Health Care Department]
DGS	<i>Direction générale de la santé</i> [General Health Care Department]
DSS	<i>Direction des services sanitaires</i> [Department of Health Services]
ECOM	<i>Enquête congolaise auprès des ménages</i> [Congolese Household Survey]
EDS	<i>Enquête démographique et de santé</i> [Demographic and Health Survey]
EmONC	Emergency Obstetric and Neonatal Care
GDP	Gross domestic product
HERA	Health Research for Action, Belgium
IFC	International Finance Corporation
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MDIPSP	<i>Ministère du développement industriel et de la promotion du secteur privé</i> [Ministry of Industrial Development and Promotion of the Private Sector]
MSP	<i>Ministère de la santé et de la population</i> [Ministry of Health and Population]
NGO	Nongovernmental organization
ONEMO	<i>Office national de l'emploi et de la main d'œuvre</i> [National Employment and Labor Office]
ONM	<i>Ordre national des médecins du Congo</i> [National Order of Physicians of the Republic of Congo]
ONP	<i>Ordre national des pharmaciens du Congo (ONP)</i> [National Order of Pharmacists of the Republic of Congo]
PDSS	<i>Programme de développement des services de santé</i> [Health System Development Project]
PNC	Prenatal consultation
PNDS	<i>Plan national de développement sanitaire</i> [National Health Development Plan]
PPP	Public-private partnership
R4D	Results for Development Institute, United States

SES	Socioeconomic status
SME	Small and medium-size business
STI	Sexually transmitted infection
SYNAPHAC	<i>Syndicat national des pharmaciens du Congo</i> [National Pharmacists Association of the Republic of Congo]
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

# 1. Introduction

## **The Republic of Congo's Interest in the Private Health Sector**

The private health sector was officially recognized in the Republic of Congo over 20 years ago in Decree 88/430 on June 6, 1988, establishing the conditions for the independent practice of medicine and the medical-related and pharmaceutical professions. The Congolese government recently expressed its commitment to working with the private health sector in order to strengthen the health system, improve the health of the population and preserve the basic human right to a healthy life through the National Health Care Policy, which it adopted in 2003, the 2007–2011 National Health Development Plan and the 2010 Health Care Services Development Program.

Throughout these various documents there is an acknowledgement that the lack of coordination with the private health sector is a weakness of the health system. Nevertheless, the scarcity of information about the private sector in policy and planning documents suggests that the government's engagement with the private health sector is limited. There is no official government policy on the private health sector, or strategies or working plans to encourage cooperation between the public and private sectors.

Very little information is available on the private health sector in the Republic of Congo, aside from a list of private providers<sup>1</sup> and some data extracted from the *Enquête démographique et de santé* (EDS) [Demographic and Health Care Survey]<sup>2</sup> and the *Enquête congolaise auprès des ménages* (ECOM) [Congolese Household Survey], both conducted in 2005. The health mapping exercise conducted in 2005<sup>3</sup> and the censuses conducted by the *Direction des services sanitaires* (DSS) [Department of Health Services] in Brazzaville and Pointe-Noire in 2009 and 2010 provided some basic information on the location and types of private providers in the major urban centers. However, there is no basic information on the private sector such as the type and quantity of services offered, human resources, number of beds and their occupancy rate, the typology of patients who use these health care services, the commercial practices of these providers, their interactions with other providers, or even what they consider to be their main challenges and opportunities. Regarding the demand for health care, the 2005 EDS and the 2005 ECOM provide some information on the use of the public sector compared to the private sector for certain types of care in urban and rural areas. However, these data have not yet been analyzed sufficiently to produce a clear picture of the role of the private health sector in terms of services provided to consumers. This lack of information pertains to both the for-profit and nonprofit health sectors, although the nonprofit sector can be considered public or semi-public. As a result, the purpose of this study is to fill in the gaps in our knowledge of this health care subsector.

As part of the Health in Africa Initiative, International Finance Corporation (IFC) and the World Bank funded an assessment of the private health sector in the Republic of Congo, at the request of the Ministry of Health and Population (MSP), in keeping with the strategic orientation of the private health sector of the 2010 *Programme de développement des services de santé* (PDSS) [Health System Development Project], supported by the Bank. The MSP conducted this study to gain a better understanding of the role played by the private health sector and to develop a plan of action and reform in order to better

integrate it into the health system and to develop public-private partnerships (PPPs). Three studies of this type were previously conducted (in Kenya, Ghana, and Mali) with support from the IFC. This assessment is part of a second wave of studies focusing on the Republic of Congo (the subject of this report) and Burkina Faso.

The objective of this assessment was to better determine the role, position, and importance of the private sector<sup>4</sup> within the health system, in order to identify the limitations to its development as well as ways it can be integrated into the efforts to meet the objectives of the *Plan national de développement sanitaire* (PNDS) [National Health Development Plan]. The World Bank Group contracted with the Results for Development Institute (R4D, United States) and Health Research for Action (HERA, Belgium) as well as with a team of local consultants, to conduct a “study of the private health sector in the Republic of Congo.” This study was conducted in close collaboration with the MSP, which arranged and oversaw a steering committee consisting of actors from the public and private sectors to facilitate and guide the study.

The objectives of the assessment were as follows:

- Determine the role that the private sector currently plays in the country’s health system
- Diagnose the nature and efficacy of the interface between the public and private sectors in the Republic of Congo, as well as the context in which the private sector is developing
- Make detailed recommendations on how to more effectively mobilize the private sector so that it can help meet national health objectives
- Promote dialogue among stakeholders in the public and private sectors by holding three mobilization workshops in order to agree on the policies and actions to be implemented to promote more effective involvement on the part of the private sector in attaining national health objectives.

The goal of the study and the workshops was a concrete plan of action for the health sector that could be used by the Congolese government, the private sector in the Republic of Congo, and international development partners. Certain aspects of the action plan should be included in the work programs of the PDSS for the years 2011–2013.

## Structure of this Report

This report is structured to meet the study objectives as follows:

- Description of the overall context in the Republic of Congo (chapter 1)
- Description of the specific context in which the private health sector is operating (chapter 2)
- Description of the methods used to gather and analyze the information from both a quantitative and qualitative point of view (chapter 3)
- Results of the study concerning (1) the demand for the services provided by the private health sector as compared to those provided by the public sector; (2) the private supply of health care services; (3) the institutional framework governing the private health sector, (chapter 4)
- Options for action 2011–2013 (chapter 5).

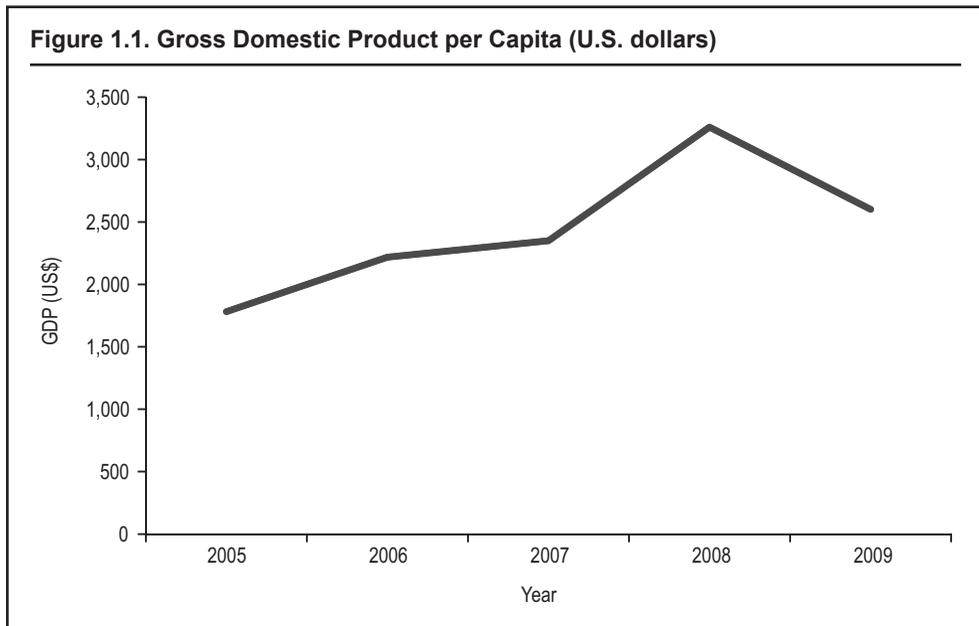
## The Congolese Context

### *The Socioeconomic Situation in the Republic of Congo*

The Republic of Congo has faced significant political instability and experienced many changes since gaining independence in 1960. The internal conflicts of the late 1990s destroyed most of the country's infrastructure, but there has been peace since 2000.

The Republic of Congo is a country rich in natural resources whose economy depends heavily on petroleum exports. Despite the abundance of these resources, it remains impoverished. Of the country's 3.7 million inhabitants, half live in urban areas (World Bank 2009), 54 percent live on less than US\$1 per day (indicators related to Millennium Development Goals of the United Nations, UN) (World Bank 2005). In 2006, the World Bank and the International Monetary Fund (IMF) ranked the Republic of Congo among the world's heavily indebted poor countries (CIA 2011).

Although the gross domestic product (GDP) per capita increased from US\$1,782 in 2005 to US\$2,601 in 2009 (figure 1.1), the poverty level and economic disparities result in unfavorable socioeconomic indicators. The country will have to overcome great challenges in order to meet the Millennium Development Goals by 2015, particularly in health.



Source : World Bank 2009.

### *The Private Sector in the Republic of Congo*

Before analyzing the role of the private sector in the health system, it is helpful to look at the state of the broader private sector in the Republic of Congo and the initiatives that have been taken to encourage increased participation from this sector in the economy (promotion of the private sector in the Republic of Congo). First we look at the general

environment for establishing a private business in the Republic of Congo, and then we provide an analysis of the initiatives designed to promote the private sector in the Republic of Congo.

### *Business Environment in Africa, 2011*

It is not easy to establish a private business in the Republic of Congo. According to the report *Doing Business 2011* (World Bank 2010), the Republic of Congo ranks 177th out of 183 countries with regard to ease of doing business, and the Republic of Congo's rank in 2011 remained unchanged from 2010. Moreover, it is below average among Sub-Saharan African countries (137th). Among countries in its subregion, only the Central African Republic (182nd place) is behind the Republic of Congo. The ease of doing business ranking takes nine areas into account (table 1.1). For all of these indicators, the Republic of Congo ranks, in the best of cases, 128th out of 183, except for "granting construction permits," for which it has distinguished itself by ranking 83rd. These nine areas are all important for commercial activity in the health sector, even "international trade," to the extent that patients travel in either direction between Brazzaville and Kinshasa (the Democratic Republic of Congo) to receive treatment.

**Table 1.1. Ease of Doing Business in the Republic of Congo**

Indicators	The Republic of Congo's rank among 183 countries
Creating businesses	176
Granting construction permits	83
Transfer of property	133
Obtaining loans	138
Investor protection	154
Payment of taxes	180
International trade	180
Enforcing contracts	158
Closing a business	128
OVERALL RANK	177

Source: World Bank 2010.

### *Promotion of the Private Sector in the Republic of Congo*

Several recent initiatives confirm the government's desire to promote the private sector in the Republic of Congo. These include, among others:

- The creation, in 2008, of the General Directorate for the Promotion of the Private Sector within the Ministry of Industrial Development and Promotion of the Private Sector
- The imminent creation of a High Council for Public-Private Dialogue
- The implementation of the ACP Business Climate Facility program, which is funded by the European Union.

The mission of the *Ministère du développement industriel et de la promotion du secteur privé* (MDIPSP) [Ministry of Industrial Development and Promotion of the Private Sec-

tor] is to promote the growth, development, and interests of the private sector. Within the MDIPSP, the *Direction générale de la promotion du secteur privé* [General Directorate for the Promotion of the Private Sector]<sup>5</sup> is responsible for ensuring the application of the government's policy on promoting private investment and for coordinating activities to promote the private sector, among other duties.

Since this General Directorate was created in 2008, no specific measures have been taken to promote the development of the private health sector. Indeed, the MDIPSP has emphasized the traditional economic sectors such as petroleum, timber, and agriculture.

A High Council for Public-Private Dialogue will be created in the near future. Placed under the authority of the President of the Republic, this High Council will be responsible for the following, among other tasks:

- Taking into account the instructions of the President of the Republic for improving the business climate and defining the terms of implementing these instructions
- Discussing issues that hinder or promote the development of the private sector
- Reviewing proposals, recommendations, and deliberations pertaining to the public-private dialogue
- Monitoring the application of measures taken and assessing their impact on the private sector.

The ministries that address social issues, including the Ministry of Health, are not part of the High Council.

The general objective of the 2009 ACP Business Climate Facility program (a plan to foster cooperation between the government and the European Union in partnership with the World Bank, the African Development Bank and the French Development Agency) is to improve the business climate in the Republic of Congo, to make it less restrictive and more attractive for private investment while establishing a framework that is favorable to developing entrepreneurship and establishing businesses. The components of the program include the following:

- Facilitating the establishment of a public-private dialogue in order to improve the business climate
- Simplifying and reducing taxes and tax-related levies and combining them with a corporate tax system that is more oriented toward growing the private sector
- Structuring the institutional support system to foster the development of the private sector
- Improving the legal environment for businesses
- Developing financial and non-financial support systems for small and medium-sized businesses (SMEs) to improve access to credit
- Promoting access to the market for SMEs
- Adapting professional training to the needs of businesses
- Raising awareness in the government regarding the realities of the private sector
- Promoting entrepreneurship
- Facilitating the establishment of export businesses and defining industrial areas and customs-free areas.

## Health Care Environment

To identify the role of the private sector within the health sector in the Republic of Congo, we first reviewed the key policy documents that define the structure of the health sector, focusing on the sections that address the role of the private sector. We then reviewed the health situation in the Republic of Congo based on the country's performance on selected health-related Millennium Development Goals, compared to other countries in the region and to other middle-income countries. In addition, we reviewed health expenditure data, once again comparing the Republic of Congo to other countries in the region and to countries in the same income category, and comparing the share of the government expenditure on health care to that of the private sector.

### *Strategic Framework for the National Policy on the Private Health Sector*

The strategic framework for health care policy consists of three documents:

- The National Health Policy adopted by the Council of Ministers in 2003, which outlines the major strategic direction for the health sector
- The National Health Development Plan (PNDS), a five-year plan that translates the objectives of the health sector into specific programs for the 2007–2011 period
- The Health System Development Project (PDSS), a four-year sectoral program funded by the World Bank that aims to improve the health system.

#### NATIONAL HEALTH POLICY

According to the vision expressed in the National Health Policy (2003), “the protection and promotion of health is a basic human right.” This policy aims to improve the state of health of the population in order to promote its participation in the country's socioeconomic development. This goal will become a reality if three general objectives are met. These objectives include:

- To promote and protect the health of individuals and communities throughout the country
- To ensure that the population has access to quality health care and services
- To improve the country's ability to manage the health system.

The National Health Policy articulates the following strategic priorities: (a) Promotion and protection of health, (b) Guarantee of access to health services, (c) Integration of activities, (d) *Promotion of the private sector*, (e) Improvement of the ability to manage the health system, (f) Decentralization of the health system, (g) Streamlining of activities and the use of resources, and finally (h) Participation of communities and individuals.

There are four main guidelines for the implementation of the national policy:

- The Ministry of Health and Population is responsible for the technical and administrative implementation of the National Health Policy under the three-way oversight of executive and legislative authorities and representatives of civil society.
- The government must restructure its organizational and administrative operations in order to mobilize and optimize the use of resources, in an effort to improve the management of the health system.

- The government must ensure, through its regulatory powers and as a guarantor of its citizens' health, the conditions for healthy competition and the harmonious development of the national health system.
- The government is seeking greater cost-effectiveness in the national health system, based on the resources available and priorities identified.

#### 2007–2011 NATIONAL HEALTH DEVELOPMENT PLAN (PNDS)

A program-based approach is used to implement the National Health Policy, and specifically the National Health Development Plan (PNDS). The 2007–2011 PNDS “is part of the efforts to achieve the Millennium Development Goals and the objectives of the ‘*Nouvelle espérance (2002–2009)*’ and the ‘*Chemin d’avenir (2009–2016)*’ programs, social projects pursued by His Excellency Denis Sassou Nguesso, President of the Republic, Head of State and Government,” and specifically aims to:

- Improve the health system, especially in the *circonscriptions socio-sanitaires* (health districts)
- Develop human resources for health
- Establish an operational national health information system
- Ensure, by establishing the *Congolaise de médicaments essentiels génériques* (COMEG) [Congolesse Agency for Essential Generic Medications], access to essential generic medicines throughout the country
- Establish a policy and sustainable systems for funding health care.

The specific objectives of the PNDS include the following:

- Improving the ability to manage the health system at all levels
- Increasing national health coverage by streamlining the *centres de santé intégrés* [integrated health care clinics] and referral hospitals, and increasing the involvement of the health care services of the Congolese Armed Forces and the *private sector*, in order to cover at least 80 percent of the population
- Improving the quality of care and services provided at the *Centres de santé intégrés* and in hospitals by implementing quality assurance programs and developing clinical departments and specialized support
- Integrating the operational components of special programs by establishing guidelines and decentralizing resources
- Boosting the participation of the population in managing its own health and the operation of the health system by improving the systems and mechanisms for participation
- Strengthening partnerships through bilateral and multilateral cooperation and collaboration with related sectors and civil society.

Implementation of the PNDS is expected to impact the private health sector in the following ways:

- The legal framework for implementing the PNDS will be improved by legislation pertaining to the organization and operation of the health system, the application of national policies, the hygiene code, health care financing, *the contribution of the private sector to available health care*, hospital reform, and the development of human resources for health.

- The private sector will be better organized and will participate in the implementation of the PNDS.
- Organizational, equipment and operational standards for *health facilities*, both public and *private*, for outpatient care and hospitalization will be published.

Although the PNDS mentions the *important role of the private sector* alongside the public sector, the above are the only three references to the private sector, among 25 expected impacts. Further, only one of these impacts pertains to *the private sector* on the whole, without making a distinction between the for-profit and nonprofit sectors. The plan does not outline the actions required and the resources available to achieve these specific results, although it does confirm that it would be helpful to establish partnerships. The scarcity of information available on *the private sector* (with regard to both for-profit and nonprofit organizations) is significant and suggests that the MSP has not yet taken concrete action towards collaborating with the private sector.

PROGRAMME DE DÉVELOPPEMENT DES SERVICES DE SANTÉ (PDSS) [HEALTH SYSTEM DEVELOPMENT PROJECT]

The PDSS was instituted by the MSP in partnership with the World Bank, in accordance with Decree 2008–25 of December 31, 2008. It is part of the implementation of the PNDS and the objectives of the Interim Poverty Reduction Strategy and is helping to achieve the corresponding Millennium Development Goals. In 2008, the World Bank approved a subsidy from the International Development Association of US\$40 million over a period of four years for the PDSS.

The objective of the PDSS is “to help improve the health care system to effectively fight the main communicable diseases and improve access to quality services for women, children and other vulnerable groups.” In particular it emphasizes the lack of mobilization on the part of other sectors, such as *the private sector*, little coordination among the involved parties, such as external partners, and a lack of cooperation between sectors.

The PDSS has four components. The first is to build the leadership capabilities necessary to manage an effective health care system, at all levels and as part of the government decentralization program, particularly with regard to monitoring and evaluation. The second component of the program is to design and establish an effective, efficient system for managing human resources for health. The third component pertains to the renovation and equipping of health facilities, and the fourth component is to improve access to a set of high-quality essential health care services (World Bank 2008).

### **Health Situation**

The PNDS is part of an effort to attain the MDGs established by the United Nations. The Republic of Congo’s current performance on the three health-related MDGs, compared to that of its regional neighbors in Sub-Saharan Africa and other middle-income countries, is presented in table 1.2.

In general, the Republic of Congo has produced results that are just barely better (and sometimes worse) than those of its neighbors in Sub-Saharan Africa, and always lower than those of other middle-income countries. For most of the indicators in question, the Republic of Congo will not achieve the MDGs in 2015. Although the country

**Table 1.2. Health Indicators Related to the MDGs**

	Congo, Rep. of	Sub-Saharan Africa	Middle-income countries
<b>MDG 4: Reduce Child Mortality</b>			
Percentage of measles vaccine coverage	79	76	86
Mortality rate in children under 5 years of age per 1,000 live births	127	120	52
Neonatal mortality rate per 1,000 live births	80	76	39
<b>MDG 5: Improve Maternal Health</b>			
Maternal mortality rate per 100,000 live births	740	832	319
Prevalence of contraception	44	25	59
Percentage of prenatal care coverage: at least one visit	86	81	93
<b>MDG 6: Fight HIV/AIDS, Malaria and Other Diseases</b>			
Prevalence of HIV among adults ages 15 and above per 100,000 inhabitants	3	6	2
Percentage of antiretroviral therapy coverage among persons at an advanced stage of HIV infection	33	49	46
Mortality rate due to malaria per 100,000 inhabitants	116	2,763	1,183
Prevalence of tuberculosis per 100,000 inhabitants	390	352	150

Sources: World Bank 2009; UNICEF 2005; UNAIDS 2010; World Health Organization 2011a; World Health Organization 2010.

has a relative wealth of resources, with a small, moderately urbanized population, these disappointing results can be explained by the poor performance of the public health system, which is exacerbated by widespread poverty and the destruction of infrastructure during the civil war.

The Republic of Congo's health indicators related to the health MDGs are below average among middle-income countries. It has had better results than most Sub-Saharan African countries for all indicators pertaining to maternal health; however, the infant mortality rate and the prevalence of HIV/AIDS and tuberculosis are higher than those of its neighbors.

The Congolese government is aware that its unfavorable health indicators are related to the poor performance of the health system. It explains in the National Progress Report on Reaching the Millennium Development Goals that:

*“Despite efforts made by the government to build and renovate health clinics, make low-cost drugs available, provide complete care for certain categories of the population such as children under the age of 15 for malaria and pregnant women, distribute free insecticide-treated mosquito nets and provide free access to antiretroviral drugs for AIDS patients, progress has been almost insignificant. The very poor performance of the health care system—despite the government's efforts to improve its efficacy—and the low quality of services have undermined the efforts made. We need to think carefully about the Congolese health care system.”*

## Human Resources

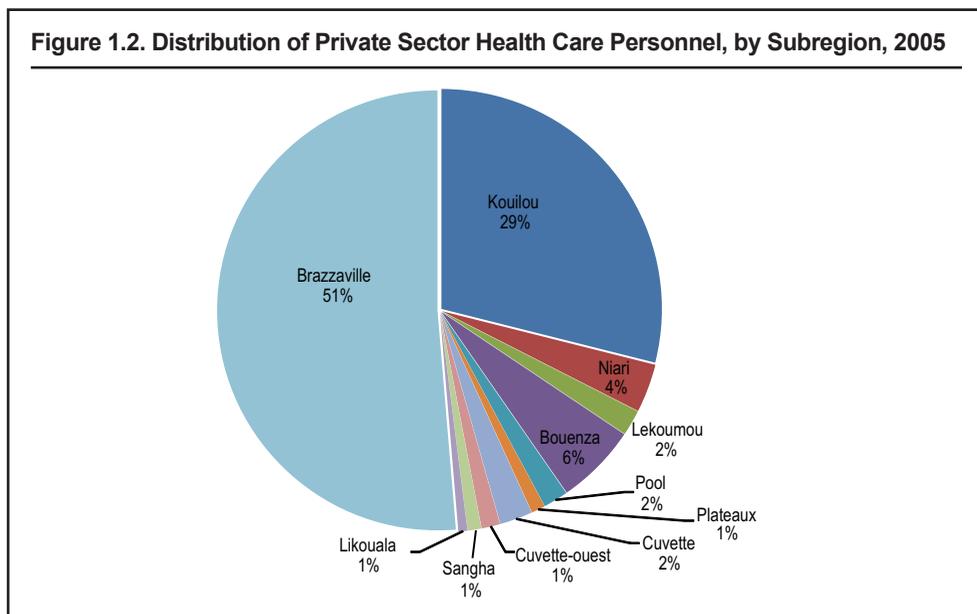
Human resources are a significant component of the health system. Unfortunately, very little reliable data exist on this topic in the Republic of Congo. The MSP does not have reliable data, at any level, on human resources in the health care system (central, intermediate or peripheral), either for the public sector or the private sector. The data presented below must therefore be interpreted with caution.

According to the MSP, in 2005 the country had approximately 10,899 health workers, all categories combined, distributed between the public sector (73.9 percent) and the private sector (26.1 percent). This ratio hides enormous disparities between the country's subregions, and particularly between rural and urban areas.

The total staff under the MSP, all categories combined, rose from 8,050 in 2005 to 10,376 workers in 2006, which is an increase of 22.4 percent. This development, following the recent civil service recruiting campaign, did not cover all of the need, as several health facilities remain closed due to lack of staff.

In 2005, 2,849 health workers were working exclusively in the private health sector throughout the country, 1,766 of them male workers (61.9 percent) and 1,083 (39.1 percent) of them female.<sup>6</sup> Moreover it is important to point out that many workers in the public sector also work part-time in the private sector. This phenomenon could not be quantified.

Following the example of the public sector, the private sector is characterized by an unequal distribution of health care personnel over the national territory. Indeed, Brazzaville alone has 1,464 private health workers, which is 51.2 percent of the total. This is more than half of the private sector personnel, while the city accounts for only 33 percent of the country's population (CNSEE ECOM 2005). Including the personnel in the subregion of Kouilou, where Pointe-Noire is located, which has 825 staff, or 29 percent of the total, we see that only one private sector worker in five works in one of the eight other subregions (figure 1.2).

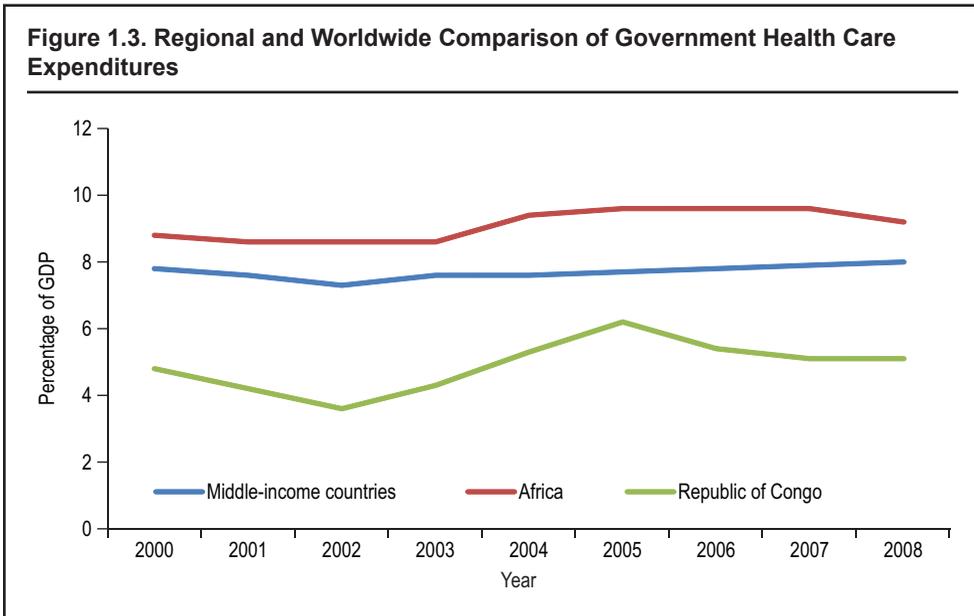


Source: Ministry of Health and Population of the Republic of Congo 2005.

### Health Care Expenditures

According to the national health care expenditure records published by the World Health Organization,<sup>7</sup> the total health care expenditures in 2008 accounted for 1.8 percent of GDP. Public health care expenditures represented 5.1 percent of national public expenditures in 2008.

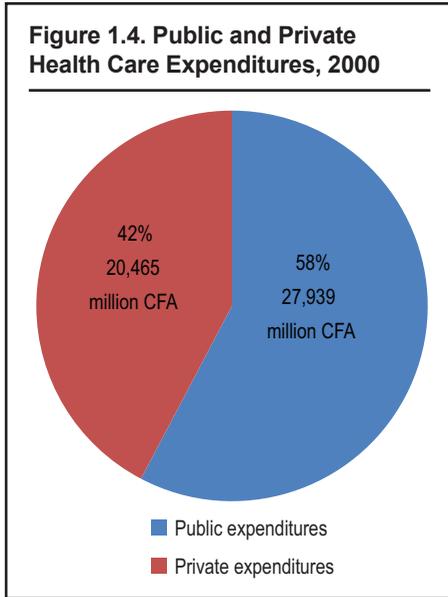
Figure 1.3 shows the percentage of expenditures made by public administrations on health care as a portion of the government's total expenditures, in comparison to the African average and the average of middle-income countries. In relative terms, the percentage of public health care expenditures as a portion of the government's total expenditures is significantly below the African average.



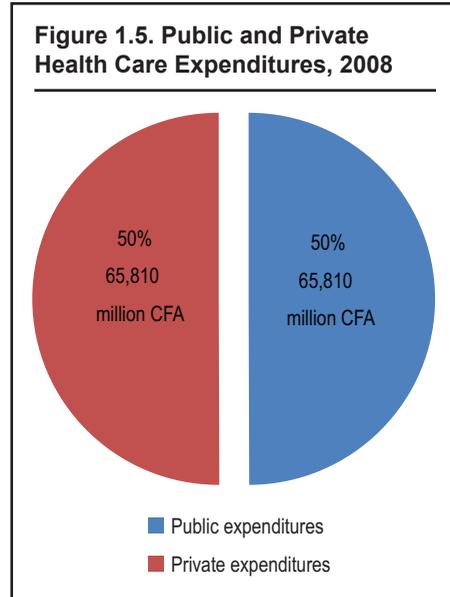
Source : World Health Organization 2011b.

Figures 1.4 and 1.5 show the changes in the Republic of Congo's public and private expenditures as a portion of the total health care expenditures between 2000 and 2008. It is clear that the relative portion of public expenditures decreased during this period, even as they increased in absolute value, and that the relative portion and the amount of private expenditures, on the other hand, increased.

In 2008, the expenditures of public health administrations accounted for 50 percent of total health care expenditures. The remaining 50 percent consisted of private expenditures, which were, at the time of the WHO analysis, incurred entirely by households.

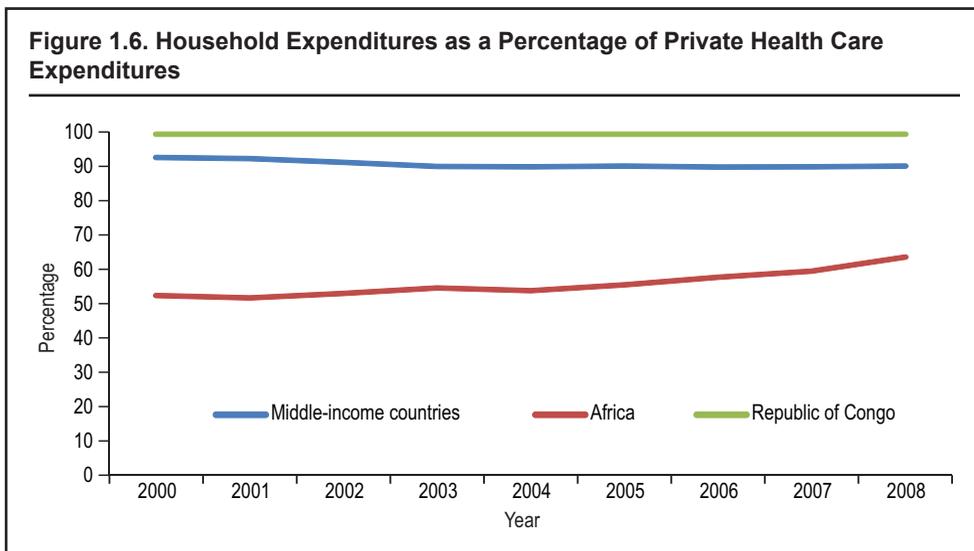


Source : World Health Organization 2011b.



Source : World Health Organization 2011b.

The percentage of private health care expenditures that are made directly by households is high in the Republic of Congo (see figure 1.6 for a comparison with the average among African countries and middle-income countries). This indicates that there are very few demand-side funding mechanisms (such as health insurance) and that health care expenditures can be a heavy burden on families.



Sources: Ministry of Planning, Land Use and Economic Integration of the Republic of Congo 2006; World Health Organization 2011b.

## Summary and Conclusions

The analysis of the Congolese context and the role played by the private health sector revealed the following:

- The role of the private sector in health has been officially recognized by the Congolese government only since 1988. Recent plans and strategies for this sector indicate a desire for collaboration between the public and private sectors. However, very little information is available about the role that the private sector plays in the health sector.
- The Republic of Congo has experienced multiple periods of political instability since it gained independence. Since 2000, however, the country has been peaceful.
- Although the Republic of Congo has a wealth of natural resources, a significant percentage of its population continues to live in poverty.
- The Republic of Congo is trying to remedy its currently unfavorable business climate by launching several initiatives to create more favorable conditions for the private sector. Nevertheless, the health sector is not included to any significant extent in these initiatives.
- The private sector, including the nonprofit private sector, is not considered to be an actor or partner in implementing the National Health Policy and National Health Development Plan. The Ministry of Health recently expressed a desire (in the PDSS) to partner with the private sector as an important participant.
- There are very few official relationships between the public and private health sectors. Those that do exist are limited to tax issues and regulations, and the authorization process for allowing private providers to practice.
- The Republic of Congo's health indicators are not much better than those of poorer Sub-Saharan African countries and they are poorer than the indicators of other middle-income countries.
- The Republic of Congo spends a lower percentage of its income on health care than other Sub-Saharan African countries and middle-income countries. Approximately half of all health care expenditures come from households.

