Humanitarian governance and the consequences of the state fragility discourse in DRC’s health sector

Working paper 63
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About us

The Secure Livelihoods Research Consortium (SLRC) is a global research programme exploring basic services, livelihoods and social protection in fragile and conflict-affected situations. Funded by UK Aid from the UK Government’s Department for International Development (DFID), with complementary funding from Irish Aid and the European Commission (EC), SLRC was established in 2011 with the aim of strengthening the evidence base and informing policy and practice around livelihoods and services in conflict.

The Overseas Development Institute (ODI) is the lead organisation. SLRC partners include: Centre for Poverty Analysis (CEPA), Feinstein International Center (FIC, Tufts University), Focus1000, Afghanistan Research and Evaluation Unit (AREU), Sustainable Development Policy Institute (SDPI), Wageningen University (WUR), Nepal Centre for Contemporary Research (NCCR), Busara Center for Behavioral Economics, Nepal Institute for Social and Environmental Research (NISER), Narrate, Social Scientists’ Association of Sri Lanka (SSA), Food and Agriculture Organization (FAO), Women and Rural Development Network (WORUDET), Claremont Graduate University (CGU), Institute of Development Policy and Management (IOB, University of Antwerp) and the International Institute of Social Studies (ISS, Erasmus University of Rotterdam).

SLRC’s research can be separated into two phases. Our first phase of research (2011–2017) was based on three research questions, developed over the course of an intensive one-year inception phase:

- State legitimacy: experiences, perceptions and expectations of the state and local governance in conflict-affected situations
- State capacity: building effective states that deliver services and social protection in conflict-affected situations
- Livelihood trajectories and economic activity under conflict

Guided by our original research questions on state legitimacy, state capacity, and livelihoods, the second phase of SLRC research (2017–2019) delves into questions that still remain, organised into three themes of research. In addition to these themes, SLRC II also has a programme component exploring power and everyday politics in the Democratic Republic of Congo (DRC). For more information on this work, visit: www.securelivelihoods.org/what-we-do
Acknowledgements

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<td>CBO</td>
<td>Community-based organisation</td>
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<td>DRC</td>
<td>Democratic Republic of Congo</td>
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This working paper examines how the discourse on state fragility affects the preferences of key actors in humanitarian governance for different types of health sector interventions in the Democratic Republic of Congo (DRC).

Based on fieldwork in South Kivu and Kinshasa, we argue that, in addition to focusing on the actual meaning of state fragility, practitioners and scholars should give attention to the interactive processes around the state fragility discourse among stakeholders in the health sector. The lack of consensus on state fragility influences humanitarian governance, especially mutual perceptions of and interactions among the host-government, donors and international non-governmental organisations (INGOs). Donors and INGOs have legitimised the persistence of vertical, emergency-based interventions by emphasising state fragility, whereas state officials have preferred to assert political statehood and a higher degree of state control.

Nevertheless, state, INGOs and donor organisations agree that donors’ financial contributions ensure the survival of the public health sector. Looking forward, it is important to build a policy coalition based on harmonised views on addressing fragility. This will be necessary for effective engagement and the sustainability of interventions but, given the current political situation, this harmonisation is not likely to happen any time soon.
Definitions

**Humanitarian arena** - Humanitarian space denotes the physical or symbolic space that humanitarian agents need to deliver their services according to the principles they uphold. This normative concept separates humanitarian action from its politicised environment and is widely used in policy documents and academic texts, even though there is plenty of empirical evidence to suggest this space is in fact highly politicised. The empirical concept of the humanitarian arena shifts the focus to a multitude of actors, including humanitarians and the disaster-affected recipients of aid, who negotiate and shape the everyday realities of humanitarian action.¹

**Empirical statehood** - Empirical statehood emphasises the empirical – the de facto – rather than the juridical – the de jure – attributes of statehood. Determining the degree of empirical statehood means asking the extent of the government’s capacity to exercise control over a state’s territory and the people residing in it. This includes the degree of its ability to pronounce, implement and enforce commands, laws, policies and regulations.²

**Predatory state** - In a predatory state ministries, state agencies, provincial administrations and other bureaucratic appendages of the state are maintained by state elites, their employees and citizens in general because they derive private benefits from them, irrespective of these institutions’ capacity to perform their initial public functions.³

Predatory behaviour is likely to emerge in societies that:

- possess large benefits of political power
- are well endowed with natural resources
- are badly endowed with factors that are complementary to public investment, such as human capital
- are intrinsically unstable, perhaps because they have illegitimate states, or because the society is highly politically mobilised.⁴

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Introduction

State fragility is a contentious concept in global and humanitarian governance. It has been understood and used differently by donors, international non-governmental organisations (INGOs) and state actors. Yet little is known about how humanitarian governance functions in fragile contexts.

In Barnett’s (2013) broad interpretation of humanitarian governance, humanitarians focus on advancing human welfare and want to address—politically and otherwise—the root causes of human suffering. Promoting livelihoods, human rights, development, conflict mitigation and environmental work all fall under this interpretation. When narrowly explained, humanitarian governance concerns traditional humanitarian action according to the principles of humanity, impartiality, neutrality and independence, thus remaining distanced from politics. An equivalent narrow understanding of humanitarian governance, which has long been dominant in humanitarian research, centres on fulfilling human needs for physical survival. This latter explanation tends to focus more on humanitarian organisations than other actors (i.e. those that fall under the United Nations (UN) umbrella, belong to the Red Cross and Red Crescent Movement, or are non-governmental). Although the two interpretations differ in their goals, both are based on normative concerns about human wellbeing.

It remains unclear whether and how these theoretical distinctions on broad or narrow governance are borne out empirically in crisis zones. To better understand humanitarian governance—in this case in the Democratic Republic of Congo (DRC)—it is important to pay close attention to humanitarian normative intentions within the study of multi-actor governance and its empirical consequences on the ground. As highlighted by the concept of the humanitarian arena (Hilhorst and Jansen 2010), action based on normative concerns and goals may have inadvertent consequences in fragile states, where multiple actors jockey for position. In these contexts, the implementation of principled humanitarian aid is complicated by many actors who do not respect those principles. Human rights work, development activities and conflict mitigation can also encounter significant opposition from these actors.