## 2. Description of the Congolese Health Care System and Its Private Component

### Introduction

This chapter describes the structure of the public and private health sectors, as well as the scope of their involvement. It also describes the specific conditions facing private businesses and organizations in the health care industry with regard to the legal structure that governs private health care activities, the role of the national orders, how the private health sector is organized, and the taxes that must be paid by actors in the private sector.

## Structure of the Health Care System

The health care sector in the Republic of Congo consists of facilities in the public sector, the private sector and government-supported facilities, as listed below:

- The public sector, including the regulatory and management bodies and facilities under the supervision of the MSP and the Ministry of Technical and Professional Training and Higher Education
- The private sector, consisting of private nonprofits (faith-based charities and various nongovernmental organizations) and for-profit facilities
- Parastatal or quasi-governmental agencies such as the *Congolaise des médicaments essentiels et génériques* (COMEG) [Congolese Agency for Essential Generic Medications].

The public health system in the Republic of Congo operates at the following three operational levels:

- *The central level.* Directed by the MSP, it plays a strategic and regulatory role in the planning, evaluation, coordination, and allocation of resources for health. The MSP focuses primarily on health services rendered by the public sector, but it also plays a governing role by regulating the private sector. The central level includes the MSP cabinet, the related departments (research and planning, cooperation), the health inspectorate, and two departments (health and population). It also includes third-level referral institutions (university hospitals, National Public Health Laboratory, National Center for Blood Transfusions).
- *The intermediate level.* This level includes the *Directions départementales de la santé* (DDSs) [Regional Health Care Departments]. Each DDS consists of the following subdepartments: health activities, research, planning and training, administration, finance, personnel, and equipment. The intermediate level also includes the general hospitals and second-referral hospitals, which are referral institutions for standard hospitals. The DDSs provide technical support to the *Circonscriptions socio-sanitaires* (CSS) [Health Districts] in transmitting information, adapting specific national standards to local conditions, applying the standards and supervising the managerial teams of the CSSs.
- *The primary level.* This level consists of the CSSs, which are each comprised of a health facility network that includes integrated health care clinics, offices and health clinics supported by a general hospital or a referral hospital.

Most private providers operate at the primary level within the health system. They offer outpatient care, which is supplemented by a secondary level of hospitals that are primarily managed by faith-based organizations. (See the section entitled “Structure of the Private Health Sector” below for further details.)

Two departments that fall under the *Direction générale de la santé* (DGS) [General Health Care Department] of the MSP supervise the private health sector: the DSS [Department of Health Services] and the *Direction des pharmacies, des laboratoires et du médicament* (DPHLM) [Department of Pharmacies, Laboratories and Medicines]. These two departments are responsible for developing standards and guidelines for the public and private sectors, for supervising the implementation of guidelines, and for verifying and managing applications submitted by private providers for provisional and final autho-

rization to practice. The supervisory and monitoring tasks are delegated to the DDSs. The departments of the DDSs also conduct supervisory visits to private facilities and, in theory, are supposed to report on the activities of all providers, both public and private, to the national health information system maintained by the DGS.

The regulatory authority within the MSP, specific to each group of providers, is listed in table 2.1.<sup>8</sup>

**Table 2.1. Regulatory Authority, by Type of Private Provider**

Provider type <sup>a</sup>	Regulatory authority
Private providers	<i>Direction des services sanitaires</i> [Department of Health Services]
Medical analysis laboratories	<i>Direction des pharmacies, des laboratoires et du médicament</i> [Department of Pharmacies, Laboratories and Medicines]
Medical imaging centers	<i>Direction des pharmacies, des laboratoires et du médicament</i> [Department of Pharmacies, Laboratories and Medicines]
Wholesalers	<i>Direction des pharmacies, des laboratoires et du médicament</i> [Department of Pharmacies, Laboratories and Medicines]
Pharmacies	<i>Direction des pharmacies, des laboratoires et du médicament</i> [Department of Pharmacies, Laboratories and Medicines]
Traditional practitioners	<i>Service de la médecine traditionnelle</i> [Department of Traditional Medicine], <i>Direction des services sanitaires</i> [Department of Health Services]

Source: Authors.

Note: a. The different types of private providers that were reviewed in this study.

Under the General Health Inspectorate, two departments [the *Inspection des pharmacies et laboratoires* (Pharmacies and Laboratories Inspectorate) and the *Inspection des formations sanitaires publiques et privées* (Public and Private Health Facility Inspectorate)] are responsible for regularly inspecting and monitoring private health care facilities, the former for pharmacies and laboratories, and the latter for public and private health facilities.

## Structure of the Private Health Sector

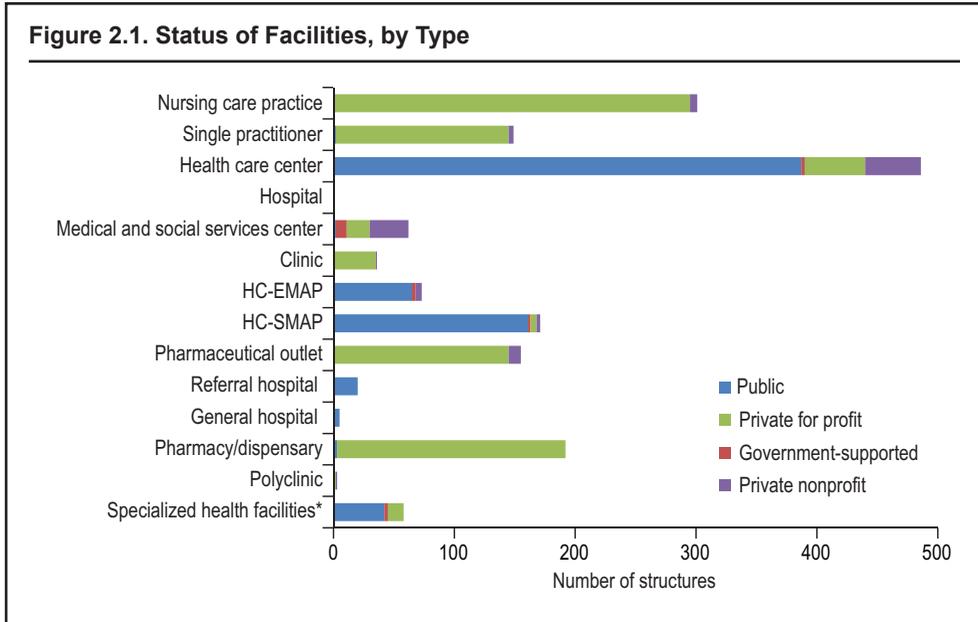
Following the country's independence in 1960, the government conducted large-scale nationalization, and it was not until 1990–1992 that the private sector began to reemerge. The private sector consists of nonprofit facilities [nongovernmental organizations (NGOs) and faith-based organizations] and for-profit facilities.<sup>9</sup>

The 2005 health mapping exercise documented a total of 1,712 facilities distributed throughout the country. Figure 2.1 shows the type of facilities by sector. Most of these facilities are private (59 percent), the vast majority are for-profit (88 percent) and located in urban and semi-urban areas (90 percent). Figures 2.2 and 2.3 show the configuration of facilities in the Republic of Congo.

The censuses of private facilities in Brazzaville and Pointe-Noire conducted in 2010 by the DDSs of Brazzaville and Pointe-Noire, respectively, documented 191 private facilities in Brazzaville and 326 private facilities in Pointe-Noire.

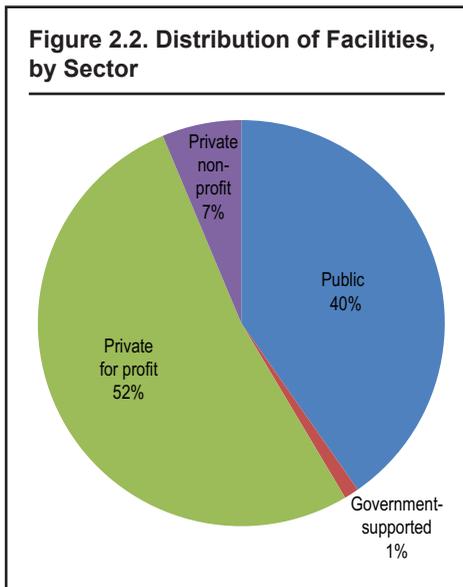
### *Private Educational Institutions*

According to Decree 99-281 from December 31, 1999, which was a revision of Decree 96-221 from May 13, 1996, which established regulations for private education, public

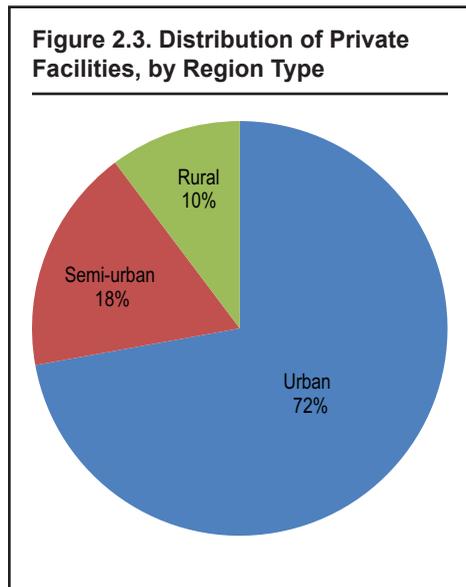


Source: Ministry of Health and Population of the Republic of Congo 2005.

Note: Specialized health facilities include outpatient treatment services, anonymous volunteer screening, tuberculosis treatment, blood transfusions, and the national laboratory



Source: Ministry of Health and Population of the Republic of Congo 2005.



Source: Ministry of Health and Population of the Republic of Congo, 2005.

health training cannot be provided in private educational institutions. Consequently, the private sector (for-profit and nonprofit) cannot open or manage schools in the health care field. This exclusion is unique to the Republic of Congo—no other country in the Central African region has the same prohibition. Only one authorized private school association exists in the Republic of Congo, a trade school that trains students for jobs such as pharmacist’s assistant or salesperson in a pharmacy.

On the national level, health care training programs do not provide training for all of the health care professions that are needed in the system. No strategic training plan exists. Moreover, no policy aiming to promote access to continuing education for personnel in the private sector has been established.

### *Legal Framework for Private Providers*

Private medical practice is permitted under certain conditions in the Republic of Congo. A brief analysis of the legal framework and legislation pertaining to the private sector is presented in appendix E. The main decrees include the following:

- Decree 88/430 from June 6, 1988, on the deregulation of medicine and the medical-related and pharmaceutical professions. This decree has made possible the establishment of offices, clinics, pharmaceutical facilities (dispensaries, wholesalers/distributors), biomedical analysis laboratories, and traditional medical facilities as private for-profit, nonprofit or government-assisted facilities. In addition, the decree has facilitated the establishment of *centres médico-sociaux* (CMS) [medical and social services centers] in businesses, both public and private.
- According to the provisions of Decree 2232/MSAS/DGSP from June 5, 1991, stipulating the conditions of establishing and opening private health facilities, the private-sector practice of medical and medical-related professions is reserved only for Congolese nationals.
- Decree 2232/MSAS/DGS from June 5, 1991, sets forth the conditions for establishing and opening private outpatient facilities.
- CIRCULATED MEMORANDUM NO. 869/MSP/DGS/DSS from September 30, 2002, regulates the medical practice of traditional practitioners, faith-based organizations, not-for-profit organizations, and NGOs offering traditional medicine.

### *Authorization to Practice*

All health care providers must obtain formal authorization granted by the MSP and by the *Centre de formalité des entreprises* (CFE) [Business Registration Center] in order to practice privately.

#### PROCEDURE FOR THE MINISTRY OF HEALTH (MSP)

The MSP, through the DDS, receives and evaluates applications to open or establish private facilities and sends them to the central level for a decision. This procedure is completed in two phases: provisional and final. These steps are mandatory for the private practice, traditional practitioners, faith-based organizations, associations, NGOs, and the pharmaceutical sector. Provisional authorization is valid for one year, with the possibility of renewal by the Ministry for one additional year. The process and the procedures are described in appendix F.

To summarize, the process consists of the following steps:

- Verification of the essential conditions, particularly with regard to university training, qualifications (for example, three years of experience) and legal formalities (being a member of the appropriate professional order)
- Handwritten request accompanied by the administrative documents related to the owner's administrative file, the technical file of the facility and a detailed statement from the personnel (see the list in appendix E), which must be approved by the DDS and then sent to the MSP (DGS) by registered mail with delivery confirmation. The application must be accompanied by a receipt of payment of the fees for opening a facility (also known as "review fees") issued by the Public Treasurer and allocated to the DGS (see the list of fee amounts by type of private institution in appendix F; the rates range from 200,000 CFA francs for a nursing practice, to 500,000 CFA francs for a medical and social services center, to 700,000 CFA francs for a health facility "intended for use as a hospital").

Once the MSP reviews the validity of the diplomas and confirms the information provided in the application, and once the required application review fees have been paid, provisional authorization to practice is granted for one year (signed by the MSP).

Before this period expires, in order to obtain final authorization, the applicant resubmits a handwritten request and supplements the application with the following information:

- Certification of fulfillment of the obligations with respect to the Ministries of Trade, Labor, Social Insurance, and Justice
- Certification of declaration to the direct taxation departments
- Personnel file certified as valid by the DDS
- Insurance certificate for the premises and for occupational hazards.

Once all of the administrative information has been gathered, final authorization is issued by the MSP, subject to the conditions of a visit to verify that the facilities comply with current standards and to verify the information and conditions based on which authorization was granted. This visit is conducted by the DG (or by the DDS for remote facilities), which reports to the Minister, and informs the applicant, when applicable, of any changes that need to be made. Final authorization is pronounced by ministerial decree and notice is sent to the applicant via registered mail.

More specifically, with regard to faith-based organizations, not-for-profit organizations and NGOs, the procedure requires additional information. In order to obtain provisional authorization, the application must be supplemented with a statement of approval from the faith-based organization, not-for-profit organization, or NGO and with a copy of the bylaws and rules of procedure. Final authorization is also issued by the MSP, following a detailed report from the DG.

Chapter 4 describes the authorization status situation for the groups of health care providers surveyed in this study.

#### PROCEDURE WITH THE CENTRE DE FORMALITÉ DES BUSINESSSES (CFE) [BUSINESS REGISTRATION CENTER]

The CFE is a public service created by Decree 94-568 from October 10, 1994, amended by Decree 95-183 from October 18, 1995. It falls under the authority of the Ministry of SMEs responsible for artisans. The CFE has the following duties:

- To observe the business climate and identify all complex systems, procedures and formalities that prevent the Congolese people from creating, modifying or ceasing a business activity, in order to simplify and reduce the time and costs necessary to do so; and
- To receive all declarations related to creating, transferring, extending, modifying, and ceasing a business activity at a single location (one office), with a single document and a single payment, in less than one hour.

The procedures (application for authorization to practice the profession of business owner for individuals or for entities, as well as the *carte professionnelle de commerçant* [professional business license]) and the registration fees are described in appendix G. The registration of the business, any modifications (such as an extension, change of location), or temporary, partial, or complete suspension of business activities must be declared to the CFE. This is done by filling out the single form (available at the single office for the district) and by submitting the supporting legal documents (appendix G) as well as paying the registration fees. The fees for creating an individual business are 110,000 CFA francs, 280,000 CFA francs for creating a company, and 160,000 CFA francs for changing business activities. The authorization fees for a foreign business are 3,000,000 CFA francs.

### *National Orders*

The three national orders of physicians, pharmacists, and midwives theoretically include every member of their respective professions qualified to practice in the Republic of Congo. They all hold the status of a legal entity and “uphold the principles of morality, integrity, devotion, and skills that are necessary to practice their professions, as well as the fulfillment, by all of their members, of professional responsibilities and the regulations set forth by the code of ethics.”

The code of ethics that addresses professional morality and the ethics that must be observed by health care personnel (Section 2, Law 009/88 of May 23, 1988, Code of Ethics) lays the groundwork for creating the national orders of health care professions. The primary function of the national orders is to ensure that ethical standards are upheld by all physicians and pharmacists. They ensure that the honor and independence of their respective professions are protected and that their responsibilities are fulfilled. However, they cannot claim to defend the financial interests of their members, as that is the exclusive domain of the unions. The order of physicians has no latitude to authorize the opening of a medical facility and does not play any regulatory or inspection role in the private practice of medicine.

The bodies of the various professional health care orders are established through elections held at general membership meetings convened for this purpose. The Minister of Health convenes the general constituent membership meetings. The orders gain members through voluntary membership registration and are funded by member dues.

### STRUCTURING OF ASSOCIATIONS IN THE PRIVATE HEALTH SECTOR

A few subgroups of professionals or types of health care providers have organized collectives to represent their interests.

The pharmaceutical sector has an active, well-respected *Ordre national des pharmaciens du Congo* (ONP) [National Order of Pharmacists] and two active unions: the *Syn-*

*dicat national de pharmaciens du Congo* (SYNAPHAC) [National Pharmacists Association of the Republic of Congo] and the *Association des pharmaciens du Congo* (ASPHAC<sup>10</sup>) [Association of Pharmacists of the Republic of Congo]. The situation for physicians is different. There is a National Order of Physicians but no union, except for a group that represents certain faith-based health care providers, *Action medico-sociale catholique du Congo* [Catholic Medical and Social Initiative of the Republic of Congo]. With regard to traditional providers, several recent initiatives aim to structure this sector more effectively, including the pending establishment of the *Fédération nationale des tradithérapeutes* [National Federation of Traditional practitioners] (three subregional federations have already been created), the development of a draft national policy on traditional medicine, and a national plan for the development of traditional medicine.

### **Taxes**

Private health care institutions, including faith-based organizations, are treated as commercial entities. They are therefore subject to taxes. On the other hand, certain facilities with social and health-related missions are exempt from paying taxes (such as the value added tax) according to agreements signed with the Ministry of Health. The list of traditional taxes includes, among others, the following (non-exhaustive list):

- Ministry of Trade (annual taxes, see below)
- Ministry of Finance (taxes and customs duties)
- Ministry of Labor (*Office national de l'emploi et de la main d'œuvre* (ONEMO) [National Labor and Employment Office], *Centre national de sécurité sociale* [National Social Insurance Center], social insurance contributions of 24.8 percent.

In order for a private facility to begin conducting activities, it must pay certain one-time taxes at the beginning of the process:

- 60,000 CFA francs to the CFE for business declaration fees, registration fees and affiliation with the Chamber of Commerce
- 70,000 CFA francs to the DDS for fees to authorize the opening of a facility
- 80,000 CFA francs to the subregional department of the Order of Physicians to register the owner with the Order of Physicians
- 10,000 CFA francs to the *Inspection divisionnaire des impôts* [Division Tax Inspectorate] to obtain a tax identification number
- A sum (that varies according to the size of the business) to register it with the ONEMO [National Employment and Labor Office].

Annual taxes include:

- Real estate tax (the amount depends on the value of the building)
- Business license (the amount depends on the estimated value of the business activities)
- Noncommercial profit (the amount depends on the annual profits achieved)
- Regional and municipal taxes.

Monthly taxes include the following:

- Salary tax
- Social insurance fund (12 percent of salaries, capped at 1,200,000 CFA francs per month; the majority being paid by the employer)

- ONEMO fees
- Fees of the *Société de promotion et de gestion immobilière* [Real Estate Promotion and Management Society] (2 percent of the total payroll)
- *Fonds national de l'habitat* [National Housing Fund] (1 percent of gross employee compensation).

For wholesalers who import medications or pharmaceutical products, customs and import duties are as follows:

- Common external tariff, or in other words, customs duties (5 percent)
- Community integration tax (1 percent)
- IT charge (2 percent)
- Common integration contribution (0.4 percent)
- Tax collector's fee (0.1 percent).

An exhaustive list of the taxes that must be paid by a private facility is provided in appendix G.

## Summary and Conclusions

The key findings about the health care system in the Republic of Congo and the role played by the private sector include the following:

- The Republic of Congo has a traditional pyramid structure for its State-provided health care services, including hospital and outpatient care institutions, with the Ministry of Health, the university hospital and the national laboratory at the top of the pyramid.
- The Ministry of Health works through the DDSs to oversee all providers. The *Direction des pharmacies, des laboratoires et du médicament* [Department of Pharmacies, Laboratories and Medicines] supervises the private pharmacies, laboratories and medical imaging centers. The *Direction des services sanitaires* [Department of Health Services] supervises the private providers and includes a department that specifically handles traditional providers.
- Private actors focus on the provision of primary care, pharmaceutical products, and second-level hospitalization. In 2005, 59 percent of the country's 1,712 facilities were private, the vast majority of which were for-profit (88 percent) and located in urban and semi-urban areas (90 percent).
- Data on the human resources for health situation in both the public and the private sectors are not reliable. There is a concentration of human resources in urban areas. The phenomenon of "moonlighting," or practicing simultaneously in the public and the private sectors, is very wide spread, but it has not been quantified.
- The private sector is not permitted to provide training in the health care professions. There is no strategic plan for developing human resources in the sector.
- A few laws exist that define the role of the private health sector, and there is a complex series of administrative procedures required to open private facilities.
- Private health providers are treated the same as private businesses from other sectors and they are therefore subject to the administrative procedures and tax

obligations required by the Ministry of Trade's CFE, plus customs duties and social insurance contributions for employees.

- Private providers are not well organized into professional associations. Their organization is generally limited to belonging to the national orders for the different health care professions. With the exception of pharmacists, most private providers have no group to represent their interests.

### 3. Methodology and Limitations of the Study

The study methodology included the following components:

- An analysis of the institutional framework (document review and key informant interviews)
- A multidimensional analysis of the supply (analysis of existing data, collection and analysis of quantitative and qualitative data from sample populations of sector participants, interactive interviews and focus groups)
- A multidimensional analysis of the demand (analysis of quantitative data from the 2005 EDS and the 2005 ECOM of the Republic of Congo and focus group discussions).

#### **Analysis of the Institutional Framework**

The analysis of the institutional framework is based on: (a) Interviews with key informants, conducted with interactive interview guides; and (b) A review of documents and legislation. Many of the key informants solicited for this analysis were managers from the Ministry of Health. Interviews were also conducted with representatives of private health care organizations and key informants from other ministries, such as the Ministry of Finance (taxes), Industrial Development and Promotion of the Private Sector (support), and Technical and Professional Education (training). The Ministry of Forestry and the Ministry of Agriculture were also solicited for interviews due to their experience with public-private partnerships (PPP). At each interview, the study team gathered legislation, analyses, and other documents relevant to the study (see the list of documents in appendix B).

#### **Multidimensional Analysis of Supply**

The supply of private health care services was analyzed based on: (a) existing data (health mapping, census of private providers); (b) surveys of a sample population of sector participants in the three locations of the study (Brazzaville, Pointe-Noire, and Ouesso-Pokola); (c) interactive interviews with key informants and a subsample of private sector participants surveyed; and (d) focus groups.

A survey in the form of a short questionnaire was conducted on a sample of 63 private providers at the three locations. In-depth, interactive interviews were conducted using a long questionnaire, with a subsample of 20 private providers chosen from among the 63 who completed the short questionnaire. Interviews with the key informants—the main private providers, the professional orders and the representatives of nonprofit providers—were conducted using interview guides. Focus groups were organized with

pharmacists, managers of medical analysis laboratories and medical imaging centers, and practitioners of traditional medicine.

### **Multidimensional Analysis of Demand**

The analysis of demand for health care services provided by private organizations was based on: (a) a supplementary analysis of the data from the 2005 EDS and the 2005 ECOM, and (b) the focus groups organized in the communities located in the study's survey locations.

The 2005 EDS was a nationwide survey conducted among 5,879 households. It included questions on the choice of providers by users. The EDS focused on priority care for children (related to fever and coughing) and mothers (prenatal consultations, childbirth), family planning, the treatment of sexually transmitted infections (STIs) and HIV/AIDS screening and treatment. The analysis of the data gathered through the EDS pertained to the breakdown of service usage among the different sectors (public and private) and revealed the relative significance of private facilities (as compared to public facilities). In addition, the analysis presented the usage choices made by users as a function of their socioeconomic quintile and their location of residence (rural or urban area).

The 2005 ECOM was a nationwide survey conducted among 5,146 households, which primarily aimed to determine a poverty threshold for the Republic of Congo. In particular the ECOM asked the households questions about their decision of whether or not to seek health care in the event of an illness, about the choice of the source of care and about their reasons for not seeking care. The ECOM allows us to differentiate the responses to the questions based on location of residence (urban or rural area) and the poverty status (poor, not poor) of the person surveyed.

In cases where the analysis of the data from the EDS and the ECOM revealed preferences on the part of the population for specific providers, focus groups were helpful in explaining the reasons behind these choices. Focus groups were organized in Brazzaville and in Pointe-Noire with the following groups: (a) heads of household (men), (b) women of childbearing age, and (c) practitioners of traditional medicine. The focus groups with heads of household and women of childbearing age were established in cooperation with the *comités de santé* (COSAs) [Health Care Committees].

### **Limitations of the Study**

The study produced important information about the role of the private sector in the supply of health services. However, the study has certain limitations. First, a portion of the information collected and analyzed (for example, the results of the interviews and focus groups) consists of qualitative data, which introduces some degree of subjectivity.

The quantitative data on private providers were collected based on information from the health mapping exercise and the censuses conducted in 2009 and 2010<sup>11</sup> by the DDSs of Brazzaville and Pointe-Noire. At the time of data collection for this study, many providers that had been chosen through random sampling from the 2005 health mapping exercise were no longer in operation. The surveyors were thus obligated to replace the initially chosen facilities, which made the final sample less random than anticipated.

It is also appropriate to point out here that the providers surveyed expressed only the opinions and information that they were willing to disclose. Because the information pertaining to certain aspects (such as the volume of business, financial volume and rates)

is sensitive and could be over- or underestimated, the opinions shared, though relevant, are not always based on objective data.

The data from the 2005 EDS comes from a nationwide representative survey. However, the EDS focuses only on health care services used by households for reproductive and maternal health, STIs, and the most common childhood illnesses. Consequently it does not include the utilization of health care for any other diseases or by other population groups.

The 2005 ECOM, on the other hand, includes data on the use of health care services and the choice of providers regardless of the illness, which is a limitation because it does not allow us to identify the types of illnesses treated by different providers, and does not take into account the severity of the illnesses.

## 4. Study Results

The study results presented in this chapter are divided into three main sections, followed by general conclusions. The sections focus on demand, supply, and an institutional analysis. Each section presents specific results and their analysis, followed by a summary of the main conclusions.

### Analysis of Demand

In order to analyze the characteristics of the demand for private health care, it is important to analyze the results of the EDS (see the box) and the *Enquête congolaise auprès des ménages* (ECOM) [Congolese Household Survey], both conducted in 2005.

This section consists of the following points:

- Tools and methodology
- Main observations
  - Why do patients choose providers in the public sector? Or providers in the private sector?
  - What types of patients choose public providers and what patients choose private providers?
  - For which types of services does the population use public providers or private providers?
- Evaluation of the prices paid for a doctor's visit and health care in the private sector
- Suggestions regarding possible improvements
- Summary and conclusions.

### Tools and Methodology

The published analysis of the EDS focused on the utilization of health care when needed, regardless of the type of provider used for the care (public, private, faith-based). The published results also show the use of health care according to the socioeconomic status of the patient. A summary of the analyses published by the 2005 EDS can be found in

appendix C of this report. This assessment also presents new analyses of the 2005 EDS database conducted by our team (for example on the issue of choice of a provider based on whether they are in the public or private sector). The ECOM focused on the issues and dimensions of poverty in the Republic of Congo. As for the EDS, this assessment presents certain analyses of the ECOM and supplements them with new analyses pertaining to the choice of provider according to whether they are in the public or private sector. By combining the results of the two surveys with the results of the focus groups,

### ***Enquête démographique et de santé (EDS) [Demographic and Health Survey]***

The *Enquête démographique et de santé* (EDS) [Demographic and Health Survey, or DHS] conducted in 2005, asked questions of a national sample of households. Some questions pertained to the choice of a provider for services related to child health and reproductive health, including the use of different types of facilities for abortions, childbirth and postnatal visits, as well as care related to children's fever/coughing and diarrhea, HIV testing and treatment for women's STIs. Based on this information, a 'proxy' estimate of household demand for private health services was determined. The EDS also gathered data on the socioeconomic status (SES) of the households. The results of this survey provide an overview of the choice of services between the public and private sectors according to the type of illness, the different population groups, the location of residence (rural or urban) and socioeconomic category. The SESs are broken down into quintiles—five groups of an equal number of households ranked from the poorest (quintile 1) to the wealthiest (quintile 5).

*Note:* The data gathered by the EDS regarding the different indicators of socioeconomic levels of households were analyzed to establish an SES index. The index scores were used to categorize households into quintiles.

we create an overview of the demand for the health care and services offered by private for-profit, nonprofit, informal, and traditional providers.

## **Main Observations**

The main findings regarding demand for health services offered by the private sector are explained in further detail in the following sections.

### ***Why do patients choose public providers or private providers?***

The choice between private and public providers depends most of all on the type of services sought, perceived quality, and the socioeconomic status of the patient as well as the flexibility of the facility to accept deferred payment. The type of patient, aside from his or her socioeconomic status, seems to be a less decisive factor.

Public services are generally preferred, since they offer a better technical platform and available, qualified personnel. However, moonlighters (public providers that also work in the private sector), absenteeism, long waits for doctors' visits, as well as the possible refusal to treat a poor patient ("you have to pay before receiving treatment for urgent care") are all disincentives for the use of public providers.

*In public service, you must buy all of the prescribed medications before receiving treatment.*

The choice of a private provider is based on several factors, such as quality and wait times,<sup>12</sup> communication and dialogue with the provider, and the possibility of negotiating the price of the services and the terms of payment after the care is given.<sup>13</sup> Other factors that quickly came up in rural areas were that public institutions are not always

*In rural areas, women believe that it is risky to go to private providers to deliver a baby: "They are death houses; that's where you go to die!" In urban areas, the quality of private maternity wards is perceived as "variable."*

open 24 hours a day, the perception of lower quality care in public facilities, and the perception that the quality of laboratory exams is superior in private institutions, as they have "more improved" equipment. On the other hand, in urban areas, and in working-class neighborhoods, the proximity of private facilities is an important factor.

One negative aspect perceived by the people interviewed is the presence of unqualified providers. Participants in the focus groups with representatives from the COSAs wonder "whether the offices are run by professionals."

The selection of provider depends on purchasing power. In the rural areas of Ouessou, the poorest people are more likely to go to public providers. Some are "covered" by a relative or an acquaintance who works for a forestry company (and who therefore receives care at the company's medical and social services center). In order to save money, men seek care only when the illness worsens,<sup>14</sup> and women are quicker to seek care for their children, who are generally more fragile.

In urban areas, given the proximity of private facilities and their greater flexibility with regard to payment of services (deferred payment, terms of payment, price), the poor also use private facilities (see below).

#### NEGATIVE ASPECTS OF THE PUBLIC SECTOR THAT EXPLAIN THE USE OF PRIVATE FACILITIES

The use of private facilities is also the result of the deteriorating quality of health care observed at public facilities, the attitude of providers who are not very attentive to patients (waiting time, patients often not seen in the order in which they arrived), the fact that service depends on a direct informal payment,<sup>15</sup> and the lack of rigor in recruiting personnel and in assigning tasks based on the level of qualification.<sup>16</sup> According to the COSAs, the lack of information on the public services available is another factor that "push[es] people toward the private sector."

For women, the situation is a little different. In general, they also prefer private facilities, while specifying that they go directly to the public hospital when their situation becomes more complicated. Most women prefer to go to the public hospital for prenatal consultations (PNCs) and childbirth, because if complications arise, the treatment is better or safer there; pregnancy monitoring (PNCs) is guaranteed and child vaccinations are available only at public facilities. In addition, private maternity wards are considered to be too expensive. Women who have already had children are familiar with the public facilities where they go to deliver.<sup>17</sup> They seem attached to them, despite the fact that the image of these facilities, which used to have a good reputation, has worsened considerably. Also in

*The personnel at public institutions accept informal payments: "They ask if you have money first."*

rural areas (Ouesso), women believe that it is risky to go to private providers (“sometimes they don’t even have any equipment”). This point of view is shared by the COSAs, who mentioned “maternal death” and believed that private offices were not appropriate facilities for childbirth.

*What types of patients choose public providers and what patients choose private providers?*

Men and women in urban areas use private facilities more frequently because of their proximity. However, proximity is a less important factor for women, who largely prefer public facilities for maternal and child health care.

It should be noted that poorer populations prefer to use the public sector because it is less expensive. However in urban areas, they also use the services of the private sector. They are reportedly motivated, among other reasons, by the possibility of negotiating prices, by the terms and timeframes of payment and by proximity in the event of an emergency.