This paper empirically studies multi-actor governance, in particular the interactions among the host state, donor governments and INGOs regarding health interventions in DRC, a country characterised by fragile statehood. We explore the consequences of these discourses on fragility for health sector governance, especially in terms of how
health policy is determined and enacted at various levels and how these discourses determine preferences for different modes of intervention. We address the following questions: How do key governance actors–state, donors and INGOs–engage in the discourse on state fragility, and how does this influence intervention models and policy coalition-building in DRC health sector?

Interestingly, we find that the interactive processes around the state fragility discourse matter more to stakeholders in the health sector than the actual meaning of state fragility. State fragility is broadly acknowledged, but there is disagreement regarding how to deal with it. Service provision–healthcare delivery in particular–has become a humanitarian arena, where state fragility is used instrumentally by state officials, donors and INGOs in divergent discourses regarding health policy and operational intervention models.

Our empirical research shows how frontline providers are affected by the reality of state fragility. However, the understanding of this condition is informed not only by organisations’ micro-level experiences at the operational level, but also by prevailing interpretations of fragility among donors and DRC government. An analysis of donors’ policy documents has revealed how concerned donors are about fragility, corruption and insecurity, and how they incorporate ideas about state fragility into all dealings with the state. This raises the question of whether this behaviour may hamper an evolution away from state fragility.

The present study shows that the political order in DRC and associated risks are such that global and humanitarian governance, as well as sectoral governance, overlap considerably in daily practice. In such a context, the intervention models and health policies of humanitarians and others do not fall neatly within either a broad or narrow interpretation of humanitarian governance. The state, donors and INGOs are mutually dependent on each other, but, as long as corruption is rife, these actors cannot work together to solve the problem of state fragility or end the chronic crisis (Dijkzeul 2003). This helps to explain the functioning of multi-actor governance in DRC and its health sector, alongside the need for aid interventions and dissatisfaction with their actual consequences.

This paper first discusses the emergence of state fragility in international discourse. Next, it elaborates on state fragility in DRC, before discussing the methods used in this study, in particular the analysis of discourse (and its instrumentalisation). After reviewing donors’ state fragility discourse, we then present the findings on divergent discourses on state fragility, centring on three issues:

- insufficient funding of the health sector;
- international engagement in the health sector, especially in terms of legitimising different intervention models;
- the difficulties with establishing a policy coalition.
The emergence of ‘state fragility’ as a discourse can be traced back to the end of the Cold War (Hehir and Robinson 2007), but there is still no common conceptual framework for this idea. The threats to global governance caused by fragile states, particularly to international security, have prompted scholars to construct a wide array of definitions of—and criteria for—state fragility. Sharp differences are also seen in the policies and strategies of donor governments and international organisations (Carment et al. 2008; IDC 2012; Stepputat and Engberg-Pedersen 2008). Usually, however, the definition of a fragile state revolves around the lack of capacity and willingness to perform key government functions for the benefit of all citizens (OECD 2014; OECD/DAC 2008b). Not surprisingly, most violent internal conflicts and subsequent humanitarian crises occur in fragile states (Tikuisis and Carment 2017).

Popularised by the World Bank in the early 1990s, the term ‘fragility’ was originally used to describe countries that proved ineffective in implementing structural adjustment reforms (Carment et al. 2008). The subsequent search for how to characterise and possibly restore ‘failing’, ‘failed’ or ‘weak’ states has provided an impetus for the evolution of the concept of state fragility (Osaghae 2007). Regarded as the sum of the pathologies of problematic states, the concept of fragility suggests deviation from the dominant and supposedly universal western paradigm of statehood and governance (ibid.).

The practical consequences of state fragility gained global attention after the 9/11 attacks in 2001. The international reaction to these attacks, focusing initially on Afghanistan, reinforced perceptions that poorly governed states are weaknesses in the fabric of international society. They also underlined the notion that the developed world has a considerable self-interest in strengthening these states’ capacities for governance (Wesley 2008). Hence, the idea of the ‘failed’ or ‘fragile’ state has shifted the focus of security thinking from an emphasis on the concentration of state power to concern about zones of state powerlessness, where transnational threats can incubate and spread while exploiting the interdependence of a globalised world to attack developed societies (ibid.).

In the 1980s, a contentious debate began regarding how to improve the effectiveness of aid by going beyond aid conditionality and structural adjustment, to emphasise country-led development, partnership and
context-specific interventions. A series of high-level global conferences set the agenda for improving aid effectiveness. These included:

- the Monterrey Consensus on Financing for Development (2002)
- the Joint Marrakech Memorandum (2004)
- the Paris Declaration on Aid Effectiveness (2005)
- the Accra Agenda for Action (2008), which sought to strengthen and deepen the implementation of the Paris Declaration (Hayman 2012; Naudé 2012; OECD 2008a; OPM/IDL 2008).

To sustain the momentum, states adopted the 2011 Busan New Deal for Engagement in Fragile States, with the aim of achieving peace-building and state-building in fragile states through international partnerships.

State fragility as empirical reality and a discourse has thus influenced international governance regarding weak states. In this respect, some—especially in the Global South—have regarded the state fragility discourse, since its inception, as not only playing a descriptive role, but also as an ideological vehicle for the advancement of western interests and statehood philosophy. This has occurred under the guise of peace-building, humanitarian intervention, the responsibility to protect, development cooperation and state-building.
DRC is a notoriously fragile state, as indicated by its poor ranking on state fragility indexes. The Country Indicators for Foreign Policy Fragility Index (Tikuisis and Carment 2017), focuses on authority, legitimacy and capacity and, here, only Afghanistan scored worse. Meanwhile, the Brookings Institution’s Index of State Weakness in the Developing World (2008) relies on four domains of public management: economic welfare provision, political institutions’ effectiveness and legitimacy of the system of governance, physical security, and social welfare (Rice and Patrick 2008). In this, DRC is the third weakest country in the world, with only Afghanistan and Somalia ranked as weaker. Both indexes show a lack of capacity in the delivery of social services, such as those related to healthcare.

Furthermore, DRC has become the embodiment of predatory statehood (Englebert 2003; Trefon 2011), enduring social conflicts, insecurity and disorder. It has weak institutional capacity and is dependent on natural resources for domestic revenues. It is also among the world’s most aid-dependent states (OECD 2014). As a low-income and fragile country, its public service provision is limited and uneven. Poor performance in public financial management also makes it difficult to achieve fiscal sustainability (IMF 2014), which can be defined as the capacity of a government to fund its desired programmes, service its debt obligations and ensure its solvency (Heller 2005). DRC actually displays limited statehood, as the central state authorities are too weak to exercise domestic sovereignty, but it continues to carry out some empirical functions of statehood in, for example, policy-making, tax collection and customs.

When public sector mismanagement reached its apex during the late stages of Mobutu’s reign, donors stopped cooperating with the government. This disruption of international cooperation compounded the plight of the population, and public institutions and social services deteriorated rapidly. Since international cooperation resumed in 2001, DRC has received international multisector assistance, particularly to its health sector but also for security, through the Mission des Nations Unies pour la Stabilisation du Congo (MONUSCO). This assistance brought new momentum to donors’ engagement in the public sector. Donor inputs have dramatically increased health sector activity, with a strong commitment to improvements in the war-torn eastern provinces. Still, with lingering wars in eastern DRC and the lack of state capacity for social and developmental performance, community healthcare continues to face serious challenges, and interventions remain essential to
save lives and improve community health.

Despite the above, DRC government, donors and humanitarian INGOs have not harmonised their perceptions of fragility. They have also failed to reach a common understanding on intervention policy and models of engagement to address this fragility. This has led to dissent about policies, interventions and coalition-building. In terms of framing collective action, prospects for success are limited without a shared vision on:

- diagnosing problems
- developing solutions
- explaining a rationale for specific actions (Benford and Snow 2000).

Policy dissent because of clashing conceptions of dealing with state fragility results in tensions among the main stakeholders. The lack of accord in the discourse on state fragility is no mere matter of semantics; as we will show, it has a direct impact on intervention models as part of humanitarian governance of risk and disorder.

The principles of the 2005 Paris Declaration set out an overall framework of agreement and structure of mutual accountability between aid-receiving countries and their development partners, to give substance to the consensus model of ‘country-led’ development (Wood et al. 2008). Our research reveals that the dissent found in health sector discourses on state fragility simultaneously helps improve community health while undermining the state-building process. Not only does state fragility give donors leeway to limit their compliance with the Paris Declaration, it also carries an implicit stigma, placing state actors in the politically defensive posture of asserting statehood. State actors then claim to align donors and INGOs and attempt to strengthen the state's control of governance and interventions. Previous research has shown that tensions between the obligation to comply with aid effectiveness principles and the practical need to deal with contextual challenges push donors and INGOs towards developing shadow alignment in fragile states (Brinkerhoff and Bossert 2008). This means that donors look for openings to introduce elements of good health governance, to the greatest extent possible. This takes place as they provide the resources for service delivery in anticipation of creating the architecture for a revived national health system that fits the country context and reflects the principles of good governance (ibid.: 19).
This primarily qualitative study is part of a larger project examining livelihoods, basic services and social protection in conflict-affected situations. The fieldwork took place in South Kivu and Kinshasa from August 2013 to March 2015. South Kivu is a conflict-affected province in eastern DRC that has received relatively high levels of humanitarian assistance over the last two decades. Each province is divided into health zones (HZs). Health policy is officially set at the national level and implemented and evaluated at the provincial level. Yet, in practice, non-state actors—in particular faith-based organisations (FBOs) in cooperation with INGOs—run most HZs.

4.1 Data collection

Open and semi-structured interviews and focus groups were conducted with three categories of participants:

1. state officials from the national-level Ministry of Health (MoH) in Kinshasa and its provincial arm, the Provincial Ministry of Public Health, in Bukavu
2. representatives of the main health sector-supporting INGOs and donor organisations
3. frontline providers, FBO representatives and community-based organisation (CBO) members.

Specifically, we interviewed:

- 22 state officials from the MoH and its related services
- 23 HZ physicians and administrative managers in the South Kivu health system
- 10 representatives of FBOs (the Bureau Diocésain des Oeuvres Médicales—the health department of the Catholic Church—and the Coordination Médicale of Eglise du Christ au Congo) in both Bukavu and Kinshasa
- representatives from five national NGOs (Agence d’Achat des Performance, Caritas Congo in both Bukavu and Kinshasa, the Provincial Civil Society Office in Bukavu, the Reseau d’Innovation Organisationnelle and the Centre d’Appui à la Santé)
- four community-based health insurance managers
- one staff member each at the World Health Organization, UNICEF, Médecins Sans Frontières (MSF) Holland and MSF-Spain, Malteser International, Louvain Coopération

Secure Livelihoods Research Consortium, funded by UK Aid and Irish Aid.
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au Développement, Cordaid, the International Rescue Committee (IRC), Projet de Santé Intégrée (PROSANI) and Coopération Suisse

- two staff members at the Department for International Development (DFID).

Six focus groups were conducted with frontline providers (medical doctors, nurses and health facility administrators) at health facilities in Katana HZ and at the Provincial Ministry of Public Health in Bukavu.

Policy records and documents were also reviewed. Donors’ country policy papers were useful for understanding the state fragility discourse in the donor community, allowing us to gain insight into a) donors’ perceptions of state fragility in DRC and b) the theoretical background of donor organisations’ intervention models. Hence, we analysed country policy documents produced by:

- the United States Agency for International Development (USAID)
- the European Union (EU)
- the World Bank
- DFID
- Coopération Belge au Développement.

These documents represent the views of the most influential donors, which contribute substantial funding to the health sector and strongly influence debates on governance and health intervention models, as well as actual health interventions.

4.2 Data analysis

We used critical discourse analysis to answer the research question. Discourse goes beyond ideas or “text” (what is said) to include context (where, when, how and why it was said). It also refers to both structure (what is said, where and how) and agency (who said what to whom) (Schmidt 2008). In social interactions, discourse plays a role in the expression of content, social relations and personal attitudes (Brown and Yule 1983).