To summarize, aside from socioeconomic status, the deciding factor is not the “type” of patient, but rather the type of services sought (and therefore their perceived quality) and the profile and severity of their condition when choosing between the public sector and the private sector.

*For what types of services does the population go to public providers or private providers?*

According to the focus group participants, most men and women prefer the private sector to the public sector to treat minor or “no risk” health problems. For “serious cases,” most men and women prefer the public sector due to the quality of the treatment (personnel, materials, equipment, surgery). With regard to maternal care, childbirth and child health care (vaccinations), women prefer the public sector.

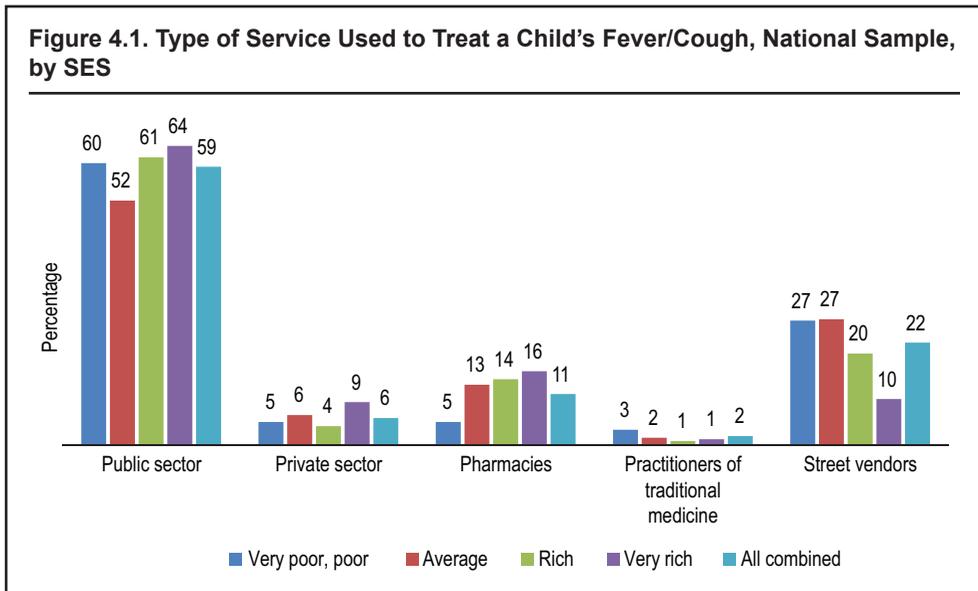
The fact that the private sector does not provide free vaccinations to children is an inhibiting factor for children’s doctors’ visits. This also influences the choice for PNCs in the private sector, since monitoring and treatment are perceived as a “complete package” – PNCs, childbirth, and monitoring the newborn.

The analysis of the EDS below distinguishes between the various sources of care that are used (public-sector facilities, private sector facilities, pharmacies, practitioners of traditional medicine and street vendors). The results are also broken down according to socioeconomic status of the household. It is important to note that the graphs combine the two poorest quintiles. This way we can compare the service users from these two poorest quintiles to those of the three other quintiles that are categorized as the richest. In addition, it should be pointed out that in rural areas, there are very few households in the fourth and fifth quintiles (the two richest quintiles). This indicates that in rural areas the sample of these two quintiles is very small (and the results should thus be interpreted carefully).

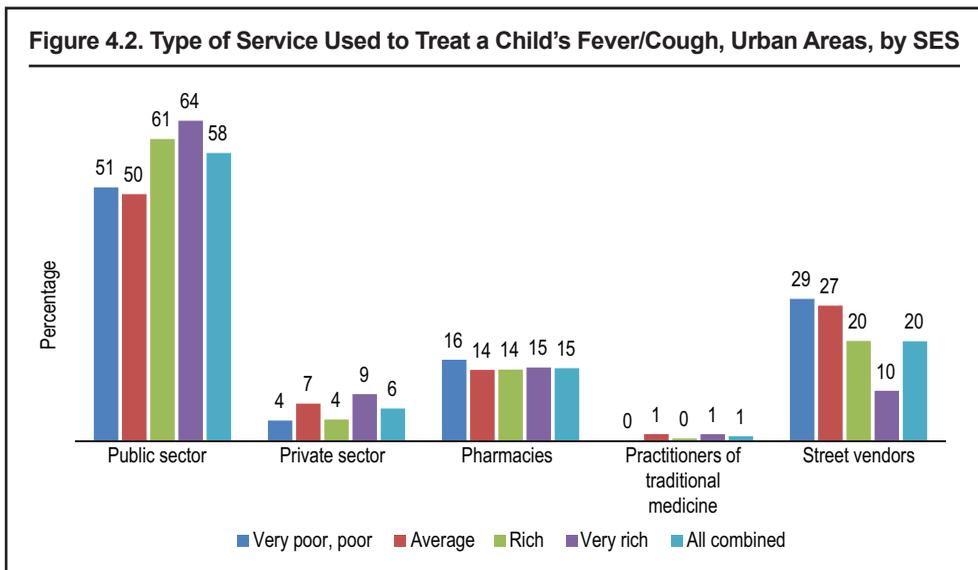
HEALTH SEEKING BEHAVIOR FOR CHILDREN WITH A COUGH AND FEVER

Figure 4.1, figure 4.2, and figure 4.3 present the results of the EDS on the choice of providers in the event of a child’s fever or cough on the national level, in urban areas and in rural areas. Regardless of the household category, the care families seek in the event of a child’s fever or cough is in most cases at public facilities (59 percent at the national level, 58 percent in urban areas and 62 percent in rural areas) over private facilities (6 percent at the national level and 6 percent in urban areas, and 5 percent in rural areas).

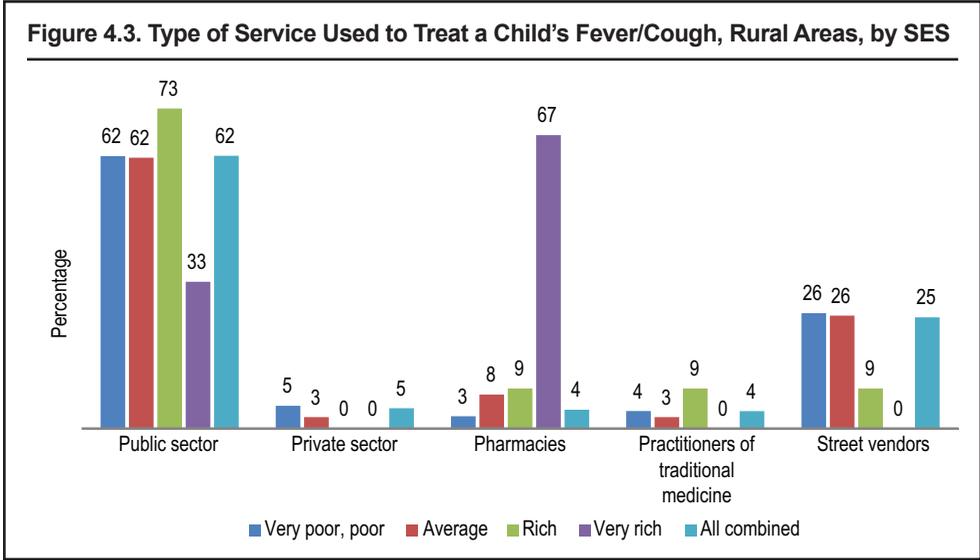
Moreover, for all categories of households in both urban and rural areas, we can see the significant importance of self-medication (direct access to the pharmacy: 16 percent



Source: Authors.



Source: Authors.

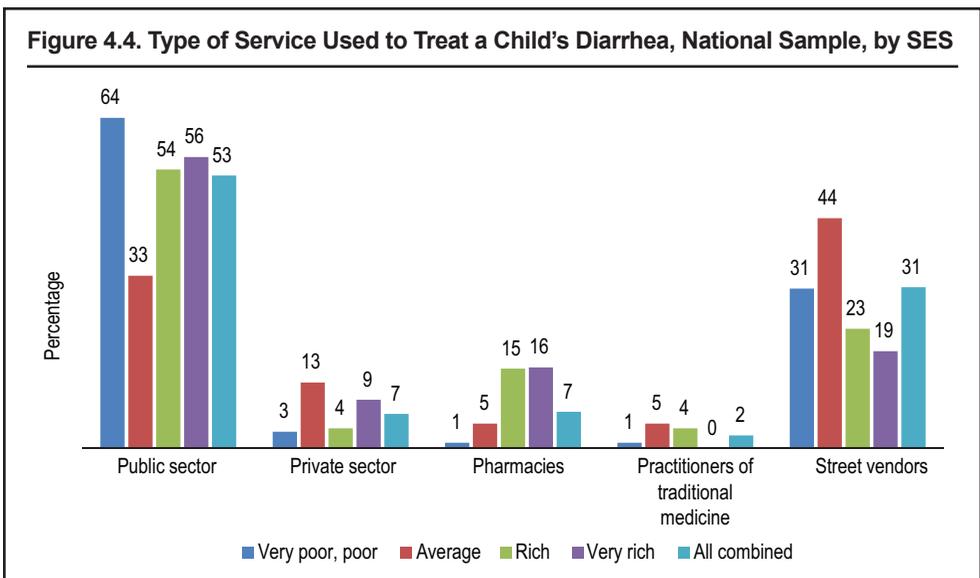


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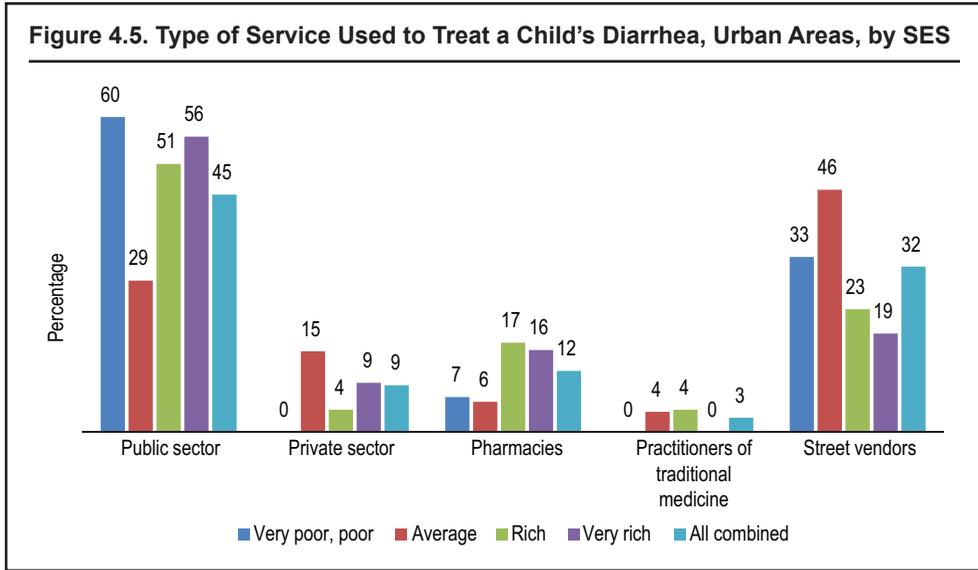
in urban areas and 3 percent in rural areas among women from poor households) and street vendors (29 percent in urban areas and 26 percent in rural areas among women from poor households). The use of traditional medicine is also especially prominent in rural areas (4 percent among women from poor households).

HEALTH SEEKING BEHAVIOR FOR CHILDREN WITH DIARRHEA

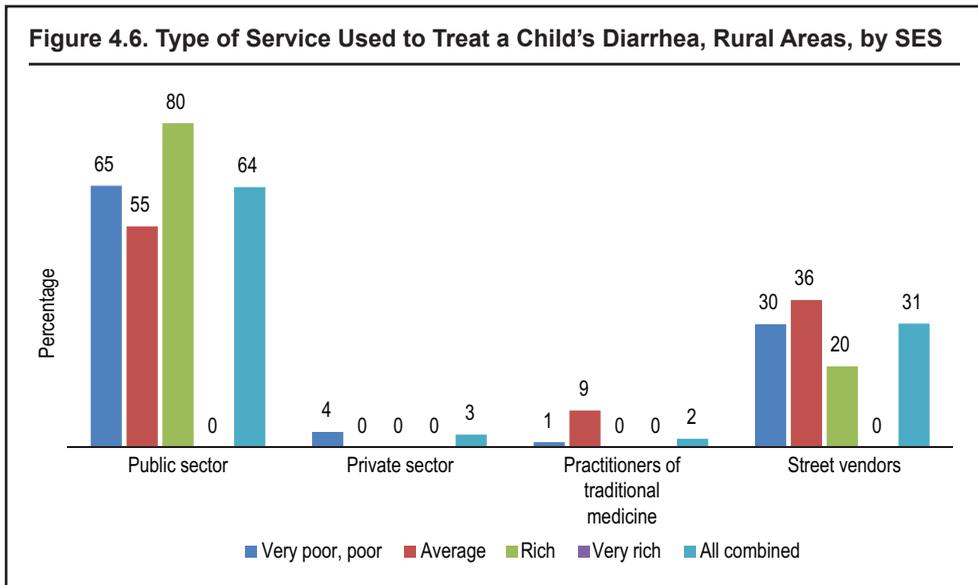
Figure 4.4, figure 4.5, and figure 4.6 present the results of the EDS with regard to the choice of a provider in the event of a child’s diarrhea on the national level, in urban areas and in rural areas. The results are similar to those for fever and cough: the public sector



Source: Authors.



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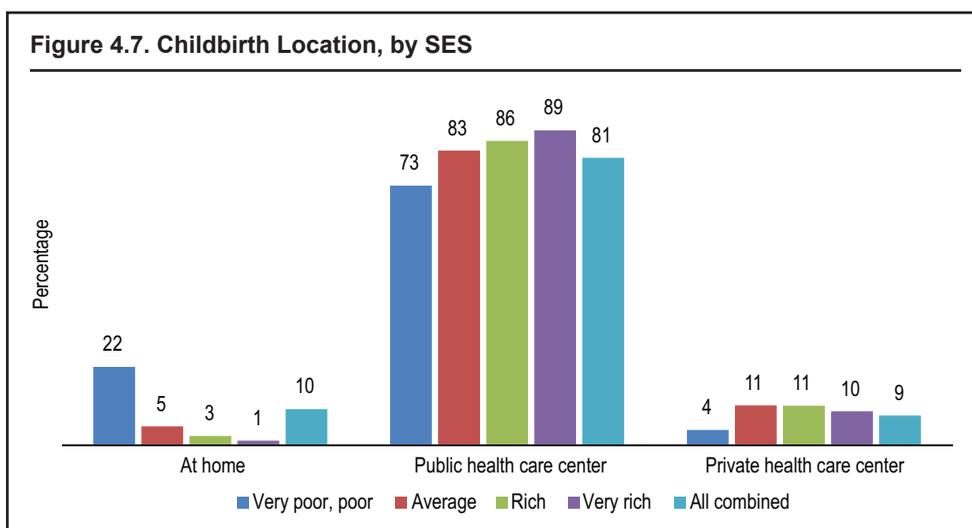
Source: Authors.

is the first choice for all of the quintiles (53 percent at the national level, 45 percent and 64 percent in urban and rural areas, respectively); the private sector is chosen 7 percent of the time at the national level, and 9 percent and 3 percent in urban and rural areas, respectively. The study team observed significant self-medication through direct access to pharmacies, especially among the rich (15 percent to 16 percent at the national level and 16 percent to 17 percent in urban areas; the data reveal almost no demand from the rich in rural areas). On the other hand, the use of street vendors is very significant (31 percent to 32 percent on the national level, and in urban and rural areas).

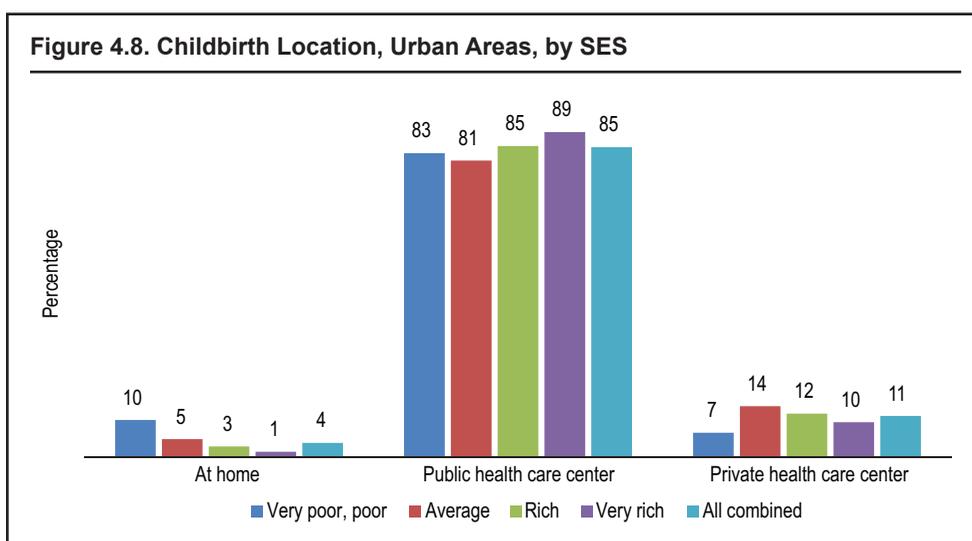
LOCATION OF CHILDBIRTH

Figures 4.7, 4.8 and 4.9 present the results of the EDS on the choice of provider for childbirth on the national level, in urban areas and in rural areas, and by SES quintile. For the three geographic groups, there is a strong preference for public facilities with regard to childbirth (81 percent at the national level, 85 percent and 75 percent in urban and rural areas, respectively). This preference increases gradually by quintile at the national level, ranging from 73 percent for the poorest to 89 percent for the rich.

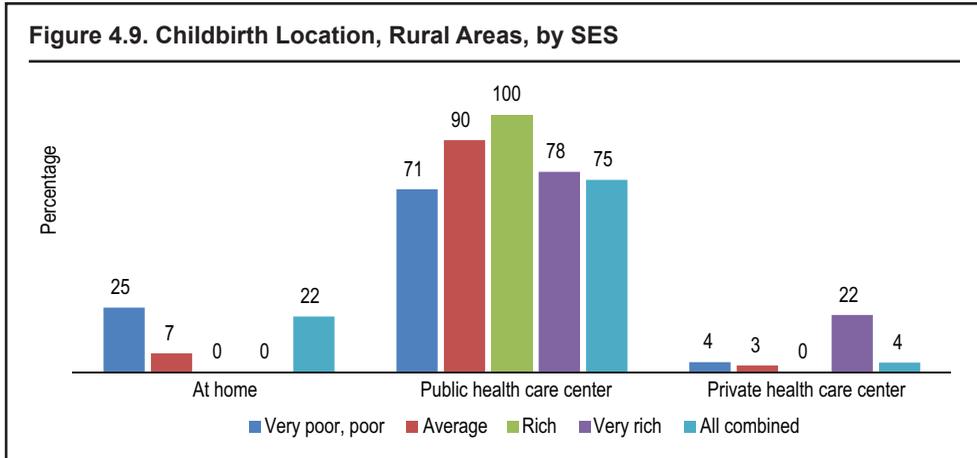
All of the quintiles use private facilities much less frequently than public facilities for childbirth. At the national level, deliveries at private facilities accounted for 9 percent of the total for all women combined, between 10 percent and 11 percent for the rich



Source: Authors.



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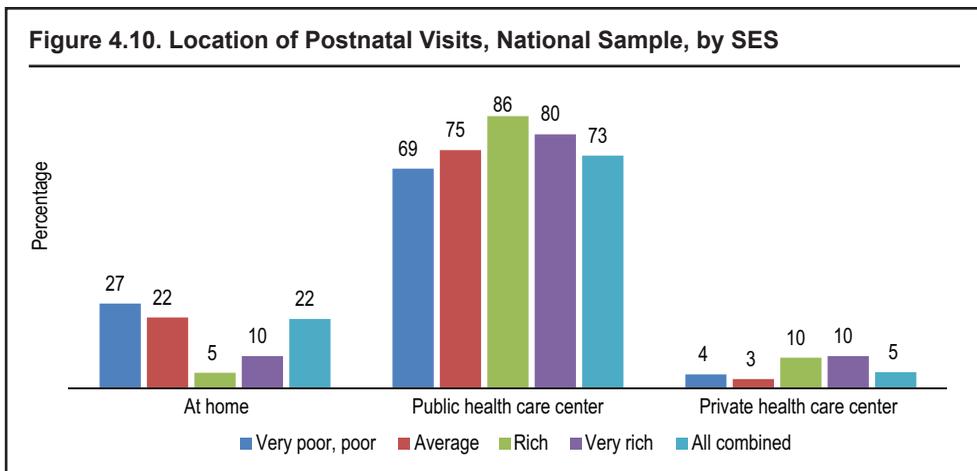


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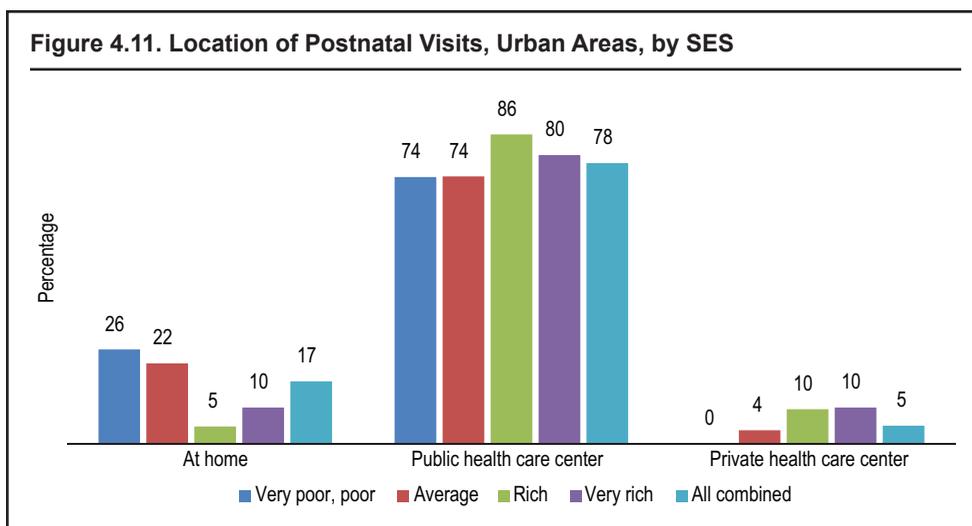
categories and 4 percent for poor women. Deliveries at private facilities account for, as a percentage of the total deliveries, 11 percent of women in urban areas and 4 percent of women in rural areas, respectively. The use of private care for childbirth by poor women is estimated at 7 percent in urban areas and 4 percent in rural areas. The use of private facilities by rich women is 10 percent at the national level and 14 percent in urban areas. However, the proportion is very high in rural areas for women from very high households (22 percent), but in light of the very limited size of the sample, this latter statistic must be interpreted with caution. It is important to note the high proportion of at-home births among women from poor households (10.1 percent in urban areas and 25.1 percent in rural areas).

#### LOCATION OF POSTNATAL VISITS

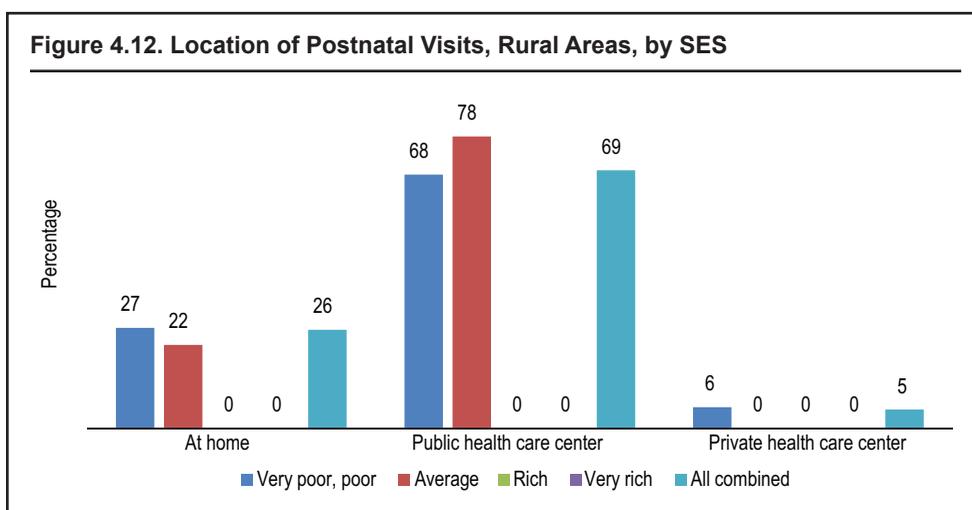
Figure 4.10, figure 4.11, and figure 4.12 present the results of the EDS on the choice of provider for postnatal services on the national level, in urban areas and in rural areas, by SES quintile.



Source: Authors.



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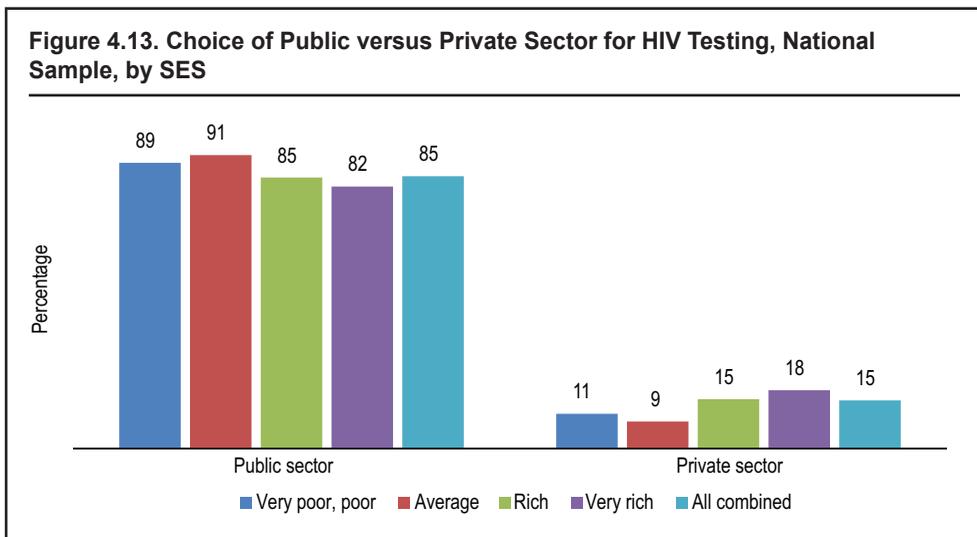
As with childbirth, these results show that the public facilities are chosen more often by the Congolese for postnatal services. On the national level, 73 percent of all women, 78 percent of women in urban areas, and 69 percent of women in rural areas choose public facilities. For the two poorest quintiles, the public sector is preferred by 69 percent of women at the national level, 74 percent of women in urban areas, and 68 percent of women in rural areas.

As with childbirth, we observed a high frequency of at-home postnatal visits (22 percent of all women at the national level, 17 percent in urban areas, and 26 percent in rural areas). This is more common among poor women (27 percent at the national level and in rural areas, 26 percent in urban areas) and for women from middle-income households (22 percent at the national level, as well as in urban and rural areas).

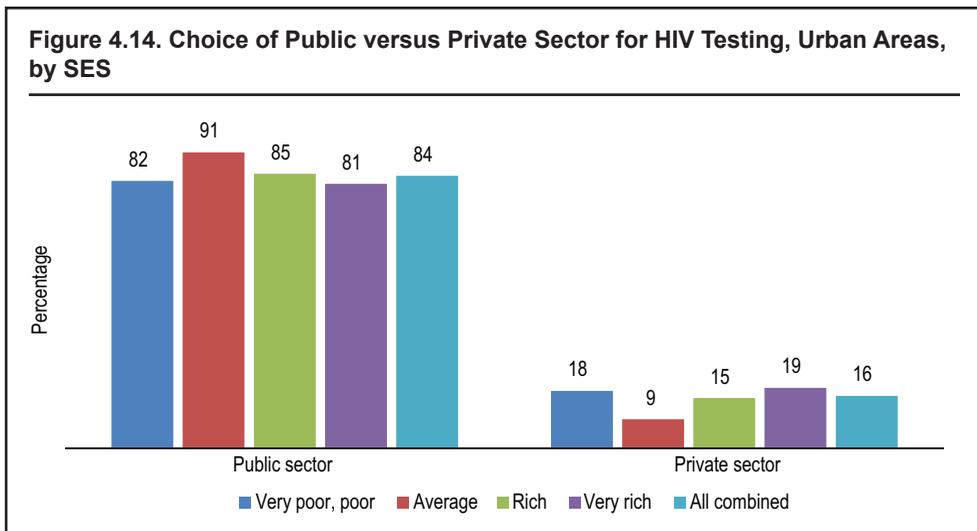
### LOCATION OF HIV TESTS

Figure 4.13, figure 4.14, and figure 4.15 present the results of the EDS with regard to where HIV tests are performed on the national level, in urban areas and in rural areas, by SES quintile. These results show that, once again, the Congolese most commonly visit public facilities. These facilities account for 85 percent of the total at the national level (84 percent in urban areas and 92 percent in rural areas).

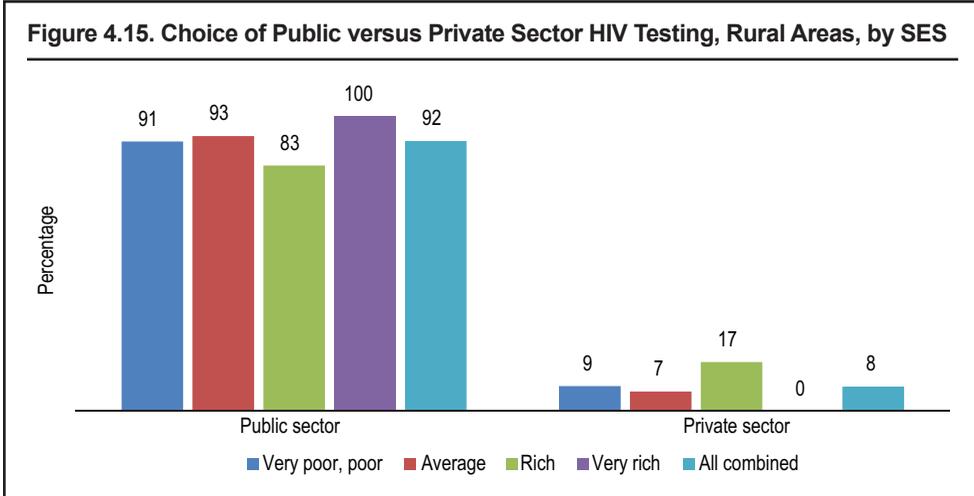
The use of private services for HIV tests accounts for 15 percent of the total, 16 percent in urban areas and 8 percent in rural areas. By SES, private services that offer HIV tests are used by women from all quintiles: women from poor households (11 percent at the national level, 18 percent in urban areas and 9 percent in rural areas) and women from rich households (18 percent at the national level, 19 percent in urban areas).



Source: Authors.



Source: Authors.



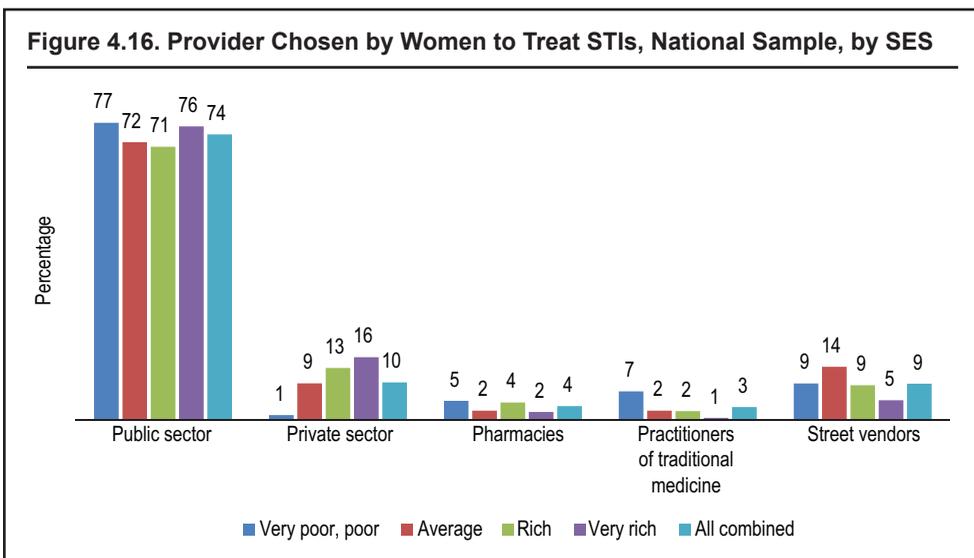
Source: Authors.