Schmidt (2008) has suggested two basic forms of discourse as it relates to the processes of policy-making and enforcement: coordinative discourse, which takes place among policy actors, and communicative discourse, which is between political actors and the public. In social and policy realms, the term discourse can be applied in different ways, to refer to generalised ideas, beliefs and assertions (Humphreys 2009). Discourse may also reflect ideologies understood as fundamental beliefs of a group and its members (Van Dijk 2000), as well as an ideological tool that is both descriptive and prescriptive. The descriptive element means providing an account of society and politics, while the prescriptive one is a normative programme for how society and politics should be organised (Humphreys 2009).

Critical discourse analysis ‘studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in a socio-political context’ (Van Dijk 2001). With this in mind, our study dissected the determinants of the use or avoidance of state fragility discourse by key governance actors. It also examined its impact on the implementation of the Paris Aid Effectiveness Principles. The analysis revolves around three main themes:

1. state fragility – governance, statehood, weak state and capacity
2. explanations for such fragility – corruption, insecurity, history and lack of financial resources
3. policy recommendations – intervention models, policy coalition, training, education, capacity-building, transparency, efficiency and performance.

4.3 Research constraints

Data collection was hindered by the limited willingness of state officials to provide information, such as evaluation reports on state-managed projects/programmes that would indicate funding embezzlement or corruption. It was also difficult to elicit responses from participants regarding the link between corruption and state fragility, although corruption and exploitation have been notorious throughout much of Congolese history (Trefon 2011). Moreover, some respondents felt uncomfortable discussing problems of dependency if current funding arrangements and vertical health interventions were to continue.

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6 PROSANI is not an independent organisation, but a project funded by USAID and carried out by a consortium of Management Sciences for Health, the IRC and Overseas Strategic Consulting, Ltd.
5.1 State fragility as a coordinative discourse in donors’ policy documents

Our review of donor documents helped contextualise statements on state fragility that were repeatedly made by donor organisations (and INGOs) on the ground. Table 1 presents an overview of the documents consulted.

Although it is defined differently depending on the donor’s focus, fragility is presented as the most dominant feature of DRC. The documents reveal how the image of fragility during strategic country policy formulation determines donors’ strategies and operational planning.7 Weak political, administrative and economic governance, along with entrenched corruption, appear to be the crosscutting aspects of state weakness. They are also the leading challenges to state-building.

According to USAID, DRC’s poor performance is a well-known result of abysmal governance (USAID 2014: 2). DRC is portrayed in two prominent ways. One is as an ‘invisible state’—not only a failed state, but also a non-state—because of its lack of sovereignty outside its urban centres. The other common depiction is of it as a ‘government by substitution,’ with multilateral and bilateral actors taking on increasing levels of responsibility for governance (USAID 2014). USAID maintains that the extreme weakness of institutions

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<td>Belgium</td>
<td>La Coopération Belge au Développement et les Etats Fragiles</td>
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Whereas donors tend to have countrywide policies, INGOs focus more on the execution of programmes and projects. Although several INGOs have their own country policies and strategies, these are rarely as comprehensive as those of donor organisations.
contributes to fragility and ultimately leads to poor social wellbeing and extreme poverty (ibid.). Based on this view, USAID has adopted an ‘institutional value chain approach’, investing in support and capacity-building to targeted national institutions that will, in turn, stimulate an enabling environment to facilitate stronger governance and service delivery at the local level (ibid.: 3).

Building its interventions on the principles of transparency and accountability according to ‘value for money’ and the ‘value chain’, DFID describes DRC as ‘one of the world’s most difficult environments in which to deliver effective aid’ (DFID 2011: 2). For DFID, strengthening state capacity to respond to citizens’ needs and expectations is critical for furthering stability. This, in turn, helps attract the investment needed for economic growth (DFID, 2011: 3). The unresponsiveness of state institutions is understood to de-legitimise public institutions and negatively impact the effectiveness of donors’ aid interventions.

In *La Coopération Belge au Développement et les Etats Fragiles* (Laer and Matthysen 2014), DRC is presented as ‘the prototypical fragile state.’ According to the Belgian Development Cooperation Law of March 2013, fragility is a condition in which government and state institutions lack the capacity and/or the political will to ensure security and protect their citizens, effectively manage public affairs and fight poverty (ibid.: 10). Here, fragility is a multidimensional concept and refers to defects in public governance and to unresponsive institutions, resulting in both critical social vulnerability and a weak state–society relationship. Political and economic fragility in governance results in defective institutions characterised by weakness and corruption, with a lack of accountability and voice for the population. DRC embodies all of the characteristics of a fragile state (ibid.: 13).

The EU’s *Evaluation de la Coopération de l’Union-Européenne avec la République Démocratique du Congo 2008–2013* depicts a post-conflict country characterised by entrenched poor public service delivery (ADE 2014: 57). It recognises some progress in terms of reform but also stresses that public actions are still characterised by structural weakness and institutional malfunction, undermining the sustainability of EU interventions. This weakness relates to institutional fragility, poor governance, shortages of budgetary resources, weak rule of law and the reticence to engage meaningfully in political sector reform (ibid.: 119–120). These prevailing problems help explain why the EU is reluctant to transfer the full management of its donated resources to the government (ibid.: 123).

In the *World Bank Country Assistance Strategy for the Democratic Republic of Congo for the Period FY 2013–2016* (World Bank 2013), DRC is described as a country with crumbling institutions that are dysfunctional and not held accountable. The state is designated as being in an ‘advanced state of degradation’ (ibid.: 3). DRC is also portrayed as ‘a destabilising factor for its nine neighbouring countries’ (ibid.: 2).

Taken together, the donor policy documents reveal that state fragility, as a perceived characteristic and a coordinative and communicative discourse, is ever-present in shaping donors’ strategic policies and operational planning. At the same time, donors use this discourse strategically to justify their funding and interventions, both to their constituents ‘back home’ and the Congolese state (see below).

For these donors, any intervention must address the humanitarian crisis faced by the Congolese population while also considering the challenging transition from a humanitarian model to a development one. Currently, donors remain reluctant to allocate aid directly through government agencies, because there is no guarantee of its effective management and they fear that insecurity may worsen again. Paradoxically, the state is both the problem and part of the solution.

### 5.2 Influence of divergent discourses on state fragility on intervention models and policy coalition-building

The analysis of divergent discourses on state fragility centres on three main points:

1. It looks at insufficient funding of the health sector and how it leads to a ‘modus vivendi’ among the Congolese state, donor governments and INGOs in daily practice.  
2. It reflects on donors’ and INGOs’ engagement in the health sector, providing insight into their prevailing intervention models. 
3. It considers fragility discourse-based interventions versus the political assertiveness of (some) state
officials regarding statehood and the subsequent difficulties with establishing a policy coalition.

5.3 Common ground for the state and donors: deficient funding of the health sector

Although several aspects of fragility spur debate among stakeholders, there is broad consensus on the deplorable state of healthcare services (Kalisya et al., 2105: 154). DRC ranks near the bottom (176/188) of the 2016 Human Development Index (UNDP 2016: 200–201) and is among the worst-performing (9/193) countries in the 2016 Under-five Mortality Rate Ranking (UNICEF 2016: 110).

Outbreaks of epidemic diseases, such as Ebola (Green 2017) and measles (Maurice 2015), further complicate this already dire situation. Since the first IRC mortality survey in 1997, high mortality and morbidity rates, especially in the eastern provinces, have been of international concern (Coghlan et al. 2008). Ongoing violence and displacement regularly cause local mortality rates to transcend international emergency thresholds (Carrión Martín et al. 2014). Health needs in the eastern provinces, including South Kivu, are also affected by appalling rates of gender-based violence.

The state, donors and INGOs recognise the dire funding needs and weaknesses in DRC’s health sector. All the participants in our study referred to the state’s incapacity to mobilise, rationally allocate and effectively disburse public resources to fund the health sector. Donors and households provide the lion’s share of resources for the functioning of the health sector. The government itself recognises this in a three-pronged approach to funding the health sector. This draws upon state funds, external contributions and community/user fees. Figure 1 summarises the aggregate health expenses for the 2013 fiscal year, as reported by the national MoH.

Figure 1: Aggregate estimate of current health expenses for 2013 by funding source

![Figure 1: Aggregate estimate of current health expenses for 2013 by funding source](image)

Estimated total of current health expenses: 1,160,297,133 USD

Source: The National Health Accounts (RDC/Minisante 2015)
International donors, including multilateral and bilateral partners, INGOs and international foundations, covered 40% of health expenses in 2013. Congolese households paid 41% of these costs, whereas the government contributed only 14%. Private enterprises paid 5% and national NGOs’ contribution was negligible.

According to the National Health Information System, in 2012, aggregated national health expenses amounted to USD 1,036,777,486.99 (around USD 1.11 per person/month) and current health expenses were USD 984,687,529.96 for a population of 77,817,000 (Matangelo 2014). Although official figures suggest incremental growth in health spending over time, DRC is still far from achieving a sustainable and well-functioning health system financed from domestic revenues.

Moreover, obtaining accurate data on health funding in DRC has been a serious problem for researchers, health providers and policy-makers. For instance, the national health accounts for 2008–2011 contradict those for 2008–2013 (Manzambi Kuwekita et al. 2015; RDC-MINISANTE/PNCNS 2013; RDC/MINISANTE 2015), although both accounts were generated by the MoH. Inconsistencies are especially seen in financial records and population estimates (Dijkzeul and Lynch 2006; Marivoet and De Herdt 2014: 102, 115).

All research participants for the study underpinning this paper–state officials, donors, INGOs and providers–recognised the small share of the government in funding the health sector, as well as the inadequacy of the whole public package allocated to the health sector from different sources. The Evaluation de la Coopération de l’Union-Europeénne avec la RDC 2008–2013 (ADE 2014: 95) estimates that, in 2012, only 25% of the public health need was met with the available government and donor resources. External support from multilateral and bilateral cooperation is integrated into the public expenditure on health, thus increasing the figures attributed to the government. The rate of disbursement for government funding and the quality of its execution have also been very erratic, making it challenging to distinguish precisely the real sources of contributions. For example, one of our interviewees, a representative of the Provincial Ministry of Public Health in South Kivu, recognised that the functioning of the health sector depends mostly on donors’ inputs and the population’s contribution. In his view, donors contributed about 60%, the population 30% and the government about 20%.9

5.4 Vertical or horizontal intervention models?

Horizontal or integrated services are delivered through publicly funded health systems and are commonly known as comprehensive primary care. Vertical or standalone health services imply a selective targeting of specific aspects of wellbeing (Msuya 2004). Interventions in the health sector can be classified as either emergency-based humanitarian aid or development-based. Initial humanitarian interventions are often vertical, donor-driven and crisis-centred (Dijkzeul and Wakenge 2010).

Although most INGO interventions in South Kivu have followed vertical, emergency-based humanitarian models, the government officially desires to move into a horizontal, sector-wide system-building (or development) model. Many MoH officials in our study indicated a preference for building integrated health systems. They regularly brought up the Paris Declaration and praised INGOs and donor organisations engaging in health system-building through development interventions. Respondents repeatedly held up Coopération Suisse and USAID (donor organisations) as laudable examples, as well as Cordaid, IRC, Malteser, PROSANI and Louvain Coopération au Développement (INGOs). According to representatives of the Provincial Ministry of Public Health, these organisations engage with an integrated vision and give comprehensive support in terms of ‘bricks-and-mortar’ projects that are designed to develop health infrastructure, improve drug supply, and help build administrative and institutional capacity.

The overall preference for system-building from public health officials in our study can be explained by the fact that, in the vertical model—and especially the emergency model—the state is sidelined and unable to coordinate, monitor or evaluate non-state actors’ interventions. The officials also indicated that they wanted more control over funding from donors. However, donor organisations and INGOs generally prefer contextual considerations of fragility to determine interventions, in particular HZs.

To contextualise recovery processes in the health sector, DRC policy classifies HZs into five categories (which implicitly recognise state fragility):
■ in emergency (ongoing war/conflict or natural catastrophe)
■ in transition (potential for early recovery)
■ in development (stabilised security situation, increased social and economic activities)
■ functioning (conditions for providing a minimal complementary health package)
■ performance (reliable performance of a certain number of results in line with health system objectives and the population’s expectations) (RDC/MINISANTE 2012b).