LOCATION OF TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS (STIs) IN FEMALES

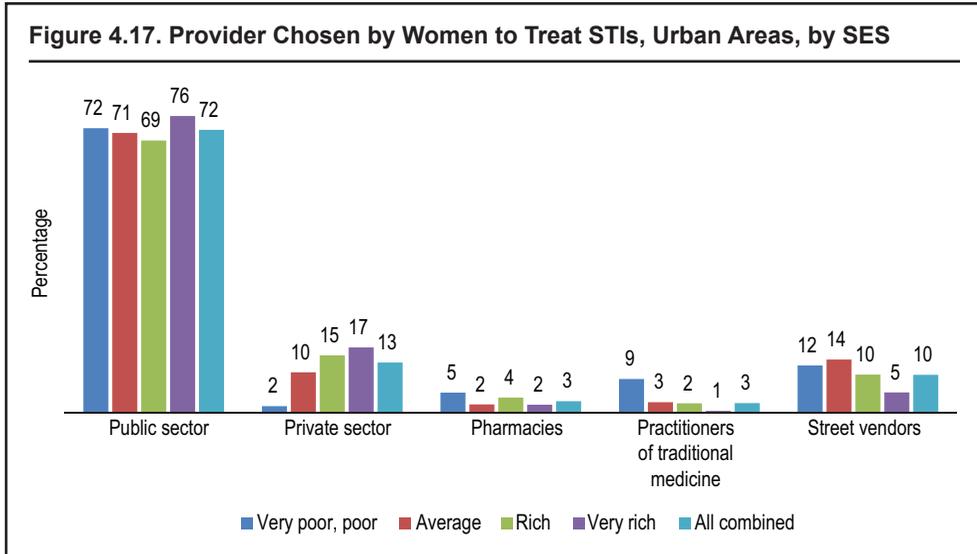
Figure 4.16, figure 4.17, and figure 4.18 present the results of the EDS regarding the choice of provider for the treatment of STIs in women at the national level, in urban and rural areas, and by SES quintile.

These results demonstrate once again that the public sector is the first choice at the national level (74 percent at the national level, 72 percent, and 80 percent in urban and rural areas, respectively).

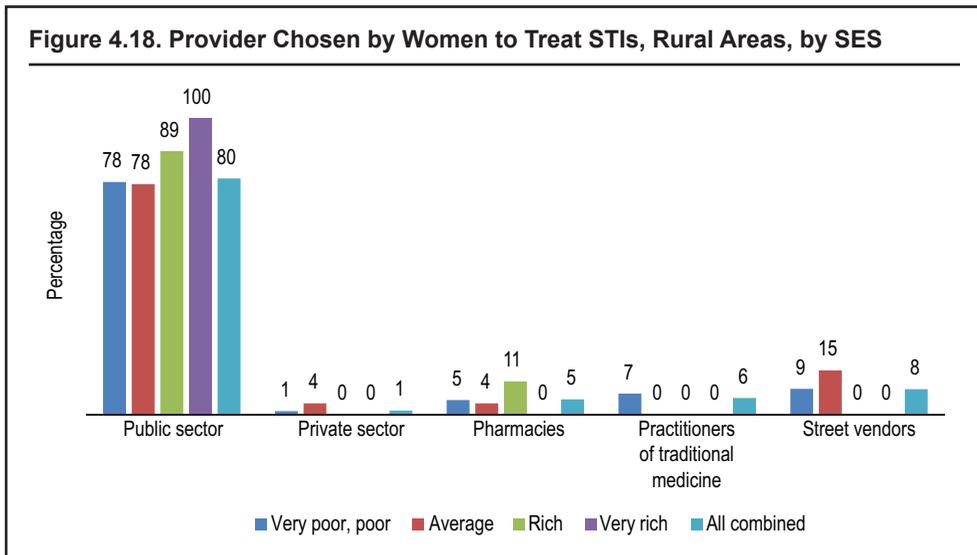
The private sector has a significant portion of STI care in urban areas (10 percent for all people combined, 13 percent, and 1 percent in urban areas and rural areas, respectively). It is interesting to note that poor women rarely use private facilities for STI treatment (1 percent at the national level and in rural areas, 2 percent in urban areas).



Source: Authors.



Source: Authors.



Source: Authors.

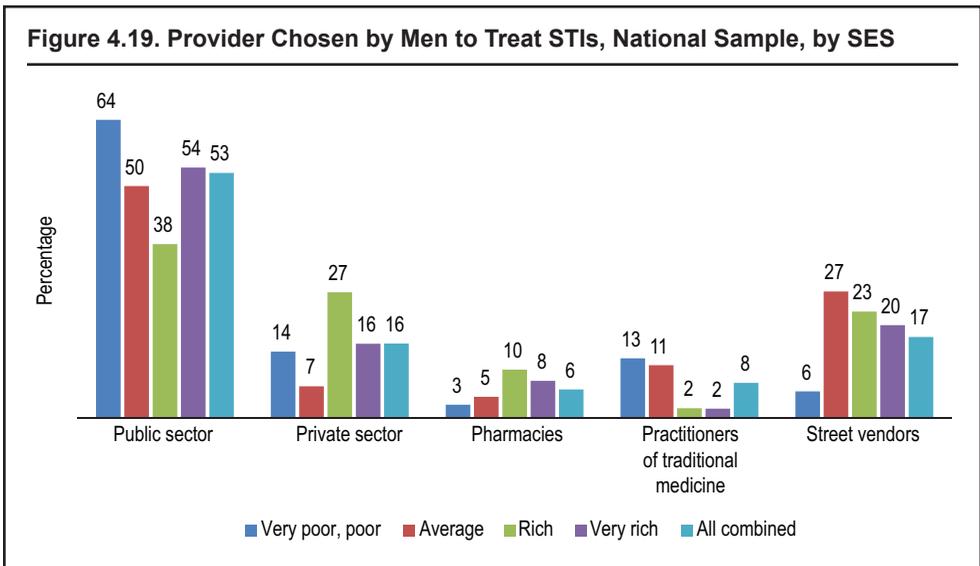
Moreover, the use of street vendors is significant in all quintiles (12 percent among poor women in urban areas, as compared to 9 percent in rural areas), while it is especially poor women and to a much lesser extent the other quintiles who use practitioners of traditional medicine (9 percent of poor women in urban areas and 7 percent in rural areas). In addition, self-medication directly at the pharmacy is rather limited (between 3 percent and 5 percent in the three areas).

LOCATION OF TREATMENT FOR MALE STIs

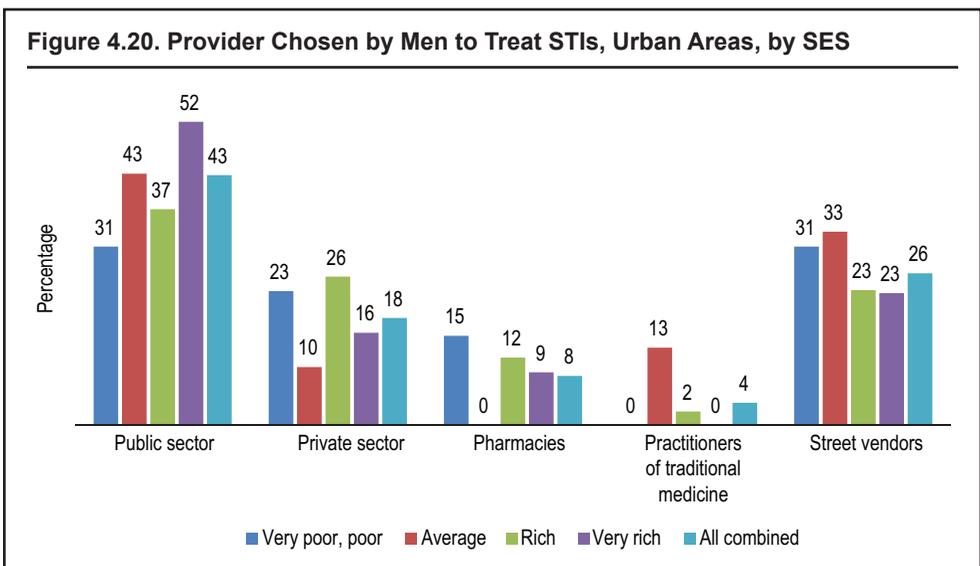
Figure 4.19, figure 4.20, and figure 4.21 present the results of the EDS regarding the choice of a provider for the treatment of STIs in men at the national level, in urban areas and in rural areas, by SES quintile.

These results also prove that the public sector is the first choice at the national level (53 percent, 43 percent in urban areas, and 68 percent in rural areas, respectively).

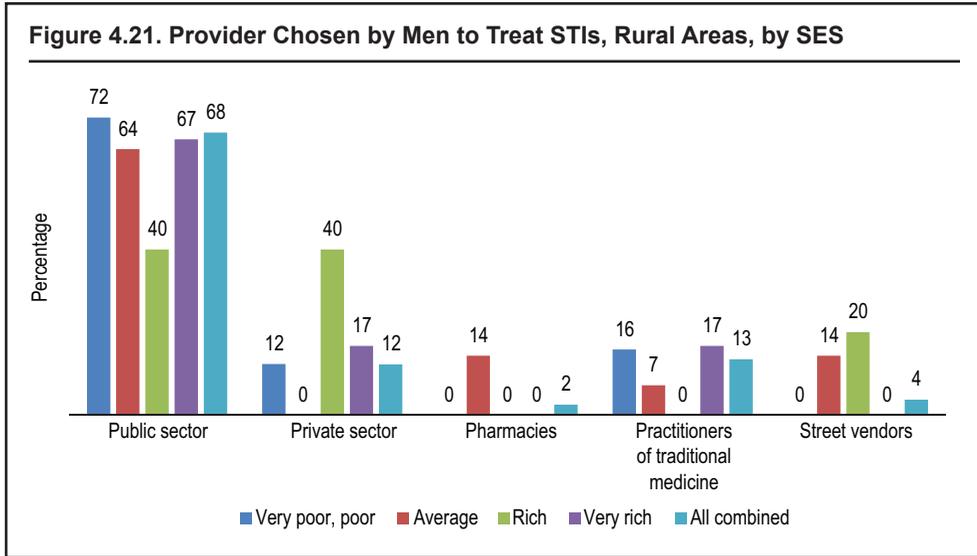
The private sector provides a significant portion of the male STI care (16 percent for all people combined, 18 percent, and 12 percent in urban and rural areas, respectively). In particular, in urban areas significant use of private facilities for the treatment of STIs



Source: Authors.



Source: Authors.



Source: Authors.

by all men in all quintiles was observed, even more notable among poor men (23 percent) and rich men (27 percent). In rural areas, use of private facilities varies greatly from one quintile to another, from 12 percent for poor men, to 40 percent for rich men, to 17 percent for very rich men. It should be noted that the sample of rich people in rural areas is very limited.

Additionally, the use of street vendors is significant for all quintiles (17 percent on average at the national level and 26 percent in urban areas) and it is markedly more significant than for women (see above). Finally, men in rural areas are particularly likely to use practitioners of traditional medicine (13 percent).

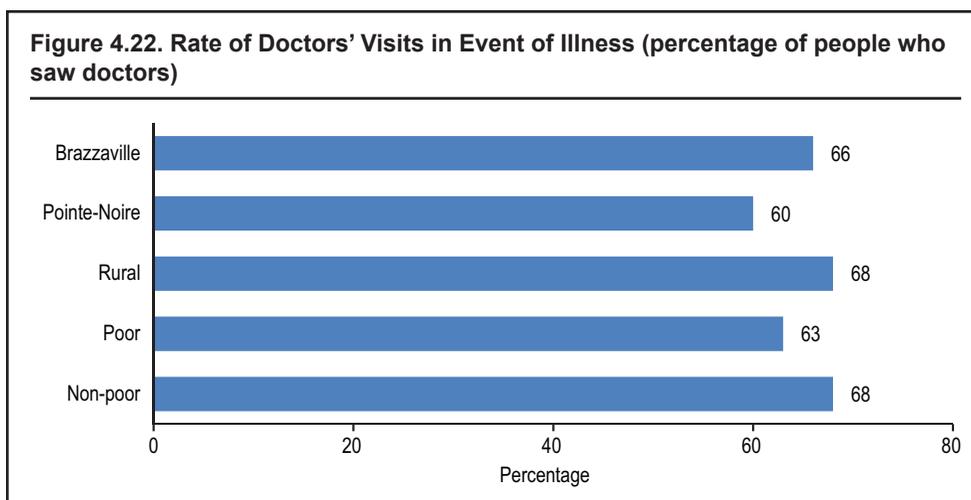
Self-medication directly at the pharmacy applies to 6 percent of men (national average), 8 in urban areas and only 2 percent in rural areas.

#### USE OF HEALTH CARE IN THE EVENT OF AN ILLNESS, ALL TYPES COMBINED

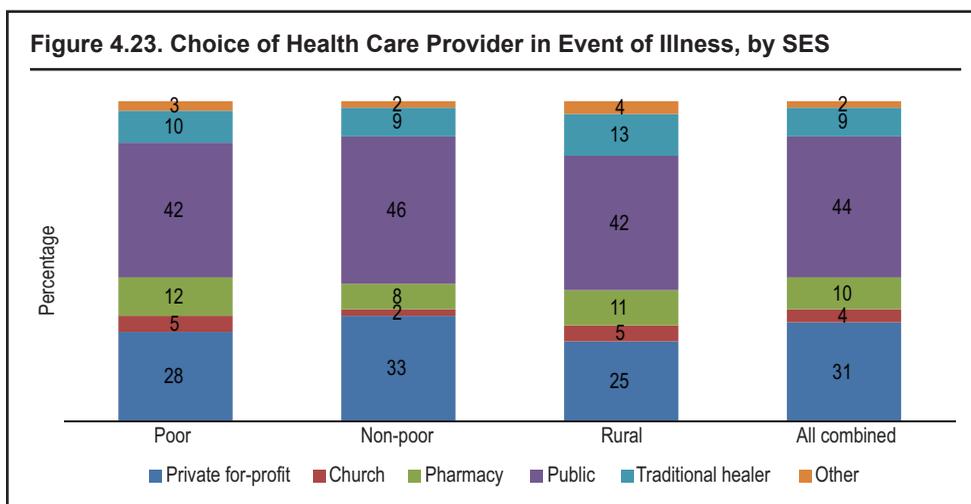
Data from the ECOM were used to analyze the use of health care by households in the event of an illness, all illness types combined. The ECOM provided utilization data on the choice of provider and the reasons for not seeking care.

Figure 4.22 presents the results of how many people visit a doctor in the event of an illness by location of residence for the users surveyed. It is important to note that the rate does not vary much (60 percent to 68 percent) between most of the different groups, but that it is higher among the nonpoor and people living in rural areas.

Figure 4.23 shows the choice of provider in the event of an illness (all illnesses combined) according to whether the patient is poor or not poor, for the rural population, and for the whole population. The type of provider most commonly used by all groups is the public sector (from 42 percent to 46 percent of the total). All of the private providers (for-profit, faith-based, traditional practitioners and pharmacies) account for 55 percent of total usage. Use of the public sector, which was lower in the ECOM study than in the EDS study, can be explained primarily by the fact that the EDS was limited to specific services such as maternal care and child health care, as well as STIs and HIV testing. As



Source: Authors.

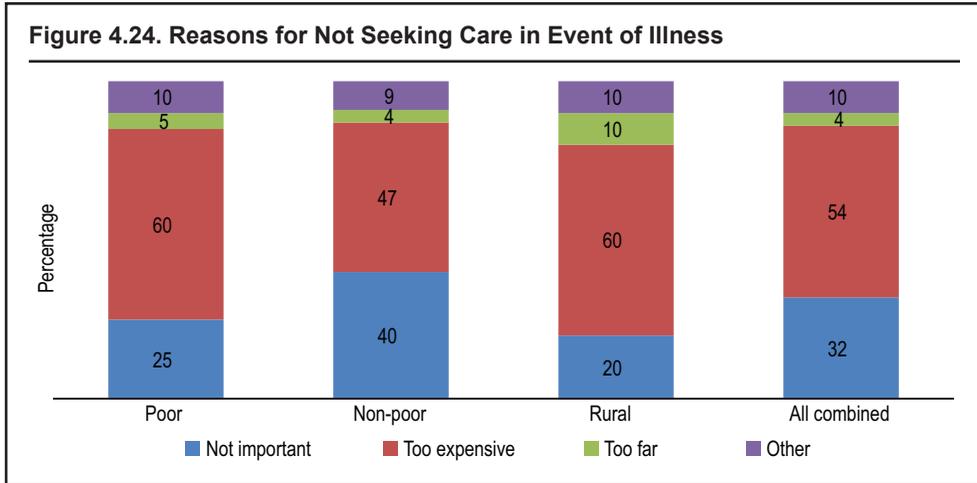


Source: Authors.

stated above, for all of this care, the patient preference for public facilities is very clear (for example, childbirth 81 percent; STIs 74 percent; HIV 85 percent). The ECOM, on the other hand, reports on all health care combined and not a specific selection of health care services.

In the data from the ECOM, private providers are used by everyone at similar rates. Rural residents use traditional healers more often (13 percent) as compared to the other groups (9 percent). Nonprofit providers (for example, faith-based) account for only 4 percent of the total use, and even in rural areas they account for only 5 percent.

Figure 4.24 presents the analysis of ECOM results for questions regarding the non-use of health care in the event of an illness. The response that health care is "too expensive" is most common for all groups. This response is more common among the poor (60 percent) and rural residents (60 percent) than for the nonpoor (47 percent) and the whole sample (54 percent). Distance is rarely mentioned (4 percent) as a reason for not seeking care, even for the whole rural population (10 percent).



Source: Authors.

#### ASSESSMENT OF THE COSTS RELATED TO DOCTORS' VISITS AND CARE IN THE PRIVATE SECTOR

People acknowledge the fact that it is legitimate for private facilities to establish the prices of the services offered to patients, and they acknowledge the right of the private sector to set higher prices ("that's understandable; they have to pay the staff").

Prices vary depending on the facility. Depending on the patient's purchasing power, the price required may be a barrier to the use of private facilities. However, the main perceived advantage of private care is that the patient is seen immediately as soon as he or she arrives (after paying the price of the doctor's visit)

*According to the COSAs, "[private] providers practice medicine under difficult conditions."*

and before asking the patient (or the patient's family) to purchase the prescribed medications. In general, the initial urgent-care medications are available and are administered right away in private facilities.

### Suggestions for Improvements

The focus groups revealed a few recommendations regarding the role played by the private sector:

#### *Suggestions for Public Providers*

Despite the existence of private providers, Congolese men, like Congolese women, would like the public sector to continue to operate and to improve the quality of its care, coverage, and accessibility ("because it is less expensive"). Evidently, the ability to choose between the two facilities is a benefit that people would prefer to keep.

*"The public sector should educate its personnel."*

#### *Suggestions for Private Providers*

Private facilities with high rates of utilization are confronted with the same long wait problems as facilities in the public sector experience. According to the men and women interviewed, the private sector should be better organized, the working conditions im-

proved, and the conditions for opening facilities should be revised by the government. These latter suggestions were also confirmed by the COSAs.

To ensure that personnel are well trained to perform their duties, the COSAs have proposed that the head doctors of the *circonscriptions socio-sanitaires* [health districts] or the subregional directors be involved in recruiting the personnel for private facilities in their field of expertise. In addition, they suggest more effective auditing, supervision and regulation: inspections and regular supervision; adequate qualifications on the staff at these facilities; and the implementation of regulations and more regulated pricing.

## Summary and Conclusions

The analysis of the EDS is limited by its focus on children's health care and reproductive health. As a supplement, the ECOM analysis helped to evaluate the use of health care services for all patients combined for the entire population and a few subpopulations. It is possible to draw the following conclusions from the analyses of the EDS and the ECOM, by combining them with the results gathered through the focus groups:

- According to the EDS, the public sector has the largest "market share" for children's services and reproductive health services.
- Private providers attract a very low portion of the demand for the health care services covered by the EDS. They account for between 5 percent and 16 percent of total demand, depending on the type of care sought.
- According to the ECOM, for all illnesses combined, private services are utilized at close to the same rate as public services. Private providers attracted 35 percent (not counting the services of pharmacies/pharmacists and practitioners of traditional medicine) to 45 percent of the demand (including pharmacies/pharmacists) and 55 percent of the demand (with traditional practitioners).
- Congolese households resort to self-medication frequently (either by private pharmacies or by street vendors) and to alternative medicine.
- Private providers are more widely used by the wealthiest quintiles for the services studied by the EDS, but they are also patronized by the poorest, especially in urban areas.
- Based on the ECOM, the nonpoor (35 percent) use the private health sector more than the poor (33 percent) for general health care services, but this difference (2 percent) is less significant than the difference in utilization of private providers by nonpoor and poor populations for the services studied by the EDS (for example, 7 percent for childbirth, 6 percent for HIV testing, 13 percent for female STIs, and 7 percent for male STIs).
- Patients acknowledge that it is legitimate for the private providers to determine for themselves the prices of services, but the cost may be an inhibiting factor in the use of private facilities. The main advantage of private providers is that patients are seen immediately upon arrival.
- The ability to choose between public facilities and private facilities is a benefit that patients would like to keep. According to the individuals interviewed, the private health sector needs to be better organized, the working conditions need improvement, and the conditions under which new facilities are opened should be revised by the state.

## Analysis of Supply

The private health sector in the Republic of Congo is an important actor in the health-related goods and services market. However, the size and configuration of private providers, as well as the limitations and challenges with which they are confronted, have not been well documented. As a result, the purpose of this supply analysis, which is based on a survey and interviews, is to confirm and to supplement the data from the 2005 health mapping exercise and the censuses performed by the DDSs, by providing additional information.

This analysis presents a comparison of the key elements shared by the different groups of providers, including the characteristics of private providers, the services offered, the volume of services rendered, the resources used, the structural quality indicators, the degree of integration with the public sector, the internal and external limitations to which the private providers are subjected, the existing or proposed public-private partnerships, as well as the plans and ideas for expanding their activities. Whenever possible, the analysis makes a distinction between for-profit providers and nonprofit providers.

## Tools and Methodology

The supply analysis is based on four main sources of information, which are (1) existing data (health mapping and censuses), (2) the survey, (3) guided interviews with key informants and providers, and (4) focus groups with providers.

A short questionnaire was used with a sample of providers in the health care sector, and then a long questionnaire was given to a subsample of providers. The short questionnaire was a quantitative survey with closed questions and the long questionnaire was used to gather qualitative data. The data were gathered from a sample of participants in the private health sector in the districts of Brazzaville and Pointe-Noire and in the subregion of Sangha (Ouesso and Pokola). The sample was chosen from the list of facilities counted in the census conducted by the DDSs in the three locations. Because the census lists were not completely up-to-date, a significant number of facilities listed were no longer operational. This sometimes forced the survey team to replace the facilities that were initially selected for the sample with other facilities. Consequently the sample is not entirely random.

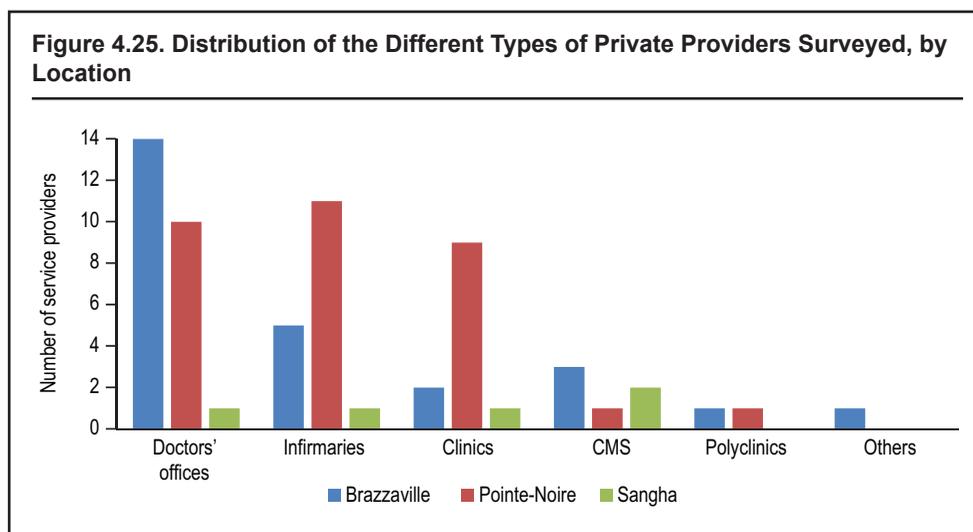
The supply analysis used the following methods to collect information from different types of providers: (a) short questionnaire: 63 private facilities and health care providers, (b) long questionnaire: subsample of 20 of the 63 providers surveyed with the short questionnaire, (c) guided interviews: four pharmacist wholesalers and managers of five biological analysis laboratories and medical imaging centers, and (d) focus groups: pharmacists (10 people) and practitioners of traditional medicine (ten people in Pointe-Noire; six people in Brazzaville).<sup>18</sup>

Table 4.1 and figure 4.25 present the distribution of providers surveyed by city and by type of institution. It is still important to note that the sample is not entirely random, and therefore that the distribution of providers surveyed does not represent the true distribution of the types of health care providers in Brazzaville and Pointe-Noire.

**Table 4.1. Number of Facilities Surveyed, by Location**

Number of people surveyed	Brazzaville	Pointe-Noire	Sangha	Total
Short questionnaire (sample)	26	32	5	63
Long questionnaire (subsampling)	9	9	2	20

Source: Authors.



Source: Authors.

## Main Observations

### *Distribution of Health Facilities by Location*

In total, the 2005 health mapping documented 1,002 private facilities in its census (including providers, dispensaries, and pharmaceutical outlets) distributed over the entire national territory, but most of them (90 percent) located in urban and semi-urban areas. Most of the private facilities were concentrated in Brazzaville and Pointe-Noire, despite the fact that these two subregions cover only 60 percent of the total population.

By comparison, the census of private facilities in Brazzaville and Pointe-Noire, conducted in 2010 by the DDSs of Brazzaville and Pointe-Noire, respectively, documented 191 private facilities in Brazzaville and 326 in Pointe-Noire.

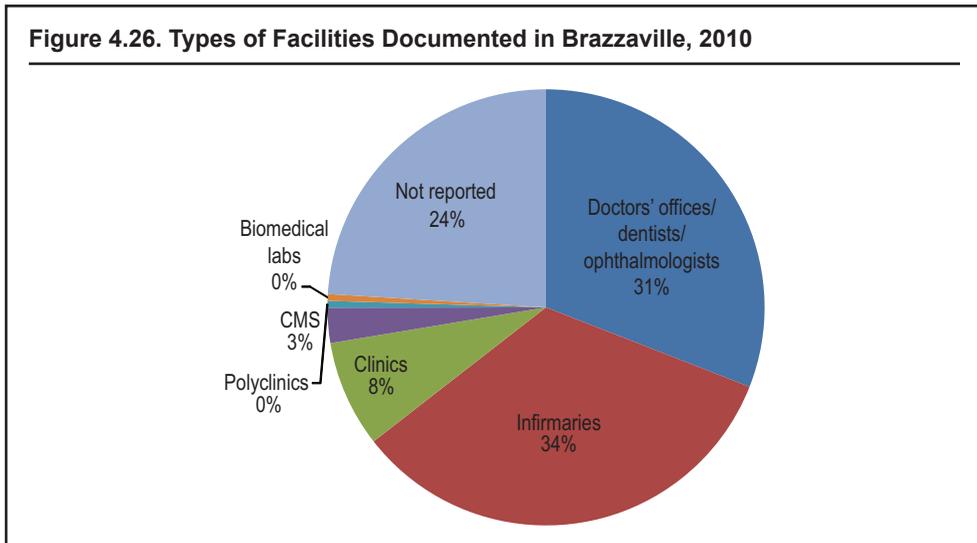
### *Distribution of Health Facilities by Type*

The 2005 health mapping showed a relatively similar distribution of types of facilities to that of the private providers found in the survey conducted as part of this study (see appendix D). Among the private facilities, nursing care practices (30 percent), followed by dispensaries (19 percent), pharmaceutical outlets (15 percent), and offices (15 percent), constituted the majority of the private providers.

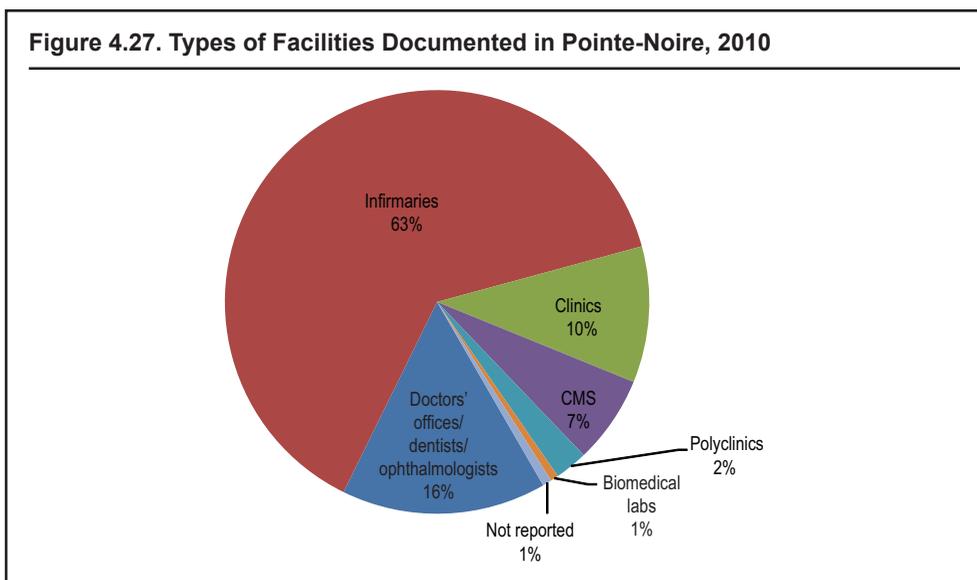
The data obtained in the 2010 census do not identify the type of facility for 24 percent of the facilities located in Brazzaville. In Pointe-Noire, on the other hand, the facility

type is known for nearly all of the facilities (less than 1 percent was unknown). The data indicate that nursing care practices are the most numerous facilities, both in Brazzaville (33.5 percent) and in Pointe-Noire (63.5 percent). This difference between Brazzaville and Pointe-Noire can be explained by the 24 percent of facilities in Brazzaville for which the type was not reported. Thus if this “missing” 24 percent in Brazzaville are all nursing care practices, then the difference between Brazzaville and Pointe-Noire is no longer very distinct for this type of facility. Offices are the second most numerous, followed by clinics and medical and social services centers.

Figures 4.26 and 4.27 present the types of facilities documented in 2010, in Brazzaville and Pointe-Noire, respectively.



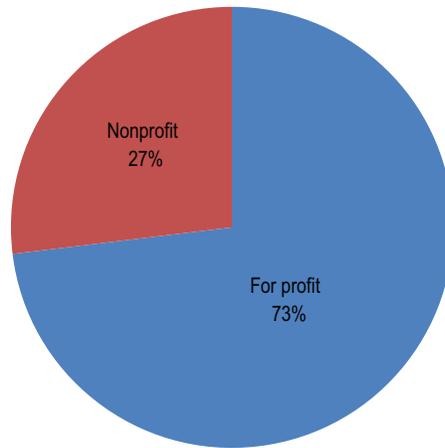
Source: Authors.



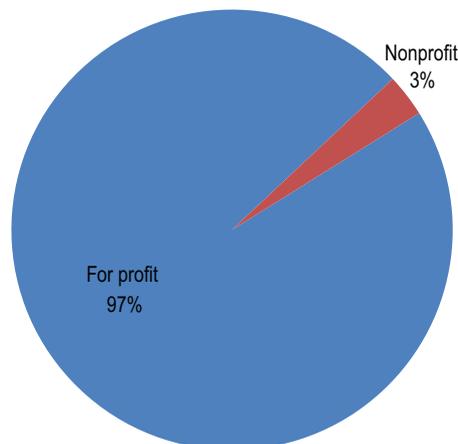
Source: Authors.

***Distribution of Health Facilities by Status (for-profit or nonprofit)***

According to the 2005 health mapping, the vast majority (88 percent) of private facilities were for-profit organizations (73 percent in Brazzaville and 97 percent in Pointe-Noire). The distribution of the 63 facilities surveyed (short and long questionnaires) is relatively similar to that of the health mapping exercise—83 percent were for-profit and 17 percent were nonprofit. The low percentage of private nonprofit facilities in Pointe-Noire can be explained by the fact that Pointe-Noire is the country's economic and industrial center and that its population has a larger concentration of wealthy residents. Figures 4.28 and 4.29 show the distribution of the facilities surveyed in Brazzaville and in Pointe-Noire.

**Figure 4.28. Distribution of For-Profit and Nonprofit Facilities Surveyed, Brazzaville**

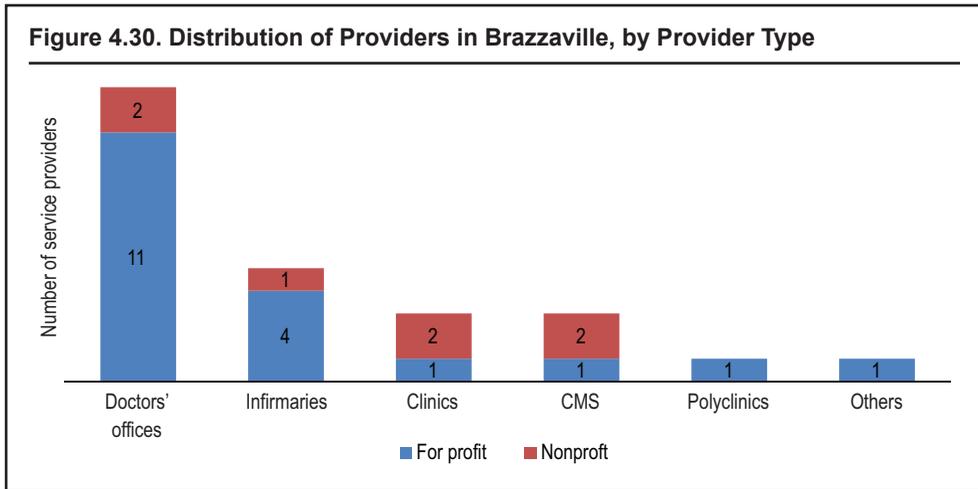
Source: Authors.

**Figure 4.29. Distribution of For-Profit and Nonprofit Facilities Surveyed, Pointe-Noire**

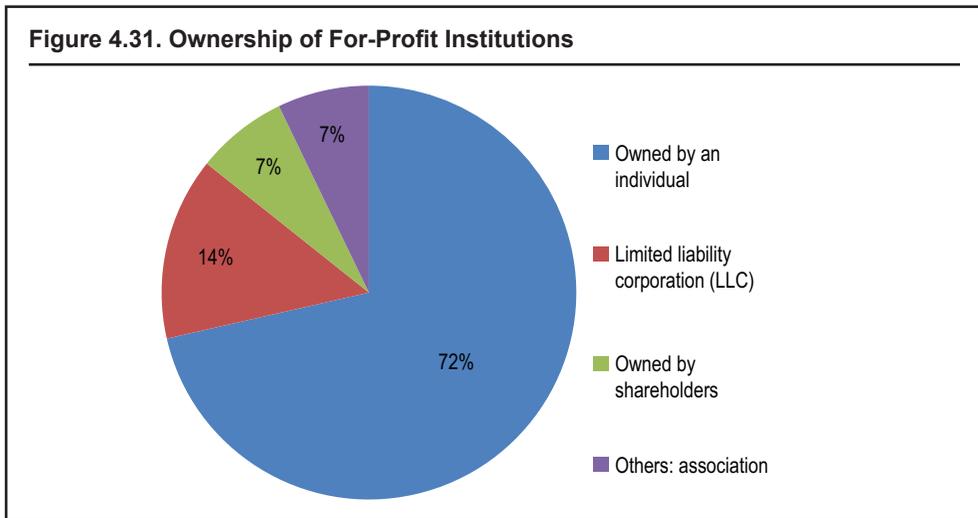
Source: Authors.

Among the facilities surveyed in Brazzaville, most offices (85 percent) and nursing care practices (80 percent) are for-profit; however, two thirds of the clinics and medical/psycho-social services centers are nonprofit. Figure 4.30 presents the distribution by profile of private providers in Brazzaville according to whether they are for-profit or nonprofit.

Among the 20 private for-profit providers who participated in the survey (long questionnaire), over two thirds belong to an individual, who is generally the owner or the director of the facility (figure 4.31).

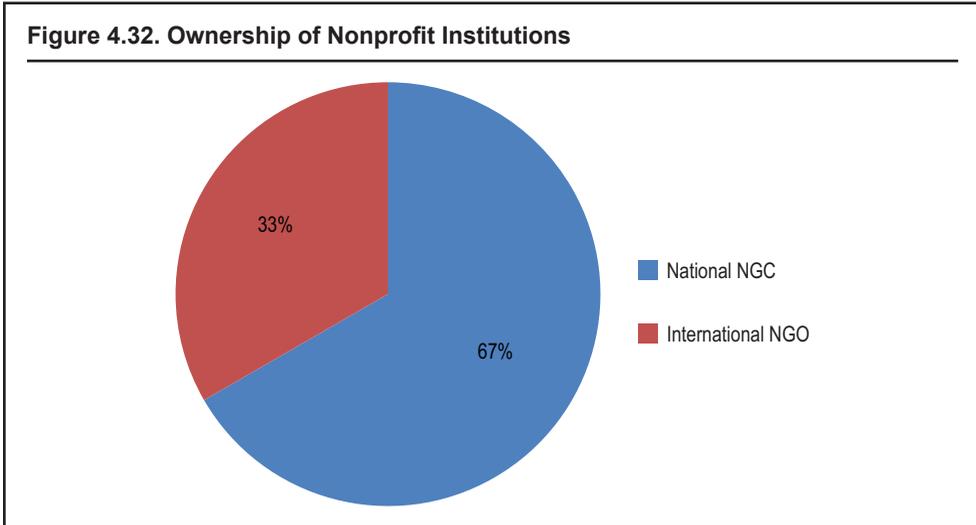


Source: Authors.



Source: Authors.

Nearly a fifth of the facilities that completed a survey (short and long questionnaires) are nonprofit and all are nongovernmental organizations (NGOs). Figure 4.32 presents the distribution of NGOs, two thirds of them national NGOs, one third international NGOs.



Source: Authors.

### ***Business Environment for Private Health Facilities***

This section presents information from the 2010 censuses and from our surveys on the management and business climate of private facilities (including the profile and nationality of the owner, startup financing needs, financial burden, access to credit, stability of the facilities, and competition).

#### **OWNER PROFILE**

The data obtained from the 2010 censuses show that there is no information on the owner's profile for 31.4 percent of the facilities in Brazzaville and for 21.8 percent of those in Pointe-Noire. In Brazzaville, the facilities for which information is available reveal that the owner is most commonly a doctor (38 percent), followed by nurses (26 percent) and then assistants (21 percent). However, in Pointe-Noire, nurses are the most common owners (46 percent), followed by doctors (33 percent) and assistants (10 percent).

#### **OWNER NATIONALITY**

It appears from the 2010 censuses that the owners are mostly Congolese nationals (75.9 percent in Brazzaville and 71.8 percent in Pointe-Noire). However, the data obtained show that information on the owner's nationality is not available in the database for one in five private facilities (Brazzaville: 19 percent and Pointe-Noire: 20 percent). Assum-

ing that the owners for whom it was not possible to collect nationality information are mostly foreigners, the proportion of foreigners practicing in the private health sector in the Republic of Congo is significant.

#### STARTUP FINANCING NEEDS

Startup financing presents a problem for all types of providers, but it is a greater problem for larger facilities (polyclinics, for example) or for facilities that require significant initial capital and/or inventory (such as wholesalers). Registration fees (described in appendix F) vary, ranging from 200,000 CFA francs for nursing care practices to 500,000 CFA francs for specialized medical practices and medical and social services centers. In addition, other significant investments are required to begin an activity (such as renting or purchasing a building, buying furniture, equipment, and supplies, and hiring personnel).

Table 4.2 lists the sources of funding for establishing different types of private facilities.

**Table 4.2. Sources of Startup Financing, by Type of Private Facility**

Funds for opening facility	Providers	Laboratories	Pharmacies	Wholesalers
Owner's (or family) equity	85%	100%	+++ <sup>a</sup>	0%
Contributions from partners/shareholders	15%	0%	0%	100%
Loans from third parties + interest	0%	0%	+ <sup>b</sup>	0%
Bank loans	0%	0%	0%	0%

Source: Authors.

a. +++ means that the source provides significant funding.

b.+ means that the source provides less funding.

Startup financing needs for wholesalers are greater and almost entirely funded by shareholders. For private providers, only the facilities organized as associations (which are often the largest) have their investment costs funded by their shareholders.

Owner's equity (personal funds or family funds without interest) are the largest source of startup funding for private providers, laboratories and pharmacies. Only the owners of pharmacies seem to borrow money from third parties.

#### FINANCIAL BURDEN

There are several taxes to be paid by private facilities (see appendix F). Medications and health care services are subject to taxation, just like other traditional business activities and commercial goods.

All of the provider groups complain of the heavy tax burden on their sales figures. For example, the following are the various taxes paid by import wholesalers:

All of these taxes, which are paid in addition to the various shipping and other costs, are reflected in the price of the medications.

Common external tariff customs duty 5% + Community integration tax 1%  
+ IT charge 2% + Common integration contribution 0.4% + Tax collector's fee 0.1%

One third of private providers considered taxes to be one of their most significant costs. In addition, the fact that several different ministries are sometimes involved in the same domains without any apparent coordination among them is perceived by the providers as an obstacle hindering efficiency. Medications, consumable supplies, and equipment are by far the most burdensome expenses. Ranked second are spare parts and maintenance. Rent was mentioned by only two facilities and personnel salaries by one facility.

The most common form of payment to input suppliers is cash, used in a little more than half of cases. Only one case reportedly received credit from input suppliers. The quality of inputs is considered to be very satisfactory in two thirds of cases, and their reliability is considered satisfactory in a little less than half of cases. Product prices are acceptable in at least 80 percent of cases.

ACCESS TO CREDIT

The accessibility to a bank loan for starting up a private facility or for expanding activities seems to present a problem for all the provider groups. This limitation is considered very significant for a large number of private providers. This problem is more acute for large businesses (such as wholesalers). Clearly this is an obstacle to the development of the private health sector.

According to one bank we interviewed, loan terms in the health care sector do not differ from those of other sectors, whether regarding interest rates or the required collateral. However, the contact person answering our questions did point out that the average loan amount granted to the health care sector was lower than that of other sectors.

It should be noted that the *Syndicat des pharmaciens* [Pharmacists Association] and a local bank recently took the initiative to review the credit access problem in order to find solutions for pharmacists and wholesalers.

PRICING

The official price schedules are not applied uniformly by all groups of providers. In the pharmaceutical sector (wholesalers and pharmacists), prices are more or less standardized throughout the country (aside from a few differences due to higher shipping costs in remote areas). However, prices are freely determined by private providers and laboratories, who do not apply the official rates (table 4.3).

**Table 4.3. Method of Pricing, by Type of Private Facility**

Pricing	Providers	Laboratories	Pharmacies and wholesalers	Traditional practitioners
Freely determined	√	√		√
Standardized			√	

Source: Authors.

For private providers, prices vary considerably depending on the type of facility (clinic, private practice, etc.) and on location. For example, the data provided in the survey shows that the price for a doctor's visit for a child with a fever varies by 430 percent (!) throughout the country and by 90 percent to 100 percent for comparable facilities (nursing care practice and medical and social services center, respectively). Prices are higher in Sangha (rural area) than in Brazzaville. For more expensive procedures (Caesarian section), the price range is much narrower (variation of 38 percent), and the lowest prices are charged in rural areas.

According to the owners surveyed, the prices charged are very often determined in an effort to provide services that are affordable for the local population and to allow owners to make a profit and/or cover their operating costs. In only two cases did the respondents say that they took the competition into account when determining their prices. Despite the fact that the law of supply and demand prevails in a free market situation, price setting does not seem to follow true market logic. In addition, the idea of completely free price determination for health care services is debatable.

#### STABILITY OF PRIVATE FACILITIES

Based on the information gathered from the providers surveyed, it seems that private facilities are rather stable. They have been in existence for several years and few failures were recorded. For example, among the private providers surveyed, two thirds of the facilities had been in existence for more than five years and 90 percent had existed for more than two years.

When the providers were asked (in the long questionnaires) if there had been any changes in the services offered or the volume of business, only six of the 20 providers responded that there had been major changes. Only one of the six had experienced a decline in business. Four facilities underwent a change in capital or ownership structure, one of which was due to the death of a partner. Two cases had relocated. In one case, there was a change of ownership; in the other, it was a humanitarian mission.

#### COMPETITION

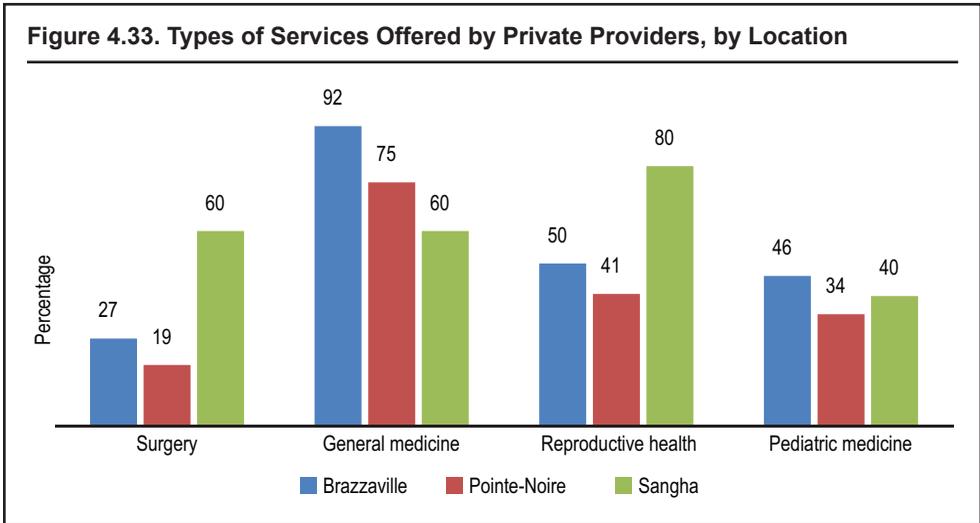
The private providers surveyed in the long questionnaire feel the effects of competition from other facilities, more so from private hospitals<sup>19</sup> (11/20) than public ones (5/20), as well as from outpatient care institutions, both private (7/20) and public (4/20). Single practitioners feel the effects of competition, especially from other private outpatient care institutions. As for the clinics, they reported that they have to compete with the other hospitals, some of which are public but most of which are private. Two facilities stated that they did not have any competition.

#### *Services Offered by Private Providers*

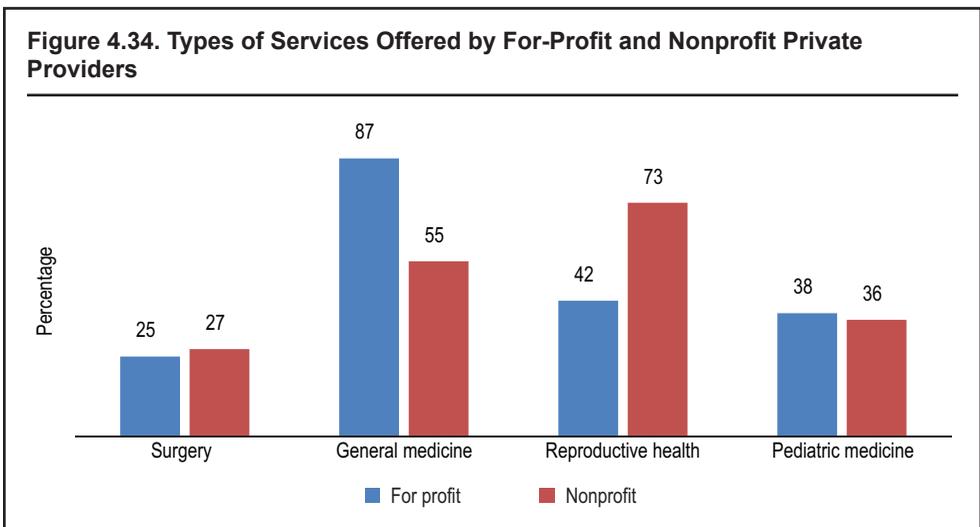
Nearly all services are available at private facilities. The main services offered by the 63 facilities interviewed (short and long questionnaires) are general medicine, reproductive health care services, surgery or minor surgery, and pediatric medicine. In addition, most of the facilities that completed the short questionnaire offer laboratory services (74 percent), and a significant number of these facilities also offer pharmaceutical services

(42 percent). Reproductive health care services are more often offered at nonprofit institutions than at for-profit institutions. The services offered at the 63 facilities cover the distribution shown in figure 4.33 and figure 4.34.

Despite the relatively complete availability of most of the main types of health care services, there are significant gaps in the private health care services, particularly with regard to specialized services. For example, among the facilities that completed the short questionnaire, only one clinic does significant business in surgery (an average of 64 sur-



Source: Authors.



Source: Authors.

gical procedures per month). In addition, the facilities surveyed rarely offer dentistry, ear-nose-throat, ophthalmology, radiology, stomatology, or physical therapy.

#### AVAILABILITY OF MEDICATIONS AND PRESCRIPTIONS

The availability of essential medications varies greatly and it is not at all guaranteed at the facilities that completed the short questionnaire. Except at polyclinics where only amoxicillin and paracetamol were stated as available (out of a list of seven medications),<sup>20</sup> the other essential medications are available in all types of institution, but not at every facility. Although these surveyed institutions are not supposed to have or sell medications, in Brazzaville 22 percent of single practitioners' offices and 33 percent of medical and social services centers have all of the essential medications in stock. In Pointe-Noire, 25 percent of clinics have all of these medications in stock.

The average number of prescriptions written for the 63 facilities (short and long questionnaires) is 22 per day among all types of facilities in the three study locations. The highest average was observed at a clinic in Ouessou/Pokola (180). In Brazzaville, the average number of prescriptions written per day is relatively high at single practitioners' offices (30). In Pointe-Noire, this average is exceeded by one medical and social services center (80), followed by one nursing care practice and one clinic (40 each).

#### BIOMEDICAL ANALYSES AND MEDICAL IMAGING

Most of the 63 facilities (short and long questionnaires) perform fewer than 20 analyses per day. The average number is by far the highest at one single practitioner's office in Brazzaville (75), one medical and social services center in Pointe-Noire (60), and one clinic in Ouessou (50).

Although laboratories and ultrasounds are available at all types of health facilities, radiology was declared only at clinics and single practitioners' offices. Thus we observed that laboratories are more common at nursing care practices than at single practitioners' offices. The opposite is true for ultrasounds.

#### HOSPITALIZATION SERVICES AND REFERRALS

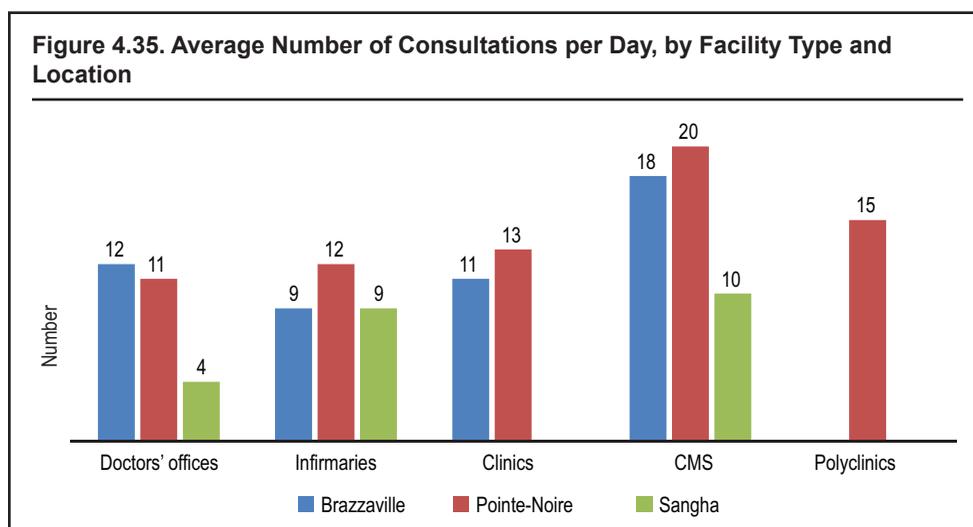
The private sector offers very few hospitalization services. Some private facilities have beds, but these facilities do not possess the technical level of a hospital. According to the responses to the short questionnaire, only two polyclinics have beds (fewer than 10 beds). Aside from polyclinics, only 25 percent of clinics and 17 percent of single practitioners' offices have a few beds (in general fewer than 10 at each institution). Referrals of difficult cases received by private facilities are sent to the large public hospitals. As for counter-referrals, the very notion is unknown by most of the respondents; it is more or less nonexistent.

#### AVAILABILITY OF EQUIPMENT

At most of the facilities that completed the survey (short questionnaire), all of the consultation equipment was declared as available. The least often declared instrument is the baby scale, which is available at only 50 percent of polyclinics and clinics, at 61 percent of single practitioners' offices, and at 43 percent of nursing care practices.

### NUMBER OF CONSULTATIONS PER DAY

The number of outpatient consultations is not very high for all categories of facilities in the three study locations. The average number of consultations per day is 14. The distribution by survey location shows that the medical and social services centers in Brazzaville and in Pointe-Noire are patronized the most (with an average of 18 and 20 respectively). A single practitioner's office in Ouessou is patronized the least often (with only four consultations per day) (figure 4.35).



Source: Authors.

### *Pharmaceutical Sector*

This section describes the private pharmaceutical sector, including supplies, medication sales, and production.

#### SUPPLY OF MEDICATIONS

The private pharmaceutical distribution network consists of nine import wholesalers, five of which are established in Brazzaville and four in Pointe-Noire, three of which are represented in both Brazzaville and in Pointe-Noire.

In theory, the COMEG (introduced in section 4) supplies private pharmaceutical facilities with essential medications according to the instructions of the chairman of the COMEG board of directors. To date, this applies only to insulin. For reasons of public health, COMEG supplies insulin to reduce the prices charged for it. The COMEG has established several partnership agreements with other organizations for the storage, management, and distribution of pharmaceutical products funded by various organizations as part of their duties. The organizations include the standing executive secretariat of the National AIDS Council,<sup>21</sup> the United Nations Population Fund (UNFPA),<sup>22</sup> and the French Red Cross.<sup>23</sup> These contracts are not true PPPs, but they could be used as an example for service agreements.

## MEDICATION SALES

There are nearly 220 pharmacies throughout the country, located primarily in the major cities of Brazzaville, Pointe-Noire, Dolisie, NKayi, and Ouesso, and nearly 400 pharmaceutical outlets are located in “secondary” areas. In 2006–2007, according to the ONP database, the number of pharmacies (referred to as “dispensaries”) and pharmaceutical outlets was 186 and 120, respectively. This confirms the general perception that the private pharmaceutical sector is rapidly growing in the Republic of Congo.

In 2007, according to the ONP, there were 205 pharmacists, including 199 dispensary pharmacists and 6 hospital pharmacists. This is the equivalent of 0.51 pharmacists per 10,000 inhabitants, compared with 0.33 for Sub-Saharan Africa and 3.07 for middle-income countries.

The pricing structure for medications is established according to the provisions of Law 6/94 establishing pricing regulations for commercial standards and finding and suppressing fraud and Decree 4790 of September 15, 1994, establishing pricing regulations for pharmaceutical products. This decree establishes the margins for wholesaler/distributors and for dispensary pharmacists.

Financial data for the whole pharmaceutical sector is not available. However one bank, the *Banque Congolaise de l’Habitat* (BCH) [Congoese Housing Bank], which works with the actors in the sector estimates that the sector has sales upwards of 42 billion CFA francs.

## PRODUCTION OF MEDICATIONS

Local production of pharmaceutical products remains very low. To date, the Vietnamese company LAPHARCO is the only pharmaceutical company established in the Republic of Congo, and it only does repackaging. Startup funding is the main obstacle to developing local production.

### *Users of Private Providers*

An analysis of the responses to the short questionnaire suggests that the owners believe that half of the clientele of private providers are poor, including the most impoverished (table 4.4). This observation is partially confirmed by the demand analysis (section 4) and is explained in part by the private providers’ flexibility with payment methods and timeframes (see below). However, most of the clientele of laboratories and pharmacies is

**Table 4.4. Distribution of Users and of Private Providers, by Socioeconomic Group (percentage of group)**

Class	Providers	Laboratories	Pharmacies	Traditional practitioners
Wealthy	14%	—	++	+ <sup>a</sup>
Middle	34%	60–70%	+++ <sup>b</sup>	+
Poor	49%	20%	+	+
Most impoverished	3%	— <sup>c</sup>	—	+

Source: Authors.

a. + means that the class is less dominant.

b. +++ means that the class is more dominant.

c. — = not available.

from the middle or wealthy classes. This suggests either a financial accessibility problem for the latter two facilities, or that the prescriber is more likely to send poor people to public facilities or does not refer them.<sup>24</sup> Although this is the reality of the situation, this presents an equality problem.

The responses regarding clientele distribution by socioeconomic group are based on the perception of the provider surveyed and not on objective data. This should be taken into account when interpreting these data.

#### FINANCIAL ACCESSIBILITY

For private sector health care services, the method of payment is direct payment by the user or payment by a third party (either health insurance or the company pays for its employees [see table 4.5]). Nearly all payments made to private facilities come directly from households. The availability of health insurance is limited (except for a few exceptions primarily in Pointe-Noire, given the presence in this city of a significant number of insurance companies).

**Table 4.5. Method of Payment in Brazzaville and Pointe-Noire, by Type of Private Facility**

Payment type	Health care provider		Laboratories		Pharmacies	
	Brazzaville	Pointe-Noire	Brazzaville	Pointe-Noire	Brazzaville	Pointe-Noire
Direct payment	55%	52%	100%	35%	>90%	60%
Payment by a third party	20%	27%	— <sup>b</sup>	65%	<10%	40%
Unable to pay	25%	21%	—	—	—	—

Source: Authors.

a. The results for the pharmacists are an estimate based on the focus groups.

b. — = not available.

Private providers are faced with the problem that nearly one in five patients is unable to pay. Free treatment associated with the inability to recover the cost of care is a cause for significant lost income for facilities, amounting to an average of 30 percent (estimate made by the providers surveyed). This percentage seems very high.<sup>25</sup>

The owners who responded to the short questionnaire reported that different measures are taken when patients cannot pay for services. In more than half of cases, the treatment is given free, and recovery of the costs is pursued later (11/20). In one third of cases, the facility states that it provides free care to these patients (6/20). In one specific case, half-price rates for supplementary exams were applied. In two cases, treatment was not provided.

This phenomenon is reportedly not experienced by the pharmacies and laboratories, which do not offer free goods or services. This suggests that the poor segments of the population do not have access to these services.

The potential for broadening health insurance coverage and/or contracting with/subsidizing pharmacies and/or lab tests in order to cover the poor should be considered, or a subsidy for the poor for medications and/or laboratories. Otherwise, effective coverage of the poor population by the public sector remains to be ensured.

### *Common Performance Obstacles*

All groups of private professionals are faced with performance obstacles. Most of these obstacles are the same for all groups.

All of the groups of providers confirmed that the regulations are not properly followed<sup>26</sup> (for example with regard to pricing of services), that the government does not enforce them effectively (inspections by ministerial authorities are rarely conducted), and that not all of the providers are aware of the content of the regulations. This enables the development of a “parallel” market in each of the fields/professional groups, especially for the sale of medications. Nevertheless, two-thirds of the owners interviewed feel that the regulations are a real burden.

More than half of the owners (11/20 in the long questionnaires) stated that public policy inhibits certain activities at their institutions. They also emphasized the significance of the administrative headaches that accompany these policies and this legislation. According to one manager, due to these policies, user demand is not met, and particularly a growing demand for abortion services, a procedure that is prohibited by Congolese law.<sup>27</sup>

The obstacles reported by professional groups are presented in table 4.6.<sup>28</sup>

### *Current Projects*

Private sector owners were asked about any investment projects that they have underway, in order to help identify developing trends in the sector, and about the limitations that they are encountering in expanding their business activities. Very few ongoing projects were identified, aside from plans for expansion of a few private providers, who are all faced with the problem of financing due to a lack of access to bank loans.

**Table 4.6. Performance Obstacles Mentioned, by Type of Private Facility**

Obstacle	Private providers	Laboratories	Pharmacies	Wholesalers	Traditional practitioners
Lack of formal representation	√	√		√	(√)
Provisional authorization	√		√		No registration
Knowledge of regulations	√	√	√	√	Nonexistent
Sector insufficiently regulated	√	√	√	√	√
Lack of subsector policies			√	√	√
No audits by the MSP	√		√		√
Lack of support and supervision	√		√	√	√
Lack of state subsidies	√	√	√	√	√
No access to capital/bank loans	√	√	√	√	
Heavy financial burdens	√	√	√	√	
Onerous administrative fees	√	√	√	√	
Weakness of public infrastructure	√	√	√	√	
Insufficient human resources	√				
Lack of demand-side financing	√		√	√	
Lack of formalized PPPs	√	√			√
Illegal competition		√	√	√	√
Rivalry with Eastern medicine					√

Source: Authors.

An interesting project under way is one pursued by the *Syndicat national des pharmaciens du Congo* [National Pharmacists Association of the Republic of Congo] which, with the help of a national bank, has created a Guarantee and Solidarity Fund with financial support from the pharmacists themselves. On the occasion of the second annual Pharmaceutical Days in Brazzaville, in October 2010, a presentation entitled “Bank and Pharmacy” was made by a local bank on the topic of financing for the sector. The creation of the fund may serve as an example for the whole private sector.

Formal contractual relationships between the private and public sectors are rare. On the other hand, the few examples of PPPs and the two formal private provider agreements mentioned above show that some examples exist. These could possibly serve as a basic framework for establishing broader contractual relationships in the private sector, if the opportunities arise and if the MSP is interested.

### *Recommendations Made by Private Providers*

Table 4.7 lists the recommendations that each professional group made in the survey and at the workshops, as well as a few recommendations added by the experts. Clearly, some of them could be applied to the whole private sector (and not only to the group that mentioned them) such as the authorization procedure or the policy on generic medicines. To a large extent, these recommendations address the common obstacles listed above, which explains why several of them came up in multiple groups.

**Table 4.7. Recommendations, by Provider Group**

Recommendations	Private providers				Traditional practitioners
	Laboratories	Pharmacists	Wholesalers		
Establish a formal framework for representation and collaboration	√	√	√	√	√
Make the authorization procedure easier and more effective	√		√		
Regulations further developed, applied and enforced as mandatory	√	√	√	√	√
Create/improve a generic medicines policy			√	√	
Promote access to continuing education	√				
Promote access to bank loans	√	√	√	√	
Promote technical support in the development of projects/management	√			√	
Reduce taxes	√			√	√
Reduce administrative fees	√	√	√	√	
Introduce demand-side financing	√				
Create/formalize PPPs	√	√			√
Establish contracts to provide health care for the poor	√	(√)			
Revise the scope of authorized services		(√)			
Subsidize certain essential medications			√	√	
Introduce measures to motivate opening facilities in rural areas	(√)		√		
Eliminate illegal and unfair competition	√			√	
Subsidize traditional medicine and formalize training and research					√

Source: Authors.

Note: The recommendations are not ranked by priority.

a. (√) Potential recommendation suggested by the team of experts (and not by the group of providers).

## Summary and Conclusions

The following points summarize the results and conclusions on supply in the private sector:

- Most of the private facilities are concentrated in Brazzaville and in Pointe-Noire, although these two subregions cover only 60 percent of the total population. Among these private facilities, nurse headed practices are the most numerous.
- The vast majority of private facilities are for-profit.
- Startup financing needs present a problem for all of the provider groups. Owners' equity is the most significant source of startup funding for private providers, laboratories, and pharmacies.
- All of the provider groups complain about the tax burden.
- The accessibility of bank loans presents a problem for all groups of providers.
- Although prices are freely determined for private providers and laboratories (the official prices are not followed), the prices are more or less standardized in the pharmaceutical sector (wholesalers and pharmacists).
- The main services offered by the private providers include general medicine, reproductive health services, surgery and minor surgery and pediatric medicine. There are significant gaps, particularly with regard to specialized services (for example, dentistry, ear-nose-throat, ophthalmology, radiology, stomatology, and physical therapy).
- The use of outpatient consultations by patients is low for all categories of facilities (the average number of consultations per day is 14).
- According to the owners, although half of the clientele of private providers are poor, most of the clientele of laboratories and pharmacies belong to the middle or wealthy classes.
- Nearly all of the payments made to private facilities come directly from households. Free treatment associated with the inability to recover the costs of care is the cause of significant lost income for providers.
- The main performance obstacles identified by the private owners included: lack of formal representation, authorizations to practice and regulations, lack of a subsector policy for the private sector, lack of support or subsidies from the State, lack of access to capital, onerous financial and administrative costs, weak public infrastructure, insufficient human resources, lack of formalized PPPs and illegal and unfair competition.
- There are very few projects under way to expand business in the private health sector. The only interesting project under way is the one by the *Syndicat national des pharmaciens du Congo* [National Pharmacists Association of the Republic of Congo] which, with the help of a national bank, has created a Guarantee and Solidarity Fund.

### Analysis of the Institutional Framework for Actors in the Private Health Sector

This section analyses the relationships between private providers and institutions with which they interact, identifies limitations brought about by the interactions, and attempts to find solutions. This analysis is based on the results of the survey conducted as part of the study, as well as on the interviews with representatives of private facilities and focus group discussions with private sector providers organized as part of the study.