Currently, the HZs comprise a blend of the first four categories, with variations between the eastern and western provinces and between the rural and urban zones. Even in eastern DRC, the situation is not homogeneous across HZs. In South Kivu, many rural HZs can be classified as either emergency zones, a blend of emergency and transition zones or, to some extent, zones in development. Only a few HZs have shifted into the ‘functioning’ category and there are no ‘performance’ HZs. Humanitarian interventions (and user fees) have prevailed in the East as a response to emergencies related to armed conflict and state fragility. Respondents from state institutions reported to us that enduring vertical humanitarian interventions have contributed to the fragmentation of the health system. They also persistently mentioned the government’s desire for horizontal engagement.

Regarding health system-building, official national public policy focuses on improving health sector governance, system management effectiveness, and service-delivery quality and performance.

5.5 Fragility discourse-based interventions versus assertions of political statehood

Fed by both donor country policy and practical experience, donors and INGOs rely on a fragility discourse to justify technocratic, vertical and emergency-based intervention models. Equally, state institutions and officials prefer to assert statehood and political sovereignty and have a less openly advocated desire for financial control, officially for the purpose of building the health system. Such differences lead any attempts to build a policy coalition to fail, as vertical interventions bump up against the state’s preferences to exercise greater political influence and financial control.  

5.6 INGOs’ fragility discourse and the need for humanitarian interventions.

Fragility leads to the persistence of humanitarian interventions and the channelling of donors’ inputs through non-state actors, despite the government’s insistence on a paradigm shift in intervention models. A representative of MSF–Spain spoke to us about his experience in Shabunda, a conflict-affected and remote HZ:

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

Likewise, most INGO representatives in our study expressed the necessity of being realistic regarding the current context. They maintained that the humanitarian approach facilitates the improvement of population access and service quality. When asked about the system-weakening effects of humanitarian interventions that bypass the state, our MSF–Spain representative said that ‘the persistence of conflicts is actually the reason why MSF is still present in certain areas such as Baraka even beyond the timeframe for relief interventions; there is a shrinking of state inputs into the health sector.’ This statement from an advocate of the vertical, humanitarian model that has outlasted its initial timeframe implies a broad understanding of both peace and state fragility. This goes beyond a minimalistic conception of peace as limited to the cessation of hostilities and of state authority as only the presence of an army or other state agents. In contrast, the state actors we interviewed often defined peace and security as the temporary cessation of hostilities or the absence of violent conflicts among armed factions. In other words, the two conceptions of peace also legitimise different preferences for intervention modalities.

10 Interview, Bukavu, 29 November 2013
11 Interview, Bukavu, 29 November 2013
All representatives of INGOs and UN agencies in our study expressed similar views regarding problems with governance and state authority. For example, a provincial UNICEF representative was very critical of the corruption plaguing the health system. He said that, for him, corruption is a central factor that has eroded the trust between donors and state actors. A provincial representative of PROSANI conveyed a similar opinion: ‘The DRC health system is rife with so many problems revolving mostly around the system of governance with all its attendant conundrums’. For the sake of community health improvement, donors and INGOs said they prefer to engage with non-state actors and/or directly with beneficiaries, as working with state agencies gives no guarantee of good management.

In most cases, representatives of INGOs also referred to failures of territorial control and to the persistence of armed groups, reflecting both contested authority and disputed statehood. They also pointed to the state’s failing institutions unable to deliver services and its inability to mobilise funding to finance the public sector, along with its lack of capacity to meet population needs and expectations for social development, human security and protection. These respondents also noted the clientelistic politicisation of the public sector and the corruption that have both long been characteristic of INGOs’ image of the DRC. Some INGO representatives expressed their disappointment about the peculiar DRC context, where they are expected to provide services beyond the purview of their mission. INGO representatives complained that donors and INGOs are expected to do everything, including ‘building a bridge, providing energy and paying national security personnel.’

The persistence of vulnerability further explains INGOs’ perspectives. Organisations such as Malteser and IRC apply mixed models that combine emergency-based interventions with system-building but even these cannot take system-building very far. Their mixed models depend not only on their donor organisations’ or project portfolios, but also on the prevailing health situation in the intervention area. For example, Malteser provides multisector support including health; nutrition; food security; and water, sanitation and hygiene activities.

All of these contributions still centre on public health in a limited set of HZs. An IRC provincial health officer in our study noted that ‘regarding the health sector, we are moving to system-building, but the problem is that the population’s vulnerability has not changed’. The case of Itombwe HZ, where the IRC was implementing full-fledged emergency interventions, is a telling example. Preparing for its withdrawal, the IRC halved its interventions beginning in 2013. This hampered the functioning of the referral hospital considerably, because the state did not take over the INGO interventions. According to an Itombwe HZ administrator in our study, the revenue of ‘the hospital plummeted since the decrease of the IRC humanitarian interventions. Health workers, especially doctors and nurses, have been leaving the hospital’. Hence, INGOs’ perceptions of state fragility and the population’s vulnerability still lie at the centre of their intervention modality preferences.

5.7 State actors’ assertions of political statehood

Our interactions with state officials revealed that the discourse of state fragility is a politically disturbing construct for governing elites striving for political survival. One state official made the following argument:

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

This statement reveals a dilemma faced by state officials: in the face of conspicuous evidence of fragility, donors’ humanitarian support is necessary, but state representatives also feel an obligation to convince society of their capability to make the state work without donors’ guidance, as this would increase its legitimacy.

A public official at the MoH in Kinshasa asserted to us...
that ‘INGOs/donors capitalise on the fragility of the state to do whatever they want’.\textsuperscript{17} These and many similar declarations show the attempts of the state to politically assert its sovereign statehood. These assertions aim to justify a political stance that the state should now be in charge of decisions about the intervention model. As a political rationale, the public officials we spoke with emphasised the state’s presence in a context of disputed legitimacy, especially concerning public service provision.