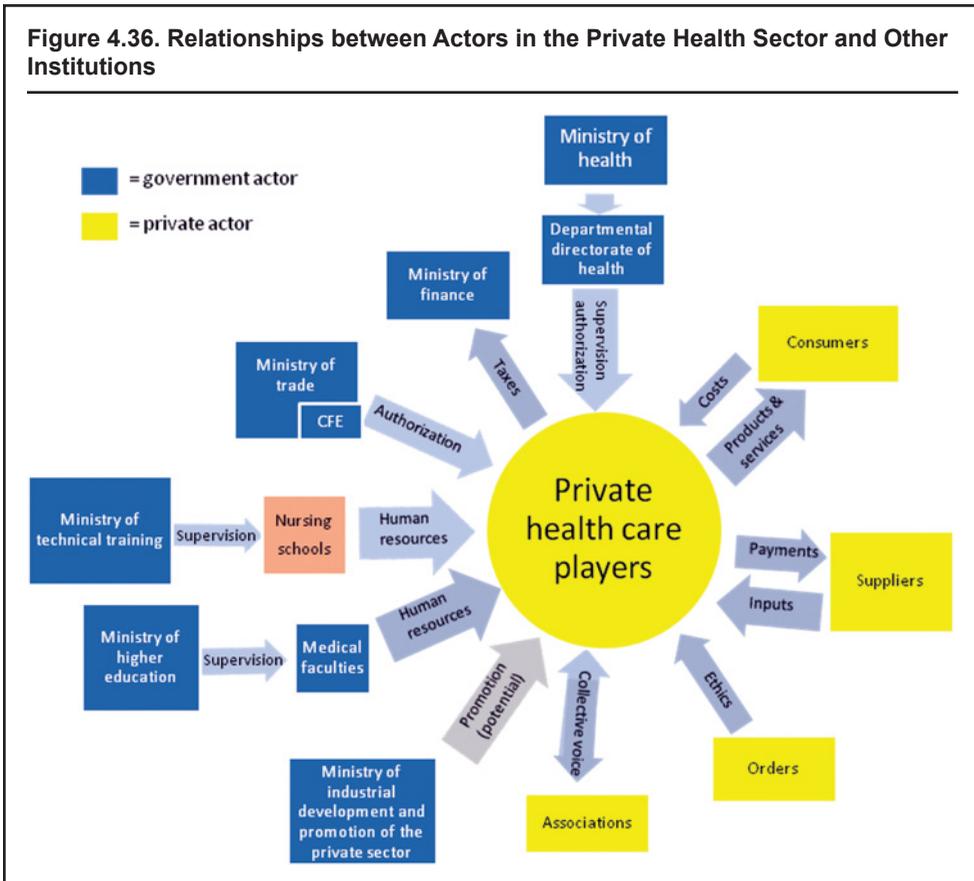
**Relationships between Actors in the Private Health Sector and Other Institutions**

As explained in section 2, private facilities interact with a wide range of institutions, both governmental and private.

In the public sector, major interactions revolve around the MSP, although direct relationships also exist with the Ministry of Trade and the Ministry of Finance. Additionally, government health care services, particularly hospitals, coordinate private facilities' activities informally.

Private health care services also maintain relationships with a wide range of private institutions. The initial interaction is the one that occurs with users who purchase products and services from private facilities. In addition, private medical equipment distributors and pharmaceutical and medical supply wholesalers sell their products to private facilities.

Figure 4.36 summarizes all of the relationships between actors in the private health sector and other institutions, as well as relationships with private suppliers, funding sources, and the recipients of their products and services. The sections below examine these relationships in an effort to identify the limitations that exist and to attempt to find possible solutions.



Source: Authors.

## HUMAN RESOURCES

There is very little coordination in terms of human resource management between the public and private sectors. This weakness is explained by the lack of framework for cooperation between the Ministry of Health and the Ministries of Technical and Professional Training and Higher Education, and the lack of willingness on the part of decision-makers. For example, certain Catholic health care centers have personnel recruited and paid by the Catholic authorities, but the government still sends them more personnel without asking their opinion, inquiring about the facility's needs, or even considering the skills of the new workers they send.

### PRIVATE HEALTH WORKER TRAINING

Despite the fact that the private health sector is not (legally) authorized to pursue training for health personnel, due to a lack of monitoring, there are private schools that unofficially train health workers.<sup>29</sup> This causes problems for the schools, as well as for the health care personnel trained in them (validity of diplomas; see section 2). Graduates from these private schools cannot take the official State examinations and find themselves without a recognized diploma. Consequently they have no other choice but to work in private health care institutions since the government facilities do not accept them. The private sector owners who employ these personnel would like them to be able to take the State exams in order to validate their skills and obtain diplomas. In addition, there is no policy to promote access to continuing education for private sector personnel.

### *Legal Framework*

Decree 88/430 of June 6, 1988 defines the conditions of practice with private clientele (for the medical, medical-related and pharmaceutical professions), including required academic training. In theory, only Congolese nationals can start a private business in the field of health care (this is not the case for some other commercial sectors). The law provides specific details on the main activities that can be conducted within private health facilities, as well as the specific tasks that can be called for by the MSP as part of national programs. On the other hand, the law does not specify the qualifications of providers for each of the procedures performed (in reality, for example, a nurse can conduct consultations, health assistants can deliver babies, etc.).

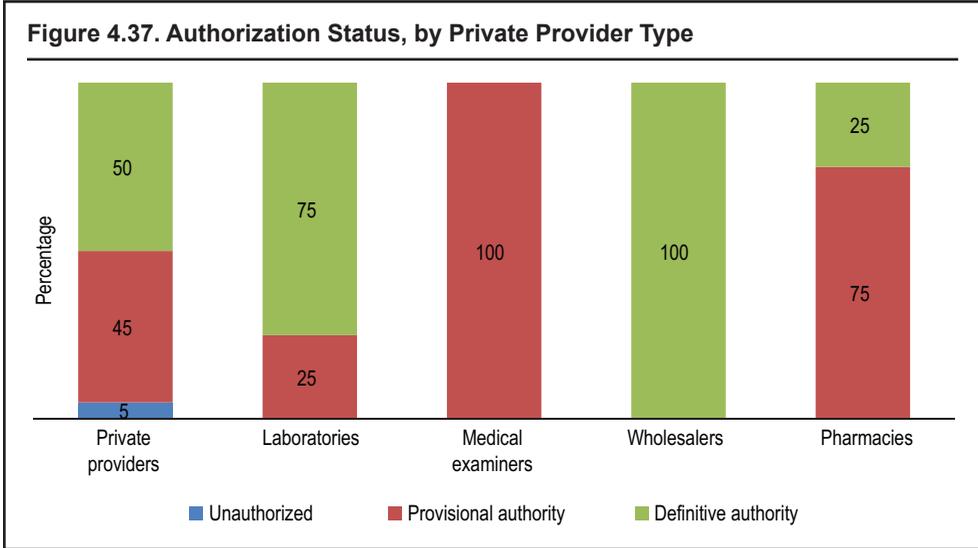
Decree 88/430 also specifies the conditions for civil servants working in both the public and private sectors (those laid off, retired, or who have resigned) but not for private providers. The law calls for a joint decree from the MSP and the Ministry of Trade specifying the prices for procedures, but price schedules are not published regularly (see section 4). Pharmaceutical products, for which official prices are published, are the exception and, according to the results of our survey, they are followed.

### *Authorization to Practice*

#### PROCEDURE WITH THE MINISTRY OF HEALTH

The procedure that must be followed in order to obtain authorization to practice (see appendix F) is not effectively applied and the system does not take full advantage of its potential. Figure 4.37 describes the statuses of the provider groups surveyed in this study.

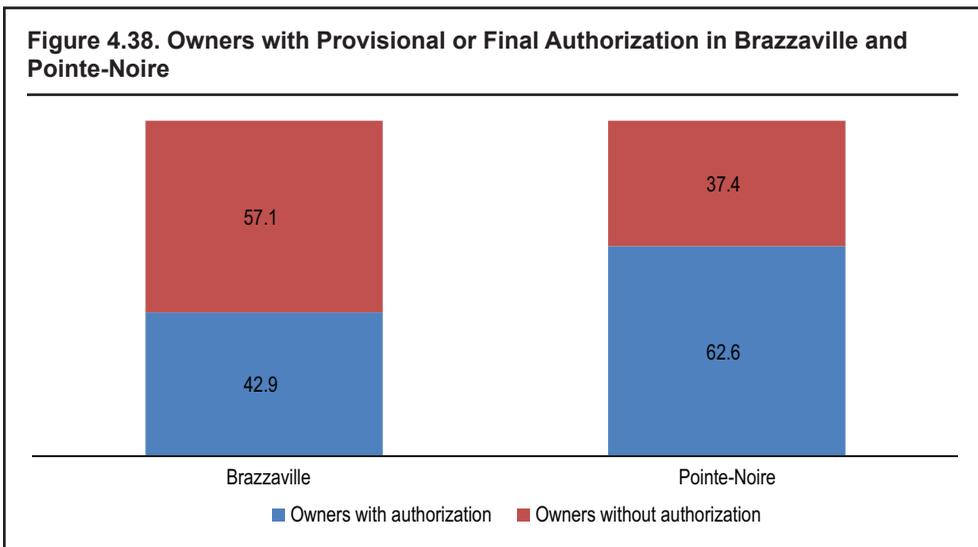
In the sample for this survey, 5 percent of private providers are working without official authorization. A very large percentage of providers work under provisional au-



Source: Authors.

thorization: up to 75 percent of pharmacists and 100 percent of medical imaging centers, and even 45 percent of medical providers and 25 percent of laboratories. The only exception were the wholesalers surveyed, all of whom have obtained final authorization.

These observations were also confirmed for all of the private facilities counted in the 2010 census by the DDSs; in Brazzaville a minority of owners had obtained final authorization to practice their profession. Indeed, only 4 owners out of 10 in Brazzaville and 6 owners out of 10 in Pointe-Noire have their status in order concerning authorization to practice. Figure 4.38 shows the authorization status of the owners in Brazzaville and Pointe-Noire.



Source: Authors.

Administrative complexity and delays, as well as the lack of financial resources are the most common problems cited concerning the process of obtaining authorization to practice. According to one of the informants interviewed in the study, "Problems of complexity; in fact it's a mentality issue, lack of professional awareness, lack of rigor and national impunity that is very noticeable among the managers of the MSP." In addition, the facilities that have been practicing under provisional authorization for more than two years suffer no penalty. A large proportion of provisional authorizations date back more than one year (normal procedure) and some are ten years old. Consequently in the not-for-profit sector, many centers have been operating for years with provisional authorization to practice. Due to a lack of inspections or a decision from the MSP, there is a "not licensed, but allowed" status; the nonprofit sector is asking for increased regulations, "because everyone wins when the rules are followed." It is clear that implementing the stated procedure poses a problem. An ineffective procedure runs the risk of promoting the development of an illegal subsector and noncompliance with other regulations in an environment perceived as "permissive."

There are many reasons for this ineffectiveness. First of all, the owner is the one who must take the initiative to apply for final authorization. Because not having final authorization is "permitted," (for example, there is no policy of different prices between institutions practicing with provisional authorization and those with final authorization), the owner is not motivated to undertake this procedure, which he perceives as burdensome. Second, it is up to the MSP to verify that the private facilities have their authorizations in order. However, the department at the MSP that is responsible for this seems to lack the resources (and motivation?) to effectively enforce the legal procedures.

#### PROCEDURE WITH THE BUSINESS REGISTRATION CENTER (CFE)

The process of obtaining authorization from the CFE begins after obtaining provisional authorization from the MSP. Health providers must pay twice: first there are the fees for obtaining provisional authorization to practice in the health care sector from the MSP, and then there are the fees associated with obtaining final authorization from the CFE (after the application is accepted by the MSP). However, the CFE does not have the authority to enforce the providers' obligation to pay these fees (the administrative police are responsible for enforcing payment in the field).

The CFE procedure uses the single-window concept, according to which providers can complete all of the administrative procedures related to creating, transferring, expanding, modifying, and ceasing a business activity, at a single location, with a single form and a single payment, in less than one hour. The CFE confirmed that it would be possible for the MSP to use the same window for the procedures that must be completed with its departments, if this were deemed helpful.

#### *Quality Assurance*

The mechanisms for ensuring the quality of private providers are insufficiently developed. However, there are many potential options for improving quality assurance. For example, the authorization procedure could be related to an accreditation process (for the institution and for professionals) that would motivate owners to maintain and continually improve the quality of the service offered.

Likewise, supervision, coaching, continuing education, and inspections are irregular and inconsistent. According to several of the informants interviewed, the lack of effective supervision is primarily explained by the limited capabilities of the relevant departments or units at the central levels (MSP) and at the decentralized level (DDSs), as well as by a lack of motivation. However, the MSP is not the only party responsible for quality and ethics within the private health sector. There are three other major actors: the national orders, the associations, and the private sector itself (its structure and self-regulation).

### *National Orders*

The primary function of national orders is to ensure that ethical standards are followed in the practice of health care professions.

The National Order of Pharmacist (ONP) seems to be the most effective of the national orders in terms of coverage (it represents all of the pharmacists in the country) and is the most respected by its members.

The membership of the National Order of Physicians (ONM) is made up, for the most part, only of private-sector physicians (as the law requires doctors who practice independently to be members). Indeed, only 350 doctors (including 200 in Brazzaville) are members of the ONM (out of an estimated total of 800). Most private-sector doctors are not members of the ONM (the law does not require them to be and the added value of the annual dues<sup>30</sup> is probably perceived as limited). Logically, the ONM is fighting to make membership mandatory to practice medicine in the public or private sector.

### *Structuring of Associations in the Private Health Sector*

No platform or association yet exists to represent the entire private health sector, and most of the subsectors do not have a collective voice for expressing their interests. Consequently, there is no principal contact person (or entity) representing the private health sector on the whole, with whom the MSP can communicate directly. In addition, this sector has not developed measures to self-regulate on issues of service quality.

Each group of providers needs one (or more) representative(s) to maintain regular contact, do lobbying, defend their interests, send information from the government to the group of providers, etc. However, only the pharmacists have a formal framework of representation with the MSP. They are represented by the SYNAPHAC, the most organized, most active professional association. SYNAPHAC plays an important role in certain activities such as revising legislation pertaining to private pharmacies, ongoing advocacy for improving policies such as those pertaining to generic products, and taking part in an initiative with a commercial bank to ensure access to credit. One of the important results of these activities is the regular updating of the price schedule for pharmaceutical products, which is standardized and followed throughout the sector.

The question has been raised as to whether the SYNAPHAC could also be the official representative of wholesalers and laboratories. Another question that has been raised is whether the doctors could have one or more comparable organizations to that of the pharmacists. Consequently the role and the functionality of the ONM merit reviewing/strengthening. Finally, no association exists for all of the nonprofit actors in the private sector.

The various representatives, by type of service, are presented in table 4.8.

**Table 4.8. Representing Entity, by Type of Private Sector Facility**

Facility type	Representing entity	Comments
Providers	No formal framework	<ul style="list-style-type: none"> <li>• Role for the ONM? Association?</li> <li>• Not all doctors are members of the ONM</li> <li>• Role for the Catholic and Protestant networks?</li> </ul>
Laboratories	No formal framework	<ul style="list-style-type: none"> <li>• Role for the ONP?</li> <li>• All biologists/pharmacists are members of the ONP</li> </ul>
Wholesalers	No formal framework	<ul style="list-style-type: none"> <li>• All pharmacists are members of the ONP</li> </ul>
Pharmacies	SYNAPHAC	<ul style="list-style-type: none"> <li>• <i>Syndicat national des pharmaciens du Congo</i> (SYNAPHAC) [National Pharmacists Association of the Republic of Congo]</li> <li>• <i>Association des pharmaciens du Congo</i> (ASPHAC) [Association of Pharmacists of the Republic of Congo]</li> <li>• All pharmacists are registered with the ONP</li> </ul>
Traditional practitioners	National federation (to be created)	<ul style="list-style-type: none"> <li>• 3 subregional federations</li> <li>• <i>Union nationale des tradithérapeutes congolais</i> [National Union of Congolese Traditional practitioners] (no longer operational)</li> </ul>

Source: Authors.

### **Taxes**

All of the private institutions, including nonprofit organizations, are considered to be commercial establishments and therefore are subject to taxes like any commercial entity. This is a characteristic specific to the Republic of Congo, and rather exceptional in the health care sector in Africa (see section 2 for the registration of all commercial entities with the CFE and for the description of the taxes). It is difficult to argue that health care, as well as education, are commercial activities, but the regulations exist and the attitude of tax authorities is that “the parties involved do not want to comply with taxation.”<sup>31</sup> The CFE believes that it is a “hollow debate” to discuss the possibility of exempting private activities with a social purpose because whenever there is invoicing, “there must be taxes, as this is revenue for the State.”

All of the provider groups complain of the tax burden. The fact that private facilities are treated as commercial entities could cause higher prices for private health care products and services. The nonprofit sector pays taxes just like the for-profit sector, but it claims that the State should treat it the same as the public sector because they “provide a social service.”

### ***Relationships with Efforts to Promote the Private Sector in the Overall Congolese Economy***

The private health sector has not yet been included in the facilities and activities of the MDIPSP, to promote private activity (described in detail in section 2). Nevertheless, a representative of the MDIPSP participated in the second workshop organized as part of this study, and he expressed MDIPSP’s interest in collaborating with the health care sector.

### ***Contractual Relationships between the Public and Private Sectors***

The term “public-private partnership” or “PPP” is often used to encompass all contractual relationships between the public and private sectors. These two sectors maintain very few official relations, and very few examples of PPPs have been observed in the

field of health care in the Republic of Congo (figure 4.37). However, all types of actors in the private health sector expressed an interest in developing PPPs.

One form of partnership is professionals who work in both sectors. Many private providers (especially specialist physicians) combine their private sector work with a job in the public sector. One third of the managers of private facilities surveyed in this study also work in the public sector. The reason most often given for working in the private sector is the desire for autonomy, which is ranked ahead of the income-generating aspect.

A frequent form of traditional partnership in the Sub-Saharan region is the one that exists between the government (MSP) and the nonprofit sector, when the latter plays a significant role in providing essential health care services or when it is involved in training medical professionals. However, this type of partnership is infrequent in the Republic of Congo and even less often formalized.

Table 4.9 presents the different type of interactions between the public and private sectors.

**Table 4.9. Types of Interactions between Public and Private Sectors, by Type of Private Sector Facility**

Interaction between public and private sectors	Providers	Laboratories	Pharmacists	Wholesalers	Traditional practitioners
Opening/registration	100%	100%	100%	100%	No
Regular/annual monitoring	65%	Variable <sup>a</sup>	Variable <sup>b</sup>	Annual	No
Informal contracts	15%	No	No	No	No
Formal contracts	10%	—	No	No	No
Arrangement with another Provider	50% (private) 10% (public)	Informal with providers	Informal with wholesalers	Informal with pharmacies	No
PPPs	4 plus examples	No	No	No	No
Work as a public- and a private sector provider	20%	No	No	No	No
Favorable toward PPPs	Yes	Yes	Yes	Yes	Yes

Source: Authors.

a. Visits from the offices of the *Direction des pharmaciens, des laboratoires et du médicament* (DPHLM) [Department of Pharmacists, Laboratories and Medications] are relatively regular and visits from the inspectorate are less regular for pharmacies, wholesaler-distributors and biomedical analysis laboratories.

b. Ibid.

c. — = not available.

A few examples of PPPs pertaining to specific services were mentioned during the surveys for this study. The COMEG is one form of partnership. The COMEG is a nonprofit pharmaceutical distribution association created by the State, faith-based organizations and development partners. The clients of the COMEG are primarily public facilities and private sector nonprofit facilities, such as NGOs and faith-based organizations with a certificate (or similar document) issued by the MSP. It is also intended to supply private pharmaceutical facilities with essential medications (for further details, see section 4).

“*Les gestes qui sauvent*” [literally: “lifesaving techniques”] is a national communication campaign promoting the survival of children ages 0 to 5 years, through a partnership between the MSP, the United Nations Children’s Fund (UNICEF), and the private sector. The aim is to teach mothers and young women of childbearing age how to perform

simple, inexpensive techniques that are easy to practice at home, in order to prevent or treat the health problems that especially affect children. The private partners include WARID-CONGO S.A., Burotop and faith-based organizations. This initiative covers the country's 12 subregions. The not-for-profit sector benefited from training sessions organized by UNICEF and it participated in a national committee to develop documents pertaining to this initiative.

However, most of the initiatives that involve public-private partnership are not formalized in a written contract; rather, they are ad hoc and pertain only to a few individual private facilities. As a few examples, there are "agreements" pertaining to referrals, vaccinations, HIV/AIDS treatment, reproductive health, and specialized care. For instance, a PPP project under consideration with Netcare for hemodialysis in Pointe-Noire concerns the public sector sharing the use of Netcare's dialysis and very modern ophthalmology equipment and facilities.

The initiatives are modest, still in the experimental phase, and not yet institutionalized. Moreover, the public sector seems to lack trust in the private sector, which it finds to be "not very organized" and "not very respectful of standards." For example, regarding reproductive health, the MSP confirmed that "the Ministry already does things with the private sector, such as with faith-based organizations, but above all, the private sector has to organize itself and meet standards with regard to qualifications and professional conduct, such as for the active management of the third stage of labor. The problem with the private sector is that they do not meet standards pertaining to treatment and often do whatever they want."

## Summary and Conclusions

The institutional analysis produced the following results and conclusions:

- Private facilities interact with a whole range of other institutions, both governmental and private.
- The nonprofit sector is faced with the same problems as the for-profit sector, such as an involved procedure for obtaining authorization to practice, the administrative burdens associated with these procedures, a significant tax burden, and the lack of contractual PPPs.
- In general, the regulations pertaining to the private health sector are not applied effectively, and the same is true for the process of obtaining authorization to practice. Because the procedure is laborious, a large number of facilities operate only with provisional authorization even after one year of practice. According to the data from the 2010 census conducted by the MSP, only 40 percent of private sector owners in Brazzaville and 60 percent of those in Pointe-Noire have final authorization to practice.
- Private providers (especially the nonprofit ones) see taxes as a significant burden. Private providers (whether for-profit or nonprofit) are considered to be commercial entities (this phenomenon applies in only a few African countries) and thus must pay commercial taxes.
- Private, for-profit providers are not organized as a group (except in the pharmaceutical sector), which means that their opinions are generally met with a faint response. As for faith-based providers, only one association exists (*Action medi-*

*co-sociale catholique du Congo*) [Catholic Medical and Social Initiative of Congo], which only represents Catholics.

- The systems in place for ensuring the quality of private providers are not well developed, but opportunities for improving quality assurance do exist (such as accreditation, supervision, coaching, continuing education and inspection).
- Recent initiatives (such as those of the Ministry of Industrial Development and Promotion of the Private Sector and a few examples of PPPs) present real opportunities for the private sector and for supporting the implementation of the reforms that were identified at the workshops conducted as a part of this study.

## Conclusions about Supply and Demand

The use of private health care providers accounts for between one third and one half of all use of modern medicine, a proportion that could increase even more if the quality of the care offered by this sector improves. Private provision is more focused on outpatient care than on hospitalization and therefore plays an important role in providing primary health care services. This pertains both to the not-for-profit and the for-profit sectors. According to the *Enquête congolaise auprès des ménages* (ECOM) [Congolese Household Survey], the public sector meets 44 percent of demand and the private sector 56 percent (private providers 31 percent, pharmacies 10 percent, traditional practitioners 9 percent, not-for-profits 4 percent, and others 2 percent).

The quality of the services offered by private providers depends on the quality of the basic training and continuing education of human resources and on appropriate coverage of human resource needs. However the quality of the basic training at schools for medical-related professions, and even at the university, is inadequate and estimates of human resource needs do not take into account the needs of the private sector. In addition, the private sector (for-profit and not-for-profit) does not have the right to open schools and does not have access to the continuing education provided by the State. This poses a problem and does not allow the private sector to take its own actions to improve the quality of the care offered by its facilities (other problems contributing to this include the lack of information and the lack of structure within the sector).

The pharmaceutical sector is the best-organized subsector. The *Ordre national des pharmaciens du Congo* (ONP) [National Order of Pharmacists], which covers all pharmacists, is well organized and respected; the *Syndicat national de pharmaciens du Congo* (SYN-APHAC) [National Pharmacists Association of the Republic of Congo] is very active and it maintains a dialogue with the ministry (for example in revising the pharmaceutical laws); and the prices for medications are standardized. However, the ONM [National Order of Physicians] represents fewer than half of physicians (this pertains especially to private-sector physicians), there is no doctors' association, and the prices for care vary considerably. The subsector of traditional practitioners is organizing more and more through the *Confédération des tradipraticiens* [Federation of Traditional Practitioners] (the creation of which is imminent), the traditional medicine policy, and the 2008–2012 strategic plan.

Although the prices for medications are standardized throughout the country (with small variations for shipping charges), the prices for care, laboratory tests and medical imaging vary (sometimes by a lot) throughout the Republic of Congo depending on the different types of facilities and even among different facilities of the same type. This

price variation is more significant for less costly care than for the more expensive care such as a Caesarian section. This clearly poses a problem of financial accessibility for the most disadvantaged populations. The responses “too expensive” or “no money” were by far the most frequent to the survey question “Why haven’t you sought health care when you were sick?”

The most unexpected finding is that private providers are appreciated for providing treatment to the poorest patients who have difficulty paying (terms of payment and timeframes, or exemption from payment). This sometimes poses problems for the financial stability of these facilities. Yet the authorities do not have a policy for using the private sector to treat the poor, or financing or subsidization strategies for providing care for the poor population. The new initiative establishing free services for certain types of care, such as malaria treatment for children ages 14 and under and pregnant women, as well as Caesarian sections, is a welcome addition. However, it should be seen within a broader context of the significant cost of providing health care to the poor (for example, consideration could be given to paying for the most significant costs through an equity fund).

With regard to financing, there is also the problem of access to credit in order to be able to establish or develop a facility. All of the private actors complain of a lack of access to bank loans.

There are many common obstacles to good performance in the private sector in the Republic of Congo, but they can be summarized as a few general areas, as follows:

### *Organization of the private sector*

The private sector is insufficiently collectively organized.

- There is a lack of structure in the private sector into associations/professional unions for most of the provider groups and there is no single organization to represent the private health sector in its entirety.

### *Regarding regulations*

Regulation is a weak point.

- The weaknesses of current regulations, the lack of awareness of the regulations on the part of the actors in the private sector and the nonenforcement of the law result in illegal competition, the establishment of “parallel” markets, and a lower quality of service offered by the private facilities.
- The private sector does no self-regulation.
- Registration and procedures to open facilities are inefficient, which leaves a large number of facilities with provisional authorization for more than one year.
- The lack of an accreditation system for facilities and health care professionals causes very large variations in the quality of care offered.
- The law does not permit the private sector to open and manage private schools to train human resources in health care professions.

### *Policy/governance*

Policy oversight, as well as coordination and cooperation on the measures to be taken with regard to the private health sector, are inadequate.

- Public health care policy and strategic plans do not encourage partnerships with the private not-for-profit and for-profit sectors (that set health objectives and focus on the Millennium Development Goals).
- The pharmaceutical sector does not have a policy on generic products at affordable prices to facilitate access to medications.
- The rivalry with the other groups of public and private providers is perceived as a serious problem by traditional practitioners.
- Information on the existence, activities, and performance of actors in the private health sector is very limited and, to the extent that any exists, it is not regularly updated.
- The lack of coordination between the different ministries that have relationships with the private health sector is an obstacle to the effective management of private sector activities.

### *Institutional context*

The quality aspect is not a major concern.

- There is a lack of motivation for performance and for maintaining the quality of the services offered.
- There is also a lack of motivation to establish facilities in remote regions where the supply of health care services is insufficient, particularly with regard to private providers and pharmacies.
- There is a lack of audits, supervision, technical support (including training), and subsidies from the State/MSP.
- There is no access to the continuing education organized by the public sector.
- The quality of personnel coming out of public schools for medical-related professions is inadequate.
- Public infrastructure (water, electricity, communications, and transport) is inadequate.
- There are very few PPP initiatives for the supply of health products and services.

### *Financing and access to credit*

Inadequate financing and financial management capacities inhibit the development of the private sector.

- The lack of demand-side financing (such as health care vouchers) and national health insurance limit financial access to health care products and services.
- There are no programs to target subsidies to promote access to health care for the poor (lack of a national policy to fund health care and target the poor).
- The onerous administrative and financial fees, required by several ministries (trade, finance, labor), both upon startup and during the ongoing management cause higher prices for private health care products and services.
- Difficult or nonexistent access to bank loans to provide startup capital or to fund the development of activities, limits the willingness to invest in the development of the private sector or take the risk of establishing a facility in a rural area.
- The low level of financial management skills on the part of private sector actors inhibits the effective and efficient operation of the facilities and the opportunities for mobilizing investments to expand their activities.

## 5. Options for Action, 2011 to 2013

A workshop to validate the results of this study and to establish a plan of action was organized on December 15 and 16, 2010 in Brazzaville. This third workshop organized as part of the study was attended by representatives of the private for-profit sector, the private nonprofit sector, the public sector (ministries of health, trade, industrial development and promotion of the private sector, and technical and professional education), representatives from the Senate and the National Assembly, the COSAs, civil society, the World Bank, IFC, the WHO, UNFPA, the French Embassy, and national and international consultants (HERA and R4D).

The main objectives of this workshop were to decide on the measures to be undertaken, based on the study. In particular:

- Review the results of the study
- Review the recommendations from the second study workshop on partial study results in October 2010
- Develop specific measures for implementing the recommendations
- Present the plan of action to the Ministry, the private sector and the technical and financial partners.

This third workshop was chaired by Dr. Bakala, Director of Monitoring and Supervision with the Ministry of Health and Population. It was attended by 91 participants (including over 20 journalists) representing all of the stakeholders in the public and private sectors, most of whom had attended the second workshop.

Following the various presentations and plenary discussions, working groups of workshop participants succeeded in establishing the priorities of a plan of action, specifying the details and validating it, through the dedicated efforts of all the participants. The workshop was closed by the Minister of Health, who confirmed that all of the partners present should respect the plan of action established (see appendix H for the plan of action). The principal components of the plan of action are as follows:

### **Actions Pertaining to Policy and Governance**

The identified actions pertaining to policy and governance are as follows:

- Create a formal, permanent platform for public and private sectoral dialogue (with a relationship with the High Council for Public-Private Dialogue)
- Increase the involvement of the private health sector in the bodies of the PDSS and in the technical commissions established by the ministry (for example, concerning free Caesarian section services, EmONC, revision of legislation, and others)
- Strengthen the structure of the private health sector by creating the *Alliance du secteur privé de la santé* (Alliance SPS) [Private Health Sector Alliance]
- Develop a strategic framework for the private health sector within the context of the National Health Care Policy. Health action plans should include working with the private sector related to the overall strategy. In addition, develop a directory of facilities and actors in the private sector.

## **Actions Pertaining to Oversight and Regulations**

The identified actions pertaining to oversight and regulation are as follows:

- Take an inventory of, update, and make public all of the legislation and regulations that govern the private health sector. This involves the creation of a joint public-private committee to revise the laws and regulations.
- Strengthen implementation of the regulatory framework by: (a) improving the institutional capacities of the MSP to enforce oversight and regulation; (b) developing and strengthening the private sector's capacity for self-regulation; and (c) improving the systems for detecting illegal activities and products, as well as a system of penalties.

## **Actions Pertaining to Incentives**

The identified actions pertaining to incentives are as follows:

- Increase the private health sector's access to bank financing/guarantee funds by: (a) Creating a guarantee fund for the private health sector; (b) Creating a government support fund for private health care initiatives; (c) Building the capacities of private operators to prepare bankable projects; and (d) Encouraging banks to grant loans to the private health sector.
- Reduce taxes. Among others: (a) Reduce or eliminate taxes for the private practice of health care professions in rural areas; (b) Eliminate taxes on generic products and raw material resources intended for local pharmaceutical production; and (c) Establish an agreement/grant a tax credit for startup (see investment code).
- Improve administration and management capabilities in the private health sector.

## **Specific Actions on PPPs in the Field of Health Care**

The identified actions pertaining to PPPs are as follows:

- Establish a public-private technical committee on the implementation and monitoring of PPPs (ad hoc committee reporting to the platform for public-private dialogue) and develop a system for implementing and monitoring PPPs.
- Implement the PPPs on subsidized public health care programs (such as existing programs for HIV/AIDS, malaria, vaccinations).
- Develop PPPs on emerging obstetric and neo-natal care (EmONC) and define the terms of providing free Caesarian section procedures through public and private networks.
- Develop PPPs on initial training and continuing education. This involves, among other things, enabling students at public schools to do their internships at private facilities; inviting private sector providers to teach at public training facilities; and inviting private sector providers to participate in continuing education seminars organized by the public sector (create a private technical committee on continuing education, as a subcommittee of the Alliance SPS).
- Develop demand-side subsidization strategies in the public and private sectors after analyzing the possibility and feasibility of introducing or improving strategies such as health insurance, mutual health insurance companies, health care vouchers and others. This should be part of a more comprehensive development of financing strategies for the public and private sectors.

## Notes

1. Directories updated in 2009 and 2010 of private health facilities dispensing care, with provisional or final authorization, Department of Health Services, Ministry of Health and Population.
2. Conducted by the Ministry of the Economy, Planning, Land Use and Integration, New Partnership for Africa's Development, National Center for Statistics and Economic Research, Brazzaville, and ORC Macro, Calverton, Maryland, July 2006.
3. Completed by the Ministry of Health and Population.
4. In this report, the concept of the private sector is used to describe both the for-profit sector and the nonprofit sector. The for-profit or independent sector refers to private for-profit providers, while the nonprofit or association sector refers to private providers such as NGOs, associations, and faith-based organizations.
5. Decree 2008-318 of August 5, 2008 assigning duties to and structuring the Directorate General for the Promotion of the Private Sector.
6. More specific data on the profiles and qualifications of health workers is not available.
7. The figures on health care expenditures by public administrations (2008) are allocations, according to the staff of the health care and social sector, IMF Report 04/231, p. 69, T. 17. The figures on health care expenditures by households come from the CNSEE ECOM 2005. The figures pertaining to external resources are from the Organization for Economic Cooperation and Development CAO.
8. The independent health care professions (all types of providers) were legalized in Decree 88/430 of June 6, 1988.
9. Company medical and social services centers (CMSs) may be part of the private for-profit or nonprofit sector. The categorization of these facilities is not available in the health map.
10. The ASPHAC was created long before the SYNAPHAC and, as the first space for private sector pharmacists to come together, it also played the role of a union. With the creation of the SYNAPHAC, it lost some of its importance, but it remains active in mobilizing pharmacists on general interest issues related to the profession, including those working in the public sector, who are not unionized.
11. Recent lists compiled of private facilities for 2009 and 2010 were used for the study, even though they are not completely identical.
12. Courtesy, attention, seeing users in the order in which they arrive, ease of seeing the doctor, promptness of reception and in administering treatment in emergency cases.
13. The interviews conducted as part of the study with private providers confirmed the practice of flexible terms of payment for patients who have difficulty paying at the time of care.
14. In Ouessou, men who often go hunting in the forest use herbalists and traditional practitioners and they consume herbs and/or bark themselves in the event of an incident while in the forest.
15. The personnel of public institutions sometimes run "rackets." This term refers to a form of fraud by the public providers, who require patients to pay them money that they keep for themselves rather than handing it over to the facility.
16. "When recruiting personnel, they will take just about anyone." "Interns who perform procedures that they are not qualified to perform."
17. The most patronized facilities are public maternity wards and the University Hospital (C.H.U.) (H. Makélékéké, Blanche-Gomez, and H. Talangaï).
18. It should be noted that the information pertaining to pharmacists and traditional practitioners came from the focus groups (and not the long questionnaires) which does not always make it possible to achieve the same level of detail in the analysis. This limitation is reflected in some of the tables.
19. The 2005 health map indicates that there are no private hospitals in the Republic of Congo. The "hospital institutions" are therefore probably facilities with beds, but not categorized by the State as "hospitals."
20. The medications checked in the survey include packets of oral rehydration solution, amoxicillin, co-trimoxazole, paracetamol, artemisinin-based combination therapies (ACTs), iron, and folic acid.
21. A memorandum of agreement for purchasing, storage, management, and distribution services for pharmaceutical products purchased with financing from the Global Fund and other funding providers. Management fees of 3.5 percent to 5 percent.
22. An annual contract not renewed in 2009 and 2010 for the management of reproductive health

products acquired by the UNFPA, as well as the organization of all related training.

23. A supply contract with the COMEG on financing from the European Union, as well as a memorandum of understanding for the supply of essential generic medications for certain CSSs funded by the European Union.

24. A more in-depth study of this issue would be interesting.

25. The average declared is 30 percent with one facility in particular that reported a loss of income of 90 percent due to the default of one company in bankruptcy. If we do not count the facility that posted a loss of 90 percent due to the bankruptcy of its user, the average lost income declared by the managers regarding the treatment of people who are unable to pay is 27 percent.

26. See chapter 4: "Analysis of the Institutional Framework for the Actors in the Private Health Care Sector."

27. Another example concerns the nonprofit sector. In each parish, there is a plan to open small pharmaceutical outlets. A request to this effect, submitted to the MSP four years ago, has still received no response until now. This initiative would help much of the population to obtain quality medications at a low price.

28. If one item was not mentioned by a group of professionals, this does not mean that the obstacle does not exist, just that they did not mention it as a priority.

29. Because the study was unable to gather information on the number of "illegal" schools, it does not have information on the extent of this phenomenon. The study attempted to organize an interview with the director of a private medical-related professional school, but he was "not available."

30. The one-time membership dues are 80,000 CFA francs, plus a regular monthly contribution of 5,000 CFA francs for specialists and 2,500 CFA francs for general practitioners (source: *Ordre national des médecins* [National Order of Physicians]).

31. According to the interviews, this pertains more so to the other taxes related to the Ministry of Trade and not the tax authority.



# Appendixes

- A. Methodological Approach
- B. List of Relevant Documents Gathered during the Interviews with Key Individuals
- C. Summary of the Analyses Published by the 2005 EDS
- D. Distribution of Private sector Providers in the 2005 Health Mapping Exercise
- E. Analysis of the Legal Framework and Legislation
- F. Process of Obtaining Authorization to Practice
- G. Procedures and Taxes of the Business Registration Center (CFE)
- H. Preliminary Plan of Action: November 2010



## Appendix A. Methodological Approach

The study methodology is composed of the following elements:

- An analysis of the institutional framework (document reviews and guided interviews)
- A multidimensional analysis of the supply (analysis of existing data, collection and analysis of the qualitative and quantitative data according to samples of participants, interactive interviews, and focus groups)
- A multidimensional analysis of the demand (analysis of the quantitative data from the 2005 DHS (Demographic and Health Survey) and the 2005 ECOM (Congolese Household Expenditure Survey) and focus group discussions)
- Three workshops that enabled: the sharing of the facts and conclusions of the study; the discussion of the issues at hand; and the development of an agreed action plan for 3 years; and
- A steering committee in charge of guiding the completion of the study and the workshops, composed of representatives from the public sector, the private sector, and the development partners.

The collection of data on the supply of services focused on private providers of health services and related products and services (pharmacies, medical analysis laboratories, centers for medical imaging) located in the two urban centers, Brazzaville and Pointe-Noire, and in rural areas in the Ouéssou-Pokola district.<sup>1</sup> Existing data concerning demand have also been analyzed in respect to the responses given by the consumers in two national studies targeting households (2005 DHS, 2005 ECOM).

### Analysis of the Institutional Framework

The analysis of the institutional framework is based on the interviews of key informants carried out by the study and the examination of legal texts and documents. Many of the key informants interviewed as part of this analysis are officials of the Ministry of Health. Guides for interactive interviews were used for the interviews with (i) the heads of Departments of Health at the district level, (ii) members of health and statistics data collection organizations, (iii) traditional healers, (iv) managers of human resources departments, (v) representatives of the pharmaceutical sector, and (vi) reproductive health practitioners. The interview guides included questions concerning policies regulating the private sector; regulations; actual practices in the field; available resources for oversight, monitoring, and regulation of private actors, as well as suggestions from interviewees to improve policies and practices. Interviews were also completed with representatives from private actors of the health sector.

The interface between the public health sector and the private health sector is not limited to the MoH. Thus, the study integrated interviews with key informants from other ministries, such as the Ministry of Finance (taxes), the Ministry of Industrial Devel-

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1. The private providers include the for-profit sector, the nonprofit sector, and traditional healers, but they do not include professionals in the fields of water, sanitation, and hygiene.

opment and Promotion of the Private Sector (support), and the Ministry of Technical and Professional Education (training). The Ministry of Forest Economy and the Ministry of Agriculture were also interviewed because of their experience in matters of PPP. Texts, analyses, and other documents pertinent for the study were collected during each interview (see the list of documents in Annex B).

### **Multidimensional Analysis of the Supply**

The supply of private health services was analyzed based on: (1) existing data (health map, inventory of private providers), (ii) surveys of participants in the three study sites (Brazzaville, Pointe-Noire, and Ouesso-Pokola), (iii) interactive interviews with key informants and a subsample of private actors surveyed, and (iv) focus groups.

A survey using a short questionnaire was carried out with a sample of 63 providers of health services in three sites. Interactive, in-depth interviews were carried out using a long questionnaire with a subsample composed of 20 participants from among the 63 surveyed using the short questionnaire. The sample was selected based on the data from health map of 2005 and the directories of facilities in Brazzaville and Pointe-Noire, which were updated by the Heads of the Departments of Health at the district level (*Directions Départementales de la Santé, DDS*) in 2009 and 2010.

The short questionnaire consisted of closed-ended questions allowing quantitative analysis. Long questionnaires as well as interviews of key informants and focus groups help generate qualitative information.

Interviews with key informants, the main providers of private health care services, professional practitioners, and representatives of nonprofit providers, were carried out with interview guides.

Focus groups were organized with pharmacists, heads of medical analysis laboratories and medical imaging centers, as well as traditional healers. The questionnaires, interview guides and focus groups aimed to collect the following information:

- Services provided (general and specialized consultations, laboratory tests, hospitalizations, surgeries, deliveries, etc.);
- Volume of provided services
- Inputs (human resources, medications and consumables, equipment, spare parts, and interviews)
- Structural indicators of quality (availability of medications, basic equipment, medical and technical personnel, as well as planned improvements to benefit patients)
- Degree of integration with the public sector (flow of information, technical exchanges, references, collaboration on issues of planning and development of strategies and programs)
- Internal constraints for actors (management capabilities, etc.)
- External constraints for actors (procedures for granting authorization, regulations, taxes, access to bank loans, availability, price and other factors related to the supply of inputs.)
- Existing or proposed PPPs (sharing of equipment, relations based on referrals and counter-referrals, service contracts, etc.)
- Recommendations to improve the interaction between the public and private sectors.

## Multidimensional Analysis of Demand

The analysis of demand for health services provided by private actors was based on: (1) additional analyses of data from the Demographic and Health Survey (2005 DHS) and the 2005 *Enquête Congolaise auprès des Ménages* (2005 ECOM), and (2) focus groups in communities located at the research sites of the study.

The 2005 DHS is a survey that was conducted on a national scale with 5,879 households. It included questions on the choice of health care providers (public, private for profit, private nonprofit) by users. The DHS focused on priority care interventions for children (with fever and/or cough) and their mothers (prenatal consultations and delivery), family planning, treatment of sexually transmitted infections (STIs), as well as HIV/AIDS screening and treatment. The analysis of DHS data focused on the breakdown of the use of services between the private and public sectors. The analysis also showed all the choices made by users based on their socioeconomic quintile and their location (rural or urban).

The 2005 ECOM is a survey that was conducted on a national scale with 5,146 households. Its main purpose was to establish the threshold of poverty applicable to the Congo. It included questions on personal consumption (including the use of health care services) and on welfare indicators. In particular, in the event of illness, the ECOM survey asked households whether they seek treatment or not, where they get care, and why they did not seek treatment. The ECOM survey contains information on the place of residence of respondents (rural or urban location) and their socioeconomic status (poor or not poor).

Focus groups organized with members of the communities allowed a follow-up after compiling the DHS and ECOM survey results. When the analysis of DHS and ECOM survey data revealed that the population preferred specific health care options, focus group discussions highlighted the reason for such choices, especially factors promoting or hindering the use of various types of health care providers, such as distance, price, perception of quality, drug availability, customer service, and access to the staff. Focus group discussions were organized in Brazzaville and in Pointe-Noire with the following categories of individuals: (1) heads of household (men) and (2) women of childbearing age (these first two groups were set up with the assistance of the Health Committees, COSAs); and (3) traditional healers. In the focus groups with male heads of households, the facilitators asked questions concerning their choice of providers when they or other members of their household were sick in 2010, followed by other questions on the factors that influenced their choice and on their opinions as to the strengths and weaknesses of the public sector, the for-profit private sector, and the nonprofit private sector. In the focus groups composed of women, the facilitators asked questions concerning their choice of providers for prenatal care and deliveries, as well as infant and child care, and other questions on the factors that influenced their choice and on their opinions as to the strengths and weaknesses of the public and private sectors.

## Limitations of the Study

The study provides information on the role played by the private sector in health care and its positioning in the supply of services. Nevertheless, the usefulness of the data generated by the study is limited by the fact that a certain part of the information (for ex-

ample, the results of the interviews and focus group discussions) is composed of qualitative data that may not be analyzed without some subjectivity.

The collection of quantitative data on private sector providers in Brazzaville, Pointe-Noire, and Ouesso-Pokolo was carried out based on information from the health map and the 2009 and 2010<sup>2</sup> inventories performed by the Brazzaville and Pointe-Noire DDSs. When the data collection activities for this study took place, many facilities selected for interviews based on information from the 2005 health map were no longer operating. Therefore, the field teams of interviewers had to replace a number of facilities initially in the sample, which made the sample less random than anticipated.

It should also be noted that the providers who were interviewed only communicated their opinions and information that they were willing to reveal. Since information on specific subjects (such as the amount of work, sales, prices) is sensitive and likely to be overestimated or underestimated, the opinions communicated may be relevant, but they are not always based on objective data.

Data from the 2005 DHS that are analyzed in this study were obtained by a representative survey of households from all parts of the country. The DHS, however, only focused on health services used by households with respect to reproductive and maternal health, STIs, and the most common children's diseases. Therefore, it did not include treatments for any other diseases or by other demographic groups.

The 2005 ECOM compensates to a certain extent for the deficiencies of the DHS because it includes data on the use of health care services and the choice of providers, regardless of the disease or illness. This survey, however, still has a serious limitation, since it does not identify the types of diseases treated by the various providers. In addition, the list contains no information on the severity of the disease.

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2. Recent directories of private facilities for 2009 and 2010 proved useful for the study, even though they are not identical.

## Appendix B. List of Relevant Documents Collected During Interviews with Key Actors

### List of Relevant Documents

#### *Company Registration and Regulation Unit, Ministry of Finance*

- Act of incorporation, modification, renewal or discontinuance for a company or suspension of operations for an individual. Procedure of application for authorization to engage in the occupation of merchant for individuals
- Procedure of application for authorization to engage in the occupation of merchant for corporations
- Fees to be paid to start up sole proprietorships and corporations
- Legal forms of organization of commercial corporations in the Congo

#### *Confederation of Traditional Healers*

- National Policy on Traditional Medicine, Ministry of Health, April 2006
- National Plan for the Development of Traditional Medicine in the Congo, Ministry of Health, 2008–2012
- Draft decree regulating the practice of traditional medicine
- Traditional healer training session in Sangha-Ouessou Department on April 15–17, 2009, WHO
  - System of certification of drugs from the traditional pharmacopeia
  - Strengthening the capabilities of traditional healers
- Minutes of the general assembly of Brazzaville traditional healers, 09/26/07
- Code of Ethics for traditional healers in the Congo (in partnership with the WHO), September 2006
- Rules and Regulations of the Federation of Traditional Healers, 09/26/07
- By-laws of the Federation of Traditional Healers of Brazzaville Department 09/26/07
- Census of traditional healers carried out in November 2008
- Schedule of activities of the BED (*Bureau Exécutif Départemental*) in Brazzaville
- Overview of a federal institution for the traditional healers of the Brazzaville Department, by Gilbert Mouanda

#### *Director of Health Services (Directeur des Services Sanitaires , DSS)*

- Decree 88/430 of 6/6/1988

#### *Ministry of Technical Education*

- Decree No. 99-281 of December 31, 1999 amending Decree No. 96-221 of May 13, 1996 regulating private education

#### *Ministry of Industrial Development and Private Sector Promotion*

- BizClim—Improvement of the business climate in the Congo Brazzaville, June 2009, including a road map for improving the business climate in the Congo
- Memorandum on the setup and composition of a public sector platform of June 14, 2010

- Final press release following the meeting of September 29-30, 2010 validating the permanent framework for public-private dialog
- Minutes of the meeting of 10/04/10 validating the permanent framework for public-private dialog
- Declaration from the private sector platform of the Congo 03/11/10
- Decree relating to the creation, attributions, and composition of the High Council for Public-Private Dialog
- Decree No. 2010-324 of 05/11/10 relating to the organization of the Ministry of Industrial Development and Private Sector Promotion
- Decree No. 2008-318 of 08/05/08 relating to the attributions and organization of the General Directorate for Private Sector Promotion
- *Doing Business in the Congo, IFC Pointe-Noire, 09/01/10*

#### ***Adviser on Human Resources, Ministry of Health***

- National Plan for the Development of Human Resources in the Health Sector (*Plan national de développement des ressources humaines pour la santé, PNDRHS*) 2011–2020 (Draft)
- Current status of human resources in the health sector. Data collection report, April 2005
- DAF-DGS Report, 2006
- DEP (Ministry of Health, Social Affairs and Family), 2009

#### ***Ministry of Health***

- National report on the progress toward reaching the Millennium Development Goals, draft, March 2010
- National report relating to the Millennium Development Goals, Republic of the Congo, 2004

#### ***Catholic institutions***

- “Les gestes qui sauvent”/Lifesavers (documents intended for mothers published under the auspices of the
- Ministry of Health in partnership with UNICEF and religious congregations)

#### ***United Nations Population Fund***

- Description of a country program (draft) 2009–2013, Republic of the Congo
- Roadmap to accelerate the reduction of maternal and infant mortality, 2009

## Appendix C. Summary of Analyses Published on the Basis of the 2005 DHS Data

### Demographic and Health Survey (DHS)

The Demographic and Health Survey (DHS) carried out in 2005 interviewed a national sample of households. The DHS included questions on choice of a provider for services related to child health and reproductive health. DHS data identified preferred institutions for abortions, deliveries, and postnatal visits, as well as for the treatment of fever/cough and diarrhea in children, for HIV testing, and for STI treatment for women. The DHS also collected data on the socioeconomic status of households. These data allowed a partial (limited to the services focused on by the DHS) assessment of the demand from households for health care from private providers.

The socioeconomic status indicator is a composite measurement. It is calculated on the basis of the assets owned by the household (for example, a radio, a television set, a motorcycle, a bicycle, the construction materials used to build the house, the type of toilets, the source of drinking water, the source of energy, etc.) using a principal components approach. Overall, 162 indicators collected for 81 countries were used by ORC Macro (the implementer of DHS) to design the standard of living indicator.

### HEALTH-SEEKING BEHAVIOR

#### 1.1 REPRODUCTIVE HEALTH AND HIV <sup>1</sup>

##### 1.1.1 Place of delivery

Among the births that occurred during the five years preceding the survey, the majority took place in a health care institution (82 percent), mostly in the public sector (75 percent). Only 16 percent of the women had their delivery at home. It is worth noting that the proportion of women who gave birth at home increases with age: from a low of 13 percent for women under 20 years of age, the proportion increases to 17 percent for women in the 20-34 year range, and to a maximum of 21 percent between 35 and 49 years. The same trend is noted based on the child's birth order: starting at 11 percent for first-born children, the proportion regularly increases to reach 26 percent for children born sixth or higher. The results also show that women living in rural areas give birth at home more frequently than those who live in urban areas (27 percent vs. 4 percent). There are also major differences based on the geographic area where women live: only 2 percent of Brazzaville women and 3 percent of Pointe-Noire women gave birth at home, while these proportions reach 26 percent for the Southern region and 25 percent for the Northern region. The level of education and socioeconomic status of the household also have an influence on the place of delivery, the highest socioeconomic status and educated women giving birth at home less often than the others.

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1. Monique BARRÈRE in "Santé"; "2005 DEMOGRAPHIC AND HEALTH SURVEY OF THE CONGO (DHSC-I)"; Ministry of Planning, Land Use, Economic Integration and NEPAD; *Centre National de la Statistique et des Études Économiques* (CNSEE), Brazzaville, and ORC Macro, Calverton, Maryland; July 2006; pp. 127

### 1.1.2 Postnatal examinations

The DHSC-1 investigators asked women whose latest delivery had occurred outside of a health facility whether, after giving birth, they had received a postnatal examination and how long after the delivery such examination had taken place. The survey revealed that among women who had given birth outside of a health facility, a high proportion (70 percent) never had any postnatal follow-up. However, 29 percent of the women whose latest delivery had occurred outside of a health facility had received a postnatal examination; in most cases (24 percent), those women had a postnatal check-up within the recommended two days after delivery. The proportion of women who had a postnatal follow-up soon after their delivery varies widely as a result of social/demographic considerations. This proportion is strongly influenced by the woman's age and the birth order of the child from a maximum of 29 percent when they are younger than 20 years old. The proportion of women who have a postnatal follow-up becomes progressively lower. It reaches a minimum of 16 percent in the 35–49 year age group. The same trend can be observed with the birth order, the proportion falling from a maximum of 30 percent for first-born children to a minimum of 14 percent for children 6th or above. Postnatal follow-up is more common for urban women and those who live in the Southern region (respectively, 53 percent and 25 percent) than for those who live in rural areas and in the Northern region (respectively, 19 percent and 11 percent). Differences were also noted as a result of the level of education. The proportion of women who went to a health facility to undergo postnatal follow-up is higher for educated women: only 6 percent for uneducated women, while the proportion rises to 23 percent for those who have an elementary school education and to 34 percent for the women who have a middle-school education. Finally, when broken down by socioeconomic status quintiles, the results showed that the proportion of women who received postnatal care within two days after delivery increases from the lower to the higher households, from 15 percent in the first quintile to 36 percent in the fourth quintile.

### 1.1.3 HIV Test<sup>2</sup>

According to the results of the survey, many young people are sexually active and often engage in high-risk sexual intercourse. Therefore, it was important to know to what extent young people take HIV tests and inquire about their results. The data showed that only 3 percent of females and 2 percent of males aged 15-24 took HIV tests and obtained their results during the 12 months preceding the survey. Regardless of the social/demographic environment, this proportion is low; however, it is much higher among the most educated young women and young men (respectively, 6 percent and 7 percent), urban youth (respectively, 4 percent and 3 percent), and among those who live in a household of the highest socioeconomic quintile (respectively, 5 percent and 4 percent).

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2. Monique BARRÈRE in "Knowledge, Attitudes, and Behaviors toward Sexually Transmissible Diseases (STDs) and HIV/AIDS"; "2005 DEMOGRAPHIC AND HEALTH SURVEY IN THE CONGO (DHSC-1)"; Ministry of Planning, Land Use, Economic Integration and NEPAD; *Centre National de la Statistique et des Études Économiques* (CNSEE), Brazzaville and ORC Macro, Calverton, Maryland; July 2006; pp. 199

## 1.2 TREATMENT OF CHILDHOOD DISEASES<sup>3</sup>

### 1.2.1 Respiratory tract infections and fever

Acute Respiratory Infections (ARI) and pneumonia are main causes of mortality for children in developing countries. In order to assess the prevalence of these infections in children, mothers were asked if their children had suffered from coughing during the two weeks prior to the survey and, if yes, they were then asked whether the cough had been associated with short, fast breathing. Since coughing can be one of the main symptoms of many diseases, including malaria and measles, mothers were asked whether their children had suffered from fever during the two weeks prior to the interview. In addition, with respect to the children who had symptoms of ARIs and had suffered from fever, further questions were asked in order to determine the percentage of those for whom a treatment or advice had been sought.

In the two weeks preceding the survey, close to one quarter of the children had bouts of fever (23 percent). It was determined that this prevalence of fever varies mainly as a result of the child's age and his/her geographic environment. As in the case of the ARIs, children between 6 and 23 months were much more likely to have had bouts of fever than older children (32 percent vs. 16 percent of the children aged between 48 and 59 months). The results showed that in the North 30 percent of the children suffered from fever, while the lowest proportion was recorded in Pointe-Noire (20 percent).

Moreover, treatment or advice was sought for only 44 percent of the children who had symptoms of ARIs or fever. When broken down by age groups, the results show that it was for the children aged between 6 and 23 months, among whom the prevalence of fever and ARIs is the highest, that treatments were most often solicited (48 percent). In addition, the geographic environment, the mother's level of education, and the socioeconomic status of the household where the child lives are important factors associated with the probability of seeking treatment. The children for whom a treatment was most frequently sought were children living in an urban environment (51 percent vs. 38 percent rural), children living in Brazzaville (57 percent vs. 39 percent in the North), children whose mother had at least a high-school education (56 percent vs. 44 percent for those whose mother had received no education), and those living in a household in the highest socioeconomic quintile (56 percent vs. 38 percent for those in the lowest quintile).

### 1.2.2 Diarrhea

Because of their consequences, especially dehydration and malnutrition, diarrheal diseases are, directly or indirectly, one of the main causes of death of young children in developing countries. Based on mothers' responses, 14 percent of the children suffered from diarrhea during the two weeks preceding the survey. The prevalence of diarrhea is especially high in young children between the ages of 6 and 23 months (approx. 25 percent). These ages of high prevalence correspond to the time when children begin to be weaned from their mother's milk. This is also when children begin exploring their environment, which exposes them further to pathogens. According to the DHS results, the sex of the children and the type of place where they live (urban or rural) have no impact on their likelihood to have diarrhea. There are slight differences between regions, the

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3. Monique BARRÈRE, *ibid.* in "Santé."

prevalence varying from a maximum of 16 percent in the Brazzaville area to a minimum of 11 percent in the Pointe-Noire area. The prevalence of diarrheal diseases does not seem to be impacted by the mother's level of education or by the standard of living of the household. The results also show that the type of drinking water does not appear to influence the prevalence rate significantly.

### ***1.3 WOMEN'S SEXUALLY TRANSMITTED INFECTIONS (STIs)<sup>4</sup>***

The survey attempted to determine whether women and men who had said that they had sexual intercourse had contracted an STI or had noticed symptoms of an STI during the 12 months preceding the survey. Among women, 4 percent responded that they had an STI. Moreover, 16 percent of the women reported that they had suffered abnormal vaginal discharge, and 8 percent mentioned a genital ulcer. Overall, one out of five women (20 percent) can be considered as having contracted an STI and/or one or several symptoms indicative of an STI. Among men, 6 percent reported having contracted an STI, 6 percent mentioned penis discharges and 7 percent a genital ulcer. Overall, 10 percent of the men can be considered as having contracted an STI and/or as having one or several symptoms indicative of an STI.

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4. Monique BARRÈRE, *ibid.*

## Appendix D. Distribution of Private Providers according to the 2005 Health Map

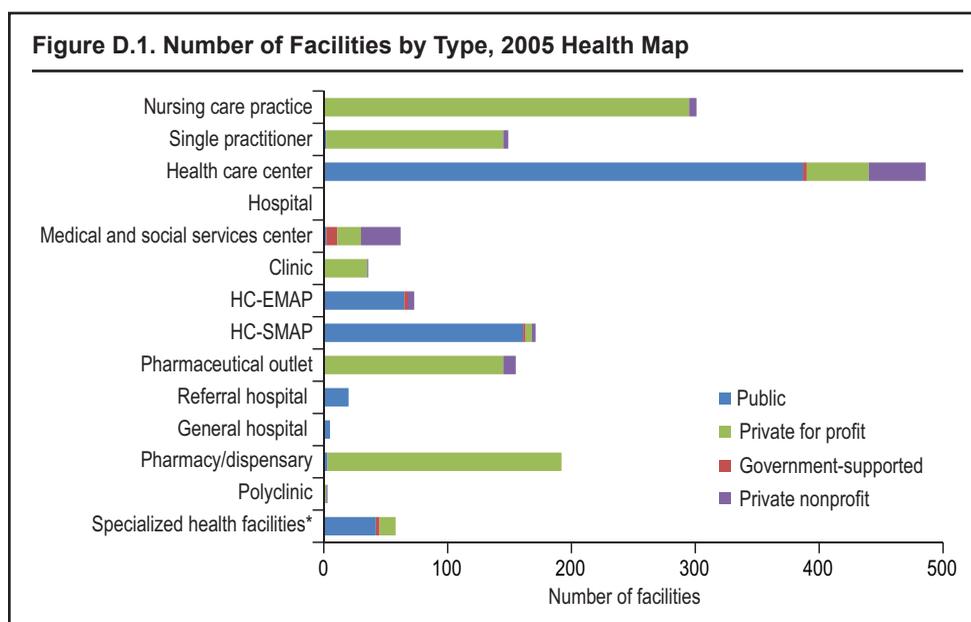
### 2005 Health Map

Table D.1. Legal Status of the Institution

Institution type	Public	Parastatal	Private for profit	Private nonprofit	Total	%
Teaching hospital	1	—	—	—	1	0.1
General hospital	5	—	—	—	5	0.3
Referral hospital	20	—	—	—	20	1.2
Health center offering the extended minimum service package	65	3	—	5	73	4.3
Health center offering the standard minimum service package	161	2	5	3	171	10.0
Health center/health post/treatment center/nursing home	387	3	50	46	486	28.4
Polyclinic	—	—	2	1	3	0.2
Clinic	1	—	34	1	36	2.1
Single practitioner	2	—	143	4	149	8.7
Nursing care practice	—	—	295	6	301	17.6
Medical and social services center	2	9	19	32	62	3.6
Dispensary	3	—	189	—	192	11.2
Pharmaceutical wholesaler	1	—	144	10	155	9.1
Specialized health facility <sup>a</sup>	42	3	13	0	58	3.4
Total	690	20	894	108	1,712	100.0

Source: Ministry of Health and Population of the Republic of Congo, 2005.

a. Including outpatient services, anonymous voluntary screening services, TB prevention and treatment centers, blood transfusion services, and national laboratory



Source: Ministry of Health and Population of the Republic of Congo, 2005.

**Table D.2. Distribution of Health Care Institutions, by Type and by Geographic Environment**

Institution type	Geographic environment			Total
	Urban	Semi-urban	Rural	
Institution type	1	0	0	1
Teaching hospital	4	1	0	5
General hospital	8	11	1	20
Referral hospital	7	33	33	73
Health center offering the extended minimum service package	58	26	87	171
Health center offering the standard minimum service package	77	31	378	486
Health center/health post/treatment center/nursing home	3	0	0	3
Polyclinic	33	2	1	36
Clinic	143	5	1	149
Single practitioner	221	33	47	301
Nursing care practice	43	5	14	62
Medical and social services center	183	8	1	192
Dispensary	22	105	28	155
Pharmaceutical wholesale	38	16	4	58
Specialized health facility <sup>a</sup>	841	276	595	1,712
Total				

Source: Ministry of Health and Population of the Republic of Congo, 2005.

a. Including outpatient services, anonymous voluntary screening services, TB prevention and treatment centers, blood transfusion services, and national laboratory.

## Appendix E. Analysis of the Legal Framework and Pertinent Legislation

### Authorizations Relating to the Private Practice of Medicine

The private practice of medicine in the Congo is authorized under certain conditions. Authorizations are secured in two steps corresponding to provisional authorizations and final authorizations. These steps are compulsory for the liberal practice of medicine, as well as medical practice by traditional therapists, religious congregations, nonprofits, and NGOs.

**Table E.1. Items Addressed and Missed in the Legal Documents on Obtaining Authorization to Practice Privately**

Legal documents	Items addressed	Missing items
Decree No. 88/430 of 06/06/88 issued by the Office of the President of the Republic/Government SG in Council of Ministers upon proposal by the Minister of Health and Social Affairs	<b>Scope of application of the Decree</b>	
	Indication of the professions affected by said Decree	
	<b>Requirements to practice medicine with private clients</b>	
	Academic requirements	The ownership of the training schools is not indicated (public or private)
	Requirements for the private practicing of medicine by dual-status government employees, retired employees, employees, and the obligation to have the agreement of the government to do so	Requirements for practicing in government facilities by dual-status private practitioners
	<b>Requirements for replacing permanent employees in their functions</b>	
	Leave of absence of a permanent employee	The work schedule of the permanent employee or any other person with similar qualifications is not specified, and it appears that employees provide services without having the necessary qualifications (for example, a nurse for consultations, a health aide for deliveries, etc.)
	Death of a permanent employee	
	Conditions of sale or transfer of a private health institution	
	<b>Annexes to memorandum No. 018 issued by the Ministry of Health on 02/23/90</b>	
	Details on the main activities of private health facilities	Nothing is stated concerning reports to government on activities conducted by private actors.
	A physician cannot practice two specialties at once	
	The operation of the facility is subject to unannounced inspections, and violations may trigger penalties that may include closing down the facility	
	<b>Applications for authorization</b>	
Forms and documents required to apply for provisional certification		
Forms and documents required to apply for final certification		

(Continued next page)

**Table E.1 (continued)**

	<b>Provisional authorization</b>	
	Withdrawal of authorization if activities other than those that have been authorized are carried out	
	Valid for one year, with possibility of extension for another year in exceptional circumstances by authorization of the Ministry	Regulations authorizing the extension of validity beyond two years
	Employees of companies practicing medicine may not work in private practice as independent health providers	
	<b>Misc. provisions</b>	
Decree No. 88/430 of 06/06/88 issued by the Office of the President of the Republic/Government SG in Council of Ministers upon proposal by the Minister of Health and Social Affairs	A joint order issued by the Ministry of Health and the Ministry of Commerce stipulates the fee schedule for privately provided services	Fee schedules are not published
	Activities authorized in health care institutions	No details on the qualifications of health care providers for specific services offered (for example, a nurse for consultations, a health aide for deliveries, etc.)
	Specific tasks that may be contracted by the Ministry as part of national programs	No details on the requirements for contract work
	Penalties will be imposed for all violations of this decree	
	<b>Circular notes intended for the owners of private facilities (signed by Dr. Ibouanga, Head of the Care and Services Division, without a date)</b>	
	Forms and documents required to apply for authorization	
	Reminder concerning application processing fees	
	<b>Application documents</b>	
	Processing time	
	Content	
	Application processing fees	
	Actions to be taken if applications are not complete	
	<b>Steps in the authorization process</b>	
Decree No. 2232/MSAS/DGS of 06/05/91 regulating the requirements concerning the location and certification of private health facilities for outpatients	Validity of the provisional authorization	
	Steps to obtain final authorization	
	<b>Misc. provisions</b>	
	Provisions relating to the death of the holder of an authorization	
	Setting of providers' fees in conjunction with the Ministry of Health	
	Qualifications required of a substitute practitioner if the permanent practitioner is on leave	
	Penalties if these provisions are violated	

(Continued next page)

**Table E.1 (continued)**

	Amended sections	
Decree No. 3092/MSP/MEFB of 07/09/03 amending Decree No. 2232/MSAS/DGS of 06/05/91	Structural requirements of health care institutions for inpatients or outpatients	
	Increase in application processing fees by an average of 63% compared to Decree No. 2232	
CIRCULAR LETTER No. 869/MSP/DGS/DSS of September 30, 2002 regulating the exercise of medicine by traditional therapists, religious congregations, not-for-profits, and NGOs involved in traditional medicine	<b>Pending publication of the legislation regulating the private practice of traditional medicine</b>	
	Forms and documents required to apply for certification	All the conditions and requirements for granting certification are missing
	Application processing fees	

Decree 88/430 of June 8, 1988 privatizing the medical and other health care and pharmaceutical professions was referred to frequently during the first two workshops; however, several items had to be clarified with respect to orders of medical and pharmaceutical professionals.