On multiple occasions, respondents showed discomfort at the mention of the state’s empirical performance and popular perceptions of the state. Some state officials told us that ‘donors and INGOs overshadow the visibility of the state’.\textsuperscript{18} For others, bad governance, corruption and clientelism in the health sector justify donors’ stances. According to one very critical state official at the MoH: ‘There is a facade of improvement, but the health sector management situation is very bad. But that cannot be talked about by the MoH’.\textsuperscript{19} Like other institutional failings, bad governance revolves around rampant corruption, which deeply worries donors, INGOs and some state officials.

Among state actors in this study, two categories of perceptions of fragility and its corresponding discursive positioning emerged. Many public health officials asserted statehood. For this group, the fragility discourse threatened the state’s political legitimacy. However, another group of public health sector officials, system managers and frontline providers were very critical of the state’s lack of capabilities, although they also expressed a desire to shift to system-building. Among state actors, the aspiration to bring the state leadership back through system-building was fervently pursued, although the conditions necessary to improve functioning were widely recognised as unfulfilled.

In contrast to the state officials we interviewed, local Congolese people and many local providers desired state provision of services and wellbeing, but simultaneously welcomed the presence of humanitarian INGOs to improve social welfare. For the state, only a paradigm shift to system-building could ensure that principles related to state ownership and partners’ alignment with the Paris Declaration would be enforced.

The state officials’ use of the fragility discourse was also instrumental. Regarding the alignment of international actors, no compromises were made: fragility as a concept was omitted, while the necessity of donors’ alignment with state policy was emphasised. A state representative in Bukavu remarked to us that ‘the state is overcoming its fragility and thus taking up its leadership role’. However, when accounting for a problem or sector management dysfunction, state officials immediately evoked fragility. The state was then cast as an impersonal, reified entity that was to blame. According to a high-level official at the Provincial Ministry of Public Health, ‘it is better to understand the context, as the DRC is still a fragile state that is emerging from a tough situation’.\textsuperscript{20}

Five reasons account for the state officials’ paradoxical stance:

1. As indicated, it is not that they failed to see state fragility and the vulnerability of the war-affected population. Rather, recurring vertical humanitarian interventions were seen as the essence of this fragility, signifying the state’s absence in service provision.

2. The humanitarian vertical intervention model creates a fragmented distribution (geographically and concerning services) of healthcare, as the activities of NGOs and donors are not harmonised, which conflicts with the administrative standardisation for system-building.

3. Relief interventions impair the sustainability of health system financing by (frequently) abolishing the user-fee system and preventing the state from managing health-related financing.

4. The priority for the state officials in our study was not only the alignment of the donors, but also recognition of the state’s central role in governance and within donors’ interventions.

5. The desire to control donors’ funding was an underlying reason for state actors to advocate a paradigm shift from humanitarian, vertical models to system-building, where the state would be in the driver’s seat of the health sector’s financial management.

\textsuperscript{17} Interview, Kinshasa, 16 February 2014
\textsuperscript{18} Interview, Bukavu, 20 March 2015
\textsuperscript{19} Interview, Kinshasa, 16 February 2014
\textsuperscript{20} Interview, Bukavu, 20 March 2015
5.8 Discursive reference to state fragility and stakeholders’ perceptions of each other

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

Many state officials made similar declarations to us, decrying how the state fragility discourse empowers INGOs while disempowering state institutions. They noted that it makes it difficult to compel donors to comply with national policy. Two themes emerged regarding state fragility and stakeholders’ mutual perceptions. First, state officials said they feel frustrated about the state’s impotence vis-à-vis the resource-based power of donors and INGOs, which also enjoy legitimacy based on both service provision and expertise. Second, there was a sense that state officials recognise the negative impact of the state fragility discourse: the prevailing image of state fragility makes it difficult for the state to assert itself.

Of course, INGOs and donors also have their own perspectives. While consenting to the Paris Declaration, they told us they feel that it is important not to overlook the fragile DRC context. One DFID representative was quite clear about her organisation’s image of the country: ‘First of all, the state needs to build trust at all levels. The money we do have is from the donor country taxpayers.’ 22 Statements like this show how donors are frustrated with the pervasive lack of capacity or corruption that permeates state institutions. The same donor representative elaborated that her organisation aims to build the institutional capacity of government structures and that it is currently difficult to channel funds directly through these structures. She told us that, for this reason, the money is given primarily to international and national NGOs, which then provide the needed inputs, while the government presently receives 7% of their financial contribution. Echoing this position, a UN agency representative made the following argument:

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

Some Congolese people would consider the above declarations too strong, as they stereotype the whole of Congolese society as weak or corrupt. But some state officials in our study used even stronger words to express their frustrations about the poor performance of statehood. 24

21 Interview, Kinshasa, 15 February 2014
22 Interview, Kinshasa, 20 February 2014
23 Interview, Kinshasa 20 February 2014
24 Donors and INGOs rarely address corruption or clientelist systems head on, or engage in civil service reform (with the World Bank as a notable recent exception) (Mohosha et al. 2017). Even when they would like to work directly with state officials who want to fight corruption, they have little room to manoeuvre because of elite control of the state and weak civil society.
Divergent discourses on state fragility account for the continuation of divergent multi-actor governance and, in particular, for the failure to build a policy coalition on intervention models to improve the health sector. For donor organisations and INGOs, persistent state fragility necessitates the ongoing emergency humanitarian approach and vertical intervention model. Only a few INGOs attempt a mixed model of intervention, but these remain technocratic efforts, mainly confined to the health, food and nutrition sectors; they circumvent most of the government bureaucracy and instead deal as directly as possible with local NGOs and beneficiaries. Donors and INGOs fear corruption and the risk of disorder, although this is rarely openly communicated. Most INGOs engaged in the health sector—especially in eastern DRC—think the state’s fragility requires maintaining approaches that respond pragmatically to both humanitarian emergencies and state fragility. Therefore, discourses on fragility become contentious, not because of conceptual ambiguity but because of divergent perspectives and interests regarding how to address this fragility.

Despite the humanitarian situation, along with a lack of capacity and/or willingness to achieve empirical sovereignty, most state officials wish to assert political statehood and aspire to a shift to the system-building development approach (i.e. the horizontal model). In the Weberian ideal type of the state, state actors rely on statehood to hierarchically coordinate the provision of common goods (Börzel et al. 2012). But in terms of health sector financing, the state cannot claim empirical sovereignty. State and donor organisations see the weakness of the state and the need for support for the survival of the sector. Hence, state officials asserting empirical statehood are actually playing a political game, aiming for political legitimacy and greater financial control.

Nonetheless, holding an a priori image of state fragility characterised by corruption, incapacity and a weak society creates a double-edged sword for donor organisations and INGOs, because it makes it difficult for recipient states to achieve the alignment of donors and mutual accountability between the state and donors. Additionally, the conviction of state fragility also affects donor organisations’ behaviours towards their Congolese counterparts.

As critical remarks in this study have indicated to us, some donors and INGO staff develop attitudes that Congolese actors perceive as condescending.
and that do not serve the population well, as not all Congolese actors involved are actually corrupt. State officials who would like to fight corruption are too rarely acknowledged or supported in the current discourse. Interestingly, the humanitarian principles can also be used—or abused—by donors and humanitarian organisations to legitimise their long-term presence: keeping a distance from the government while waiting for a window of opportunity for change and working more directly with local organisations and beneficiaries.
This paper has explored the impact of the state fragility discourse on the process of humanitarian governance among state officials, INGOs and donors in DRC’s health sector in light of the Paris Declaration on Aid Effectiveness. Although the state fragility discourse has gained currency and shaped international policy in weak states, there is not yet a universally agreed conceptualisation of state fragility. The present study has drawn upon field research and adopted critical discourse analysis to understand the extent to which the state fragility discourse influences the health sector, in particular intervention models and policy coalition-building.

In DRC health sector, government and donors/INGOs have not harmonised their perceptions of fragility or, especially, their understandings of how to address it, meaning they cannot reach a shared preference for intervention models. State fragility therefore has a particularly strong impact on donors’ and INGOs’ coordinative discourse on intervention models. The discourses on state fragility also affect compliance with the Paris Declaration in terms of donors’ alignment and recipient countries’ ownership. At best, the situation in DRC can be described as shadow alignment, despite limited common ground on the topic of health sector financing, where all parties recognise the necessity of extra-state funding.

Discursive references to state fragility reveal a contentious issue among INGOs, donors and the state concerning intervention models. Whereas donors in our study used state fragility to legitimise their emergency-based interventions and channelling of funding through INGOs, state officials asserted political statehood and a strong desire for horizontal interventions, including system building.

As shown in Table 2, most INGOs and donors in DRC continue with vertical intervention models. Humanitarian principles usually legitimise short-term life-saving aid, but in the fragile DRC context, these principles are also used to justify the long-term presence of INGOs and donors, while keeping a distance from the host state. A few mixed interventions that integrate some development elements also continue over a lengthening period. Donors and INGOs thus go beyond the narrow interpretation of humanitarian governance but because donors and INGOs do not significantly expand their activities, they also do not fit a broad interpretation. In all likelihood, such hybrid humanitarian governance is also the case in other fragile states, but
Humanitarian governance and the consequences of the state fragility discourse in DRC’s health sector

State fragility is thus not a neutral concept in a context of contested statehood, politically disputed legitimacy and multi-actor governance. Discursive references to state fragility empower donors and INGOs but disempower the state. The government officials we spoke to saw the concept of state fragility as stigmatising, making it difficult for the state to assert its policy perspective, especially regarding partners’ compliance with the Paris Declaration.

For INGOs, donors and UN agencies, it is necessary to take contextual fragility constraints into account when interpreting the Paris Declaration. At its core, the Paris Declaration follows a consensus model of aid, but key actors tend to dissent in terms of actual humanitarian governance in DRC. Donors and INGOs do not want to run the risks associated with corruption and disorder. Despite this, they stay for ever-longer periods to reduce suffering and prepare for the next crisis. Moreover, against great odds, they have succeeded in technocratically improving parts of the health system, in particular at the operational (HZ) level. Hence, the humanitarian arena is a useful concept to explain the consequences of multi-actor humanitarian governance in DRC health sector.

Ultimately, building a policy coalition based on harmonised views about addressing fragility is necessary for effective engagement and for the sustainability of interventions in the health sector. Ideally, this coalition-building should promote more than the implementation of the Paris Declaration on alignment. It should also facilitate the accountability and social responsibility of all stakeholders for the purpose of improving humanitarian governance. However, this would require agreement and commitment among all stakeholders regarding the fight against corruption and chronic insecurity, to establish a more humane order in DRC. This is not likely to happen any time soon. Indeed, donors, INGOs and the state are stuck in their divergent discourses and mutually dependent funding relationship.

Table 2: Forms of humanitarian governance

<table>
<thead>
<tr>
<th>Humanitarian governance interpretation</th>
<th>Humanitarian principles</th>
<th>Intervention model</th>
<th>Actor in control ‘on the ground’</th>
<th>Main target group</th>
<th>Policy coalition</th>
<th>Paris Declaration</th>
<th>Long-term presence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrow</td>
<td>Yes</td>
<td>Vertical</td>
<td>Humanitarian INGOs</td>
<td>Beneficiaries</td>
<td>Ideally, as acceptance of the humanitarian principles</td>
<td>Not directly relevant</td>
<td>No</td>
</tr>
<tr>
<td>Broad, no more developmental</td>
<td>No</td>
<td>Horizontal, including integrated system building</td>
<td>Host-state government</td>
<td>Host-state with international support</td>
<td>Donors, INGOs and host-state agree</td>
<td>Yes, ideally consensus-based</td>
<td>Yes</td>
</tr>
<tr>
<td>Hybrid</td>
<td>Yes, but to justify narrow intervention models over longer periods of time</td>
<td>Mainly vertical, alongside a few mixed intervention models with limited health system building</td>
<td>Humanitarian INGOs (with donors in the background)</td>
<td>Beneficiaries and local organisations</td>
<td>No</td>
<td>Yes, but shadow alignment because of dissent on addressing state fragility</td>
<td>Yes, also as a waiting game for opportunities to improve governance (and government)</td>
</tr>
</tbody>
</table>
References