### **Professional Orders of the Health Sector (Physicians, Pharmacists, and Midwives)**

Law 009/88 of 05/23/88 creating a Code of Professional Ethics for the health-related and social affairs professions in the Popular Republic of the CONGO (at that time, the two ministries were combined into one)

The National Orders of Physicians, Pharmacists, and Midwives are composed of, respectively, all the physicians, pharmacists, and midwives authorized to practice their specialty in the Republic of the Congo. (Nevertheless, by way of exception, midwives employed as members of international technical assistance organizations are not registered in the National College of Midwives.)

All the orders have corporate status.

The National Orders of the health professions ensure that all the principles of morality, probity, and dedication, as well as all the skills required to enable them to practice their professions are maintained and that all their members comply with their professional obligations and the rules imposed by the Code of Professional Ethics.

The Code of Professional Ethics discusses the professional principles and ethical rules that must be complied with by health and social workers (Art 2 Law 009/88/05/23/88, Code of professional ethics)

#### **Art. 5 (Chapter I: General Duties Imposed by the Code of Professional Ethics)**

Health and Social workers shall:

- Respect life and other human beings
- Attend and treat all patients, regardless of their conditions, their nationality, their religion, their politics and philosophies, and their reputation

- Come to the assistance of any person in trouble or victim of an accident, or any abandoned child, even if other care can be provided

### **Art. 7**

Members of the personnel of the Ministry of Health and Social Affairs shall respect: the right of patients to choose their own doctors, surgeons, and midwives; the professional fee schedule set by the Ministry of Health and Social Affairs (based on the results of the surveys, there is no professional fee schedule set by the Ministry in charge of health affairs, except for the pharmaceutical sector)

The National Orders of Physicians, Pharmacists, and Midwives oversee the honor, duties, and independence of their respective professions.

They may not act in defense of the material interests of their members because such an activity would be exclusively the duty of a professional union (to date, only pharmacists have created their own professional union).

### **Operation**

The leadership of the various professional orders of the health sector shall be elected by the participants in general assemblies convened for this purpose.

The Minister in charge of health affairs shall convene the constituent general assemblies.

## Appendix F. Procedure to Obtain Authorization

### Step 1:

Before any administrative documents of an application may be considered, the candidates for management positions in any type of facility involved in the liberal practice of medicine shall meet the following requirements:

- With respect to their level of education:
  - They must be holders of a diploma issued by the Congolese government or a foreign diploma recognized as technically equivalent to comparable Congolese diplomas
  - Physicians or pharmacists specialized in biology must be holders of at least two specialty study certificates or have a recognized title
- With respect to qualifications and from the legislative standpoint:
  - They must have at least three years of work experience either in the public sector or in the private sector
  - Civilian or military government workers must have been relieved of their regular functions, they must be retired, or they must have resigned
  - They must be registered as members of the national order of the profession to which they belong

When the above requirements are met, a written application accompanied by the administrative documents indicated hereafter must be addressed to the district-level health affairs authorities (*Direction Départementale de la Santé*), which will then forward them to the Ministry of Health, to the attention of the head of the relevant department (DGS) by certified letter with a request for an acknowledgement of receipt or the appropriate receipt if the application documents are hand delivered.

- A birth certificate, or a copy thereof
- 2 photos
- Authenticated copies of the diplomas
  - A physician is authorized to practice medicine either as a generalist, or as a specialized practitioner if he/she has the required qualifications
  - A physician may never have a practice in two specialties at the same time. Therefore, it is strictly forbidden for medical specialists ( radiologists, dentists, etc.) to schedule general medicine consultations in their offices since that would expose them to the risk of losing their license to practice medicine as a private practitioner
- Criminal records
- Medical certificate
- Curriculum Vitae
- Documentary title to real property, occupancy permit, or leasing agreement
- Diagram of the facilities
- Detailed list of services offered and staff
- Complete list of the equipment
- Preliminary study of the operation plan
- Summary estimate of the cost of the operation

- Briefing note on the financing of the operation
- Projected operating statement
- Receipt for the payment of provincial authorization fees issued by the Controller of the Public Treasury assigned to the DGS
  - Health institutions for outpatient services:
    - Single practitioner, general practice, CFA 300,000
    - Single practitioner, specialized practice, CFA 500,000
    - Medical-social centers of businesses, faith-based organizations, or companies, religious congregations, charitable organizations, CFA 500,000
    - Nursing practice, CFA 200,000
    - Dental office, CFA 400,000
    - Changes, CFA 200,000
  - Health institutions for inpatient services: CFA 700,000

In addition, there are taxes and fees on commercial activities that must be paid.

## Step 2:

After the Ministry of Health determines that the diplomas are authentic and the application is complete and following payment of the appropriate fees to the General Directorate of the Health Ministry, a provisional authorization allowing the recipient to practice in the health sector for one year will be issued. Only the provisional authorization issued by the General Directorate of the Health Ministry is valid. Authorizations issued by local authorities are not valid.

Prior to the expiration of a one-year period, in order to secure a final authorization, the applicant shall send another written application and complete the application by adding the following documents:

- Certificate of fulfillment of commitments with respect to administrative requirements from the Ministries of Commerce, Labor Relations, Social Security, and Justice
- Certificate of registration with the tax collection office
- Personnel files reviewed and approved by the *Direction Départementale de la Santé*
  - Detailed list of the medical personnel providing services in the health care institution
  - A statistical table showing all the other categories of staff members
  - A written commitment to use personnel based on their qualification exclusively and to refrain from modifying the proposed staffing
- Proof of insurance coverage for facilities and professional liability

Provided that all these administrative requirements are met, the final authorization shall be issued by the Ministry of Health subject to the completion of an inspection to verify that the facilities are in compliance with the regulations in effect and with the terms and conditions of the authorization. Said inspection shall be carried out by a representative from the General Health Directorate, who will report to the Minister and who will notify the applicant of changes to be made, if applicable.

The final authorization shall only be delivered after the application is deemed complete. It shall be issued by means of a Ministerial Order and sent to the applicant by certified mail.

*In particular, with respect to religious congregations, not-for-profits, and NGOs:*

- In order to secure a provisional authorization, in addition to subjecting themselves to investigations of character and supplying all the documents required to open a private medical practice, the applicant shall provide the following:
  - An accreditation order to the name of the faith-based organizations, not-for-profit, or NGO
  - A copy of the Articles of association
  - The By-laws
- The final authorization shall be issued by the Minister of Health after receiving a detailed report from the General Health Directorate, in conjunction with issuing a professional ID card.

## Appendix G. CFE Procedures and Fees

### Company Registration and Regulation Unit

The Company Registration and Regulation Unit (*Centre de Formalité des Entreprises*, CFE) is a public agency created by Decree No. 94-568 of 10/10/1994 as modified by Decree No. 95-183 of 10/18/1995, under the supervision of the Ministry of Small and Medium Businesses and Trades.

#### Purposes of the CFE:

- Oversee the operating environment of businesses and identify all the regulations, procedures, and administrative requirements that prevent Congolese nationals from creating, modifying, or ceasing their economic activities to simplify the regulations and reduce the cost and time constraints they produce.
- Accept in one single location (single office), in a single package, in a single payment, and in less than one hour, all the documents associated with the creation, transfer, extension, modification, and cessation of activities.
- Secure prior approvals required when companies apply for authorization in regulated professions and activities
- Notify and advise entrepreneurs of procedures that must be followed when setting up a corporate body.
- Maintain and update the files of businesses created, transferred or modified, as well as the files of companies under liquidation or in bankruptcy
- Promote and encourage the creation of businesses in the Congo

#### CFE's partners:

- Registry of the Commercial Court
- Chamber of Commerce, Industry, Agriculture, and Trades (Chambre de commerce d'industrie de l'agriculture et des métiers, CCIAM)
- National Social Security Fund (Caisse nationale de sécurité sociale, CNSS)
- National Center for Statistics and Economic Studies (Centre national de statistiques et des études économiques, CNSEE)
- Departmental Tax Offices
- Departmental Labor Offices
- Departmental Trade Offices

#### Categories targeted by the CFE:

The beneficiaries of CFE's services are:

- Merchants
- Industries
- Providers
- Business corporations
- Potential business owners

## Events requiring notification of the CFE:

### *Registration*

- of a sole proprietorship
- of a corporation

### *Modification*

- Launch of an additional business unit
- Change of name or main office
- Extension of the activity
- New *modus operandi*
- Rental, leasing, ...
- Other (transfer of operations)

### *Discontinuance of business*

- Temporary or Partial discontinuance of business
- Total discontinuance of business

## Procedure to be followed:

- Fill out the single form (available in the single in each district)
- Attach supporting legal documents
- Attach the regulatory fees per the official schedule

## Supporting documents to be attached

### *For Congolese nationals practicing as independent health services providers*

- Original of identity card + 2 photocopies
- 3 photographs
- For married couples, copy of the marriage certificate

### *For foreign nationals from CEMAC qualified to practice as independent health services providers*

- Originals of documents verifying that said foreign nationals are authorized to reside in the Republic of Congo, as well as 2 photocopies or 2 copies of those documents certified as true copies by the single office
- Receipt for the opening of a bank account in the Congo and commitment to use it to perform financial transactions
- 3 photographs

### *For other foreign nationals who are required to incorporate, and for all filings by corporations, the following documents related to the official representative of the corporation must be submitted*

- 4 copies of notarized articles of association indicating the name of the corporation's official representative or, in lack thereof, minutes of a corporate meeting where the representative is named
- A commercial lease including, if applicable, a suspension clause concerning the administrative regularization of the company as well as a true copy certified by the single office

*Note:* The government documents reproduced on the following pages are available only in French.

**Figure G.1. Procedure: Demande d'autorisation d'exercice de la profession de commerçant pour les personnes physiques**



**CENTRE DE FORMALITES ADMINISTRATIVES DES ENTREPRISES**

Téléphone : 628 72 90  
cfe\_congo yahoo.fr

## PROCEDURE

**I/- DEMANDE D'AUTORISATION D'EXERCICE DE LA PROFESSION DE COMMERÇANT POUR LES PERSONNES PHYSIQUES**

- extrait d'acte de naissance ou tout document administratif justifiant de son identité;
- une copie de la carte de séjour avec visa long séjour;
- un extrait d'acte de mariage en tant que de besoin;
- un extrait de casier judiciaire émanant des autorités du pays d'origine ou tout autre document en tenant lieu;
- un certificat de résidence;
- le récépissé d'ouverture d'un compte dans une banque locale ou dans toute institution ou établissement financier, d'épargne et de crédit dûment établi;
- une copie du titre de propriété ou de bail justifiant l'implantation du siège de la boutique ou de l'échoppe, et le cas échéant, du principal établissement et de celui de chacun des autres établissements;
- en cas d'acquisition d'un fonds de commerce ou de location-gérant, une copie de l'acte d'acquisition ou de l'acte de location-gérance.

**II/- DEMANDE DE LA CARTE PROFESSIONNELLE DE COMMERÇANT**

- une autorisation d'exercice des activités commerciales délivrée par le Directeur Général du Commerce;
- un extrait du registre de commerce et du crédit mobilier;
- trois photos de format d'identité;
- les frais réglementaires.

*NB : la dénomination sociale doit être différente de l'identité du requérant*

Imp. Kipim Tel: 628 36 60

Figure G.2. Procedure: Demande d'autorisation d'exercice de la profession de commerçant pour les personnes physiques (*continued*)



**C.F.E.**

**CENTRE DE FORMALITES ADMINISTRATIVES DES ENTREPRISES**

Téléphone : 628 72 90  
cfe\_congo yahoo.fr

## PROCEDURE

**I/- DEMANDE D'AUTORISATION D'EXERCICE DE LA PROFESSION DE COMMERÇANT POUR LES PERSONNES MORALES**

- deux copies certifiées conformes des statuts;
- deux exemplaires de la déclaration de régularité et de conformité, ou de la déclaration notariée de souscription de versement du capital;
- deux exemplaires de la liste certifiée conforme des gérants, administrateurs ou associés tenus indéfiniment et personnellement responsables ou ayant le pouvoir d'engager la société;
- deux extraits du casier judiciaire des personnes visées à l'alinéa ci-dessus; si le requérant est de nationalité étrangère, il devra fournir un extrait de casier judiciaire émanant des autorités de son pays de naissance, et à défaut, tout autre document en tenant lieu;
  - **de la catégorie B : (les sociétés anonymes, les sociétés à responsabilités limitées et les sociétés unipersonnelles)**
- la déclaration de la dénomination sociale;
- le récépissé d'ouverture d'un compte dans une banque locale;
- le programme d'investissement de création d'emplois et un compte d'exploitation prévisionnel sur les trois premières années;
- le programme de protection de l'environnement lié à l'activité exercée, le cas échéant;
- le programme d'équipement garantissant le respect des normes de travail et de sécurité;
- le titre de propriété ou contrat de bail justifiant l'implantation du siège de la société;
  - **de la catégorie C : (les groupements d'intérêt économique)**
- le contrat de constitution de groupement d'intérêt économique;
- le titre de propriété ou contrat de bail justifiant l'implantation du siège du groupement d'intérêt économique;
- le programme de protection de l'environnement lié à l'activité exercée, le cas échéant;
- le récépissé d'ouverture d'un compte dans une banque locale ou dans toute institution ou établissement financier, d'épargne et de crédit dûment établi.

**II/- DEMANDE DE LA CARTE PROFESSIONNELLE DE COMMERÇANT**

- une autorisation d'exercice des activités commerciales délivrée par le Directeur Général du Commerce;
- un extrait du registre de commerce et du crédit mobilier;
- trois photos de format d'identité;
- les frais réglementaires.

*NB : la dénomination sociale doit être différente de l'identité du requérant*

Impr. April 198 : 628 38 60

Figure G.3. Tarification: Centre de formalites administratives des entreprises

CFE		CENTRE DE FORMALITES ADMINISTRATIVES DES ENTREPRISES	
		Av Foch (à côté de DHL) - BP 2013 - Tél : 628 72 90 - E-mail : cef_congo yahoo.fr	
<b>TARIFICATION</b>			
Les frais de formalités administratives de création d'entreprise sont fixés comme suit pour les nationaux comme pour les étrangers (Décrets n°95-96 du 29 mai 1995 et n°2008-446 du 15 novembre 2008, et l'arrêté n°3088/MJDH/MEFB du 03 juillet 2003)			
<b>1. Frais de création d'une entreprise individuelle :</b>			
- Immatriculation au RCCM.....			30 000 FCFA
- Immatriculation au Fichier du CNSEE.....			10 000 FCFA
- Immatriculation à la Chambre consulaire.....			10 000 FCFA
- Carte professionnelle de commerçant.....			50 000 FCFA
- Frais de dossier.....			10 000 FCFA
<b>TOTAL.....</b>			<b>110 000 FCFA</b>
<b>2. Frais de création d'une société :</b>			
	<i>G.I.E.</i>	<i>S.A.R.L.</i>	<i>S.A.</i>
- Immatriculation au RCCM.....	75 000	100 000	150 000 FCFA
- Immatriculation au Fichier du CNSEE.....	10 000	10 000	10 000 FCFA
- Immatriculation à la Chambre consulaire.....	10 000	10 000	10 000 FCFA
- Carte professionnelle de commerçant.....	100 000	100 000	100 000 FCFA
- Frais de dossier.....	10 000	10 000	10 000 FCFA
<b>TOTAL.....</b>	<b>205 000</b>	<b>230 000</b>	<b>280 000 FCFA</b>
<b>3. Frais de modification d'activité :</b>			
		<i>Entreprise Individuelle</i>	<i>Société (G.I.E, S.A.R.L, S.A)</i>
- Mention modificative du RCCM.....		20 000	50 000 FCFA
- Mention modificative de la Carte de commerçant.....		50 000	100 000 FCFA
- Frais de dossier.....		10 000	10 000 FCFA
<b>TOTAL.....</b>		<b>80 000</b>	<b>160 000 FCFA</b>
<b>4. Frais d'autorisation d'exercice temporaire d'activité commerciale pour les entreprises étrangères</b>			
- Première installation :			
* 5% du montant des prestations pour tout contrat dont le montant est inférieur ou égale à 3 000 000 FCFA			
* 3 000 000 FCFA pour tout contrat dont le montant excède 30 000 000 FCFA			
- Renouvellement semestriel.....			3 000 000 FCFA
<b>5. Autres frais</b>			
		<i>E.I.</i>	<i>Société/G.I.E</i>
- Renouvellement de la Carte de commerçant.....		65 000	115 000 FCFA
(Entreprise individuelle tous les 3 ans et Société tous les 5 ans)			
- Duplicata.....		60 000	110 000 FCFA
- Régularisation pour RCCM informatisé.....		20 000	50 000 FCFA
<b>6. Dispositions particulières pour les opérateurs économiques étrangers non ressortissants des pays de la CEMAC</b>			
* Paiement d'un cautionnement : 1% du capital social, le minimum à payer étant.....			
			1 000 000 FCFA
<b>Avantages particuliers :</b> Les entreprises des secteurs agricoles, d'élevage, d'industrie et des transports fluviaux bénéficient d'abattement de 50% du montant du cautionnement.			
<i>N.B. : Le paiement des frais de formalités dans les Guichets Uniques vaut inscription au Registre du Commerce et du Crédit Mobilier (RCCM), à la Caisse Nationale de Sécurité Sociale (CNSS), au Centre National de la Statistique et des études économiques (CNSEE), à la Direction Départementale du Travail (DDT), à la Direction Départementale des Impôts (DDI) et à la Direction Départementale du Commerce (DDC)</i>			
<i>Stg : G.I.E. : Groupement d'intérêt économique</i>		<i>S.A.R.L. : Société à responsabilité limitée</i>	
		<i>S.A. : Société anonyme</i>	

The amount generated by private health practitioners is not specifically itemized, but the interviewed representative stated that such amount is an extremely small share of the total income.

Figure G.4. Formulaire de déclaration, modification, renouvellement, cessation de sociétés ou d'activités pour un particulier

REPUBLICQUE DU CONGO  
Unité--Travail--Progrès

N° 3002376  
*Cette liasse est autocopiant. La remplir très lisiblement au stylo à bille*

N° RCCM  
N° SCIE (N ou T).....  
N° NIU.....  
N° C.N.S.S.  
réservé au service

DÉCLARATION UNIQUE DE CRÉATION  DE MODIFICATION  DE RENOUELEMENT  OU DE CESSATION   
DE SOCIÉTÉ  OU D'ACTIVITÉ POUR UN PARTICULIER

GUICHET UNIQUE POINTE-NOIRE/2010

*A remettre accompagnée des pièces justificatives et des frais réglementaires au C.F.E, il ne pourra pas refuser la déclaration si les parties foncées sont remplies*

**DENOMINATION:** \_\_\_\_\_  
**SIGLE** \_\_\_\_\_ Enseigne ou Nom Commercial \_\_\_\_\_

**NOMBRE DE SALAIRES** de l'entreprise à la date de déclaration \_\_\_\_\_ dont Étrangers : \_\_\_\_\_ Congolais : \_\_\_\_\_

**FORME JURIDIQUE** \_\_\_\_\_ Chiffre d'Affaires prévisionnel de l'Année : \_\_\_\_\_ Prévion d'emplois sur 3 ans \_\_\_\_\_

**CAPITAL (montant)** \_\_\_\_\_ Si Capital variable, montant minimum : \_\_\_\_\_ INVESTISSEMENTS APPB APPEX  
APPORT PERSONNEL

**DATE DE CREATION** \_\_\_\_\_ Adresse du siège \_\_\_\_\_ Rue \_\_\_\_\_ N° \_\_\_\_\_ Tél : \_\_\_\_\_ Fax : \_\_\_\_\_ B.P : \_\_\_\_\_  
Quartier / Arr. \_\_\_\_\_ ville de : \_\_\_\_\_

**Dirigeants, associés, ou tiers autorisés à signer pour la société**

Noms - Prénoms	Date et lieu de naissance	Nationalité	Fonctions	Etablissement / Société
1				
2				
3				
4				

Liste à suivre sur intercalaire Oui  Non

**Activité Principale** \_\_\_\_\_  
Secondaire : \_\_\_\_\_  
Secteur d'activité : Primaire  Secondaire  Tertiaire  Système comptable utilisé : \_\_\_\_\_

Profession/Activité réglementée Oui  Non  Si oui, réf. de l'agrément : \_\_\_\_\_  
Délivré par : \_\_\_\_\_  
Datede signature : \_\_\_\_\_ date d'expiration : \_\_\_\_\_

**Etablissements, Boutiques et Succursales**

Enseignes ou Sigles	Nature de l'Etablissement (Société)	Adresses (Lieux d'implantations)	Dates d'ouverture	Activité	Effectifs Permanents	Chiffres d'affaires Prévisionnel
1						
2						
3						

Liste à suivre sur intercalaire Oui  Non

Date de cessation d'activité : \_\_\_\_\_ Motif : \_\_\_\_\_

Adresse permanente du déclarant : \_\_\_\_\_  
Réf. pièce d'identité : \_\_\_\_\_  
Pour un étranger, adresse dans le pays d'origine : \_\_\_\_\_  
Le soussigné : \_\_\_\_\_  
de nationalité : \_\_\_\_\_ Né le : \_\_\_\_\_ à \_\_\_\_\_  
déclare sur l'honneur qu'il n'a pas fait l'objet d'une condamnation interdisant la profession de commerçant et demande par ce document  
Immatriçulation au Registre du Commerce et du Crédit Mobilier (RCCM), l'inscription au Centre national de Statistiques et des études économiques,  
à la Chambre Régionale du Commerce, à la Caisse Nationale de Sécurité Sociale, aux Directions Départementales des Impôts, du Travail, et du  
Commerce, ainsi que l'établissement d'une carte professionnelle de commerçant

Fait à \_\_\_\_\_ le \_\_\_\_\_  
Signature du déclarant \_\_\_\_\_

reçu ce formulaire, les pièces justificatives égales ainsi que la somme de :  
par M. : \_\_\_\_\_ Fonction : \_\_\_\_\_ tampon et signature

Un exemplaire de la présente liasse vous est remis immédiatement, date et tamponné par le C.F.E. à titre de reçu de cette formalité, des pièces justificatives légales, et des frais réglementaires. Votre carte de commerçant vous est remise dans les 30 jours qui suivent la déclaration, conformément à la réglementation en vigueur, elle vous autorise à exercer et, pour les sociétés, à débloquer les fonds déposés à la banque. Pour toute observation ou proposition d'amélioration du système écrire au Ministre chargé du Commerce.

04/2009 Rev. 01, 3, 04/09

**Table G.1. Liste des taxes à payer par une structure privée de la santé (toutes taxes confondues)**

N°	Libellés des taxes	Montants à payer (FCFA)	Sites de paiement	Périodicité	Observations
1	-Frais de déclaration d'activités -Enregistrement au Registre du commerce -Affiliation à la chambre de commerce -SCIEN -SCIET	60 000	Centre des formalités des entreprises (CFE)	Une seule fois au début des activités	N.B : Toutes ces pièces administratives sont payées au même moment. La création du CFE a réglé la question de la lenteur administrative dans la constitution de dossier d'ouverture d'une entreprise.
2	Frais d'autorisation d'ouverture (Agrément)	70 000	Direction des Services de Santé	Une seule fois au début des activités	
3	Inscriptions du promoteur à l'ordre des médecins	80 000	Direction départementale de l'ordre des médecins	Une seule fois au début des activités	
4	Numéro d'identification fiscale	10 000	Inspection divisionnaire des impôts	Une fois à l'ouverture de dossier fiscal	N.B : Cette pièce est exigible à toute operation avec la fiscalité
5	Taxe immobilière	—	Inspection divisionnaire des impôts	Annuelle	N.B : Le montant dépend de la valeur de l'immeuble ou de la valeur du contrat de bail
6	Patente	—	Inspection divisionnaire des impôts	Annuelle	Elle dépend de la valeur estimée des activités
7	Taxe sur la valeur ajoutée (TVA) sur l'achat des produits	—	Inspection divisionnaire des impôts	Permanente	Elle dépend de la valeur estimée des achats
8	Taxe sur la valeur ajoutée (TVA) sur les services offerts	—	Inspection divisionnaire des impôts	Permanente	Elle dépend de la valeur estimée des services offerts
9	Bénéfice non commercial		Inspection divisionnaire des impôts	Annuelle	Elle dépend du bénéfice annuel réalisé
10	Impôt salarial		Inspection divisionnaire des impôts	Mensuelle	Il dépend du barème des impôts

(Suite page suivante)

Table G.1 Liste des taxes à payer par une structure privée de la santé (toutes taxes confondues) (continued)

N°	Libellés des taxes	Montants à payer (FCFA)	Sites de paiement	Périodicité	Observations
11	Caisse de Sécurité Sociale (Régime Assurance vieillesse)	—	Services des cotisations sociales	Mensuelle	Salaires plafonnés à 1 200 000 F par mois x12% N.B : La plus grande part à payer est supportée par l'employeur, celle de l'agent dépendant du salaire brut et prime
12	Caisse de Sécurité Sociale (Accidents de travail — maladies professionnelles — allocations familiales)	—	Services des cotisations sociales	Mensuelle	Salaires plafonnés à 1 200 000 F par mois x12% N.B : La plus grande part est payée par l'employeur, celle de l'agent dépendant du barème C.N.S.S. tendant du salaire brut et des primes de l'agent
13	Enregistrement au fichier de l'Office Nationale de l'Emploi et de la Main d'Œuvre (ONEMO)	—	ONEMO	Une fois à l'ouverture de la société	Le montant dépend de la grandeur de l'entreprise notamment du nombre des employés
14	Frais de l'Office Nationale de l'Emploi et de la Main d'Œuvre (ONEMO)	—	ONEMO	Mensuelle	Le montant à payer dépend de la masse salariale et 0,5% de cette masse salariale est recouvrée
15	Frais de SOPROGI (Société de Promotion et de Gestion Immobilière)	—	SOPROGI	Mensuelle	Le montant à payer est de 2% de la masse salariale
16	Fonds National de l'Habitat	—	Inspection divisionnaire des impôts	Mensuelle	Le montant à payer est de 1% du traitement brut des salaires
17	Taxe régionale	2 000 par agent	Perception communale	Annuelle	Le montant total à payer dépend du nombre total des agents
18	Taxe municipale sur les boutiques, baraques, cliniques implantées sur le périmètre urbain	60 000	Perception communale	Annuelle	Le montant à payer est fixé par le Conseil Départemental

## Appendix H. Preliminary Action Plan: November 2010

The following table shows the guidelines of the preliminary action plan. It combines two categories of actions: (1) high-priority actions agreed on by the participants at the second workshop and (2) Additional actions proposed by the consultant who conducted the study (with gray shading).

ST = Short term

MT = Medium term

LT = Long term

	FIELD/ACTION	TIMING (ST, MT, LT)
<b>A</b>	<b>POLICY AND GOVERNANCE</b>	
	<i>Involve both the public and private sectors through the following actions:</i>	
<b>A1</b>	<b>Create a formal, ongoing platform for public-private sectoral dialogue</b>	<b>ST</b>
A1.1	Develop draft statutes, in cooperation with the Ministry of Health and the High Council for Public-Private Dialogue	ST
A1.2	Create an official platform	ST
<b>A2</b>	<b>Increase the involvement of the private sector in developing health care policy and its implementation</b>	<b>ST</b>
A2.1	Include the private sector in the coordinating bodies of the Health System Development Plan (PDSS) (coordination and technical committees)	ST
A2.2	Include the private sector in technical committees established by the Ministry	ST
<b>A3</b>	<b>Improve the organization of the private health sector</b>	
A3.1	Establish a structure to represent the sector that includes all involved parties	ST
A.3.2	Improve and/or establish institutions such as orders, professional associations and unions, etc. for each subsector	MT
<b>A4</b>	<b>Develop a policy on the private health sector</b>	
A.4.1	Develop and approve the policy document	MT
A.4.2	Create a directory of institutional structures and actors in the sector that is continually improved and updated	MT
<b>B</b>	<b>OVERSIGHT/REGULATIONS</b>	
<b>B.1</b>	<b>Take stock of, update and increase public awareness of all legislation and regulations governing the private health sector, through a multi-sector technical committee established by the formal, ongoing platform</b>	
B.1.1	Simplify registration procedures (single office system) and revise the technical criteria for granting licenses	ST
B.1.2	Revise the categories of institutions (commercial nature of independent health care practitioners)	ST
B.1.3	Revise the legislation, adding principles of self-regulation for the private sector (including peer monitoring systems) and accreditation for health care structures	ST

(Continued on next page)

**Appendix H (continued)**

	FIELD/ACTION	TIMING (ST, MT, LT)
B.1.4	Recognize and regulate staff working simultaneously in the public and private sectors	ST
B.1.5	Approve new legislation	ST
B.1.6	Increase public awareness of new legislation	ST
<b>B.2</b>	<b>Improve the implementation of the regulatory framework</b>	
B.2.1	Establish a joint public-private consultation committee to <u>monitor</u> the regulations at the central and subregional levels	ST
B.2.2	Improve the institutional capacities of the MSP regarding oversight, regulations and implementation	MT
B.2.3	Improve the self-regulation capacities of the private sector	MT
B.2.4	Restructure private institutional arrangement (orders, associations, unions) to bring them up to standard	MT
B.2.5	Establish systems for detecting illegal activities and products, as well as a related penalty system	MT
<b>C</b>	<b>STIMULATION OF PRIVATE ACTIVITY</b>	
<b>C.1</b>	<b>Increase access to bank financing / guarantee funds</b>	
C.1.1	Create a guarantee fund for the sector funded by private actors	MT
C.1.2	Create a government support fund for private initiatives in the health care sector	MT
C.1.3	Improve the capability of private operators to assemble bankable projects	MT
C.1.4	Inform banks about the features and potential of private health businesses to encourage them to grant loans to the private health sector	MT
<b>C.2</b>	<b>Reduce taxes</b>	
C.2.1	Reduce / eliminate taxes on the private practice of <u>health care professions in rural areas</u>	MT
C.2.2	Eliminate taxes on <u>generic drugs</u> and raw materials and suppliers for <u>local pharmaceutical production</u>	MT
C.2.3	Establish a <u>startup tax credit</u> (see investment code)	MT
<b>C.3</b>	<b>Capacity building</b>	
C.3.1	Develop systems that provide / facilitate technical support for increased private sector capacity in several fields (business skills, management, information technology, etc.)	MT
<b>D</b>	<b>SPECIFIC MEASURES RELATED TO PPPs</b>	
<b>D.1</b>	<b>Make PPPs operational for public health care programs that entitle citizens to free care</b>	<b>ST</b>
D.1.1	Establish a joint public-private technical committee on how to make PPPs operational (at the level of the DGS)	ST
D.1.2	Formalize / extend existing PPPs on HIV, AIDS, malaria, and vaccinations	ST

*(Continued on next page)*

**Appendix H (continued)**

	<b>FIELD/ACTION</b>	<b>TIMING (ST, MT, LT)</b>
<b>D2</b>	<b>Develop PPPs on Emergency Obstetric and Neonatal Care</b>	<b>ST</b>
D.2.1	Include representatives of the private sector (associations and independent practitioners) in the national needs evaluation committee and develop an implementation plan	ST
D.2.2	Include representatives of the private sector in the four national subcommittees on free Caesarian sections and care for complicated deliveries and develop an implementation plan	ST
<b>D3</b>	<b>Develop PPPs on pre-service training and continuing education</b>	<b>MT</b>
D3.1	Allow students of public professional schools to do their internships at private structures	MT
D3.2	Invite private-sector providers to teach at public training institutions	MT
D3.3	Invite private-sector providers to attend the continuing education seminars organized by the public sector	MT
<b>D4</b>	<b>Develop demand-side subsidization strategies</b>	<b>MT</b>
D4.1	Analyze the possibilities and the feasibility of introducing or improving strategies such as health insurance, community-based health insurance (mutuelles), health care vouchers, etc.	MT
D4.2	Develop financing strategies for the public and private sectors	MT
<b>D5</b>	<b>Develop a system and an implementation plan for monitoring PPPs</b>	<b>ST</b>

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*Professor Georges Moyon  
Minister of Health and Population  
The Republic of Congo*



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