

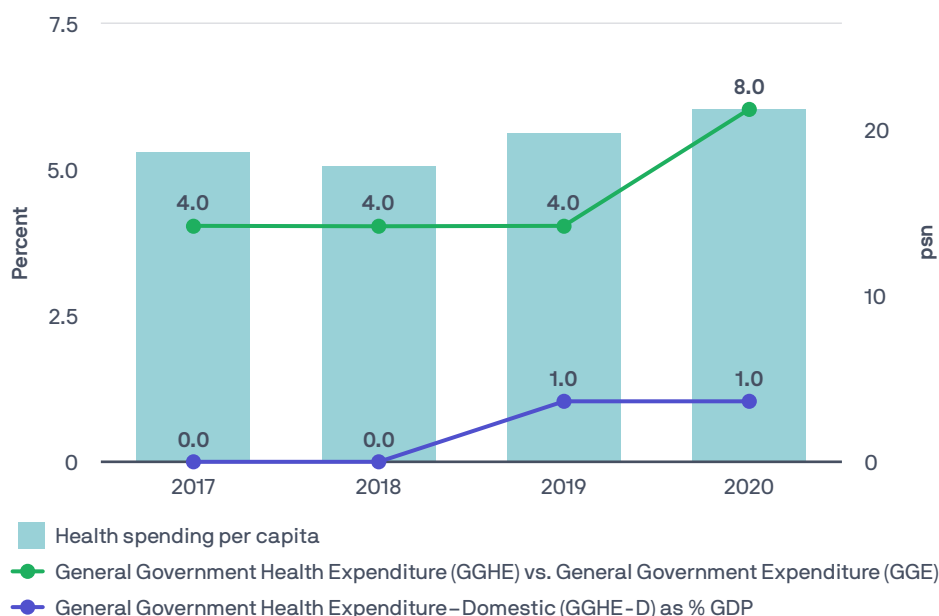
Demographic context

The population of the Democratic Republic of the Congo (DRC) progressively increased from 84 million to 99 million from 2017 to 2022. Infants less than 12 months and children under five years old accounted for less than 8% and 20% of the entire population respectively. During the same period, the Human Development Index remained just below 50%, a below average performance on individual longevity, education and income capabilities. The Human Capital Index was 0.4, which was below average in terms of the expected productivity of future generations owing to deprivations related to health and education. This implied that children born during the period would attain only 40% of their productivity potential. The life expectancy at birth remained constant at 59 years.*

Health financing

Government spending on health was at 1% of the Gross Domestic Product (GDP) which was markedly below the minimum of 5% recommended for progression towards UHC (McIntyre et al., 2017). The per capita spending on health was about USD 21 in 2020, which was substantially below the recommended per capita target of USD 86 (McIntyre et al., 2017). Further, the government expenditure on health relative to other sectors ranged between 4% and 6% across the years, which was substantially below the 15% Abuja target.

FIGURE 1. Health financing trends in DRC



Source: WHO Global Health Expenditure Database, Analysis by Consultant

Out-of-Pocket (OOP) payments and donor funding were the largest sources of financing for health in DRC between 2017 and 2020. OOP payments accounted for between 38% and 42% of all health financing while donor funding accounted for between 35% and 42% (Figure 2). This was followed by government funding which accounted for less than 20% of all health financing. Other sources accounted for less than 10% of health financing during the period.

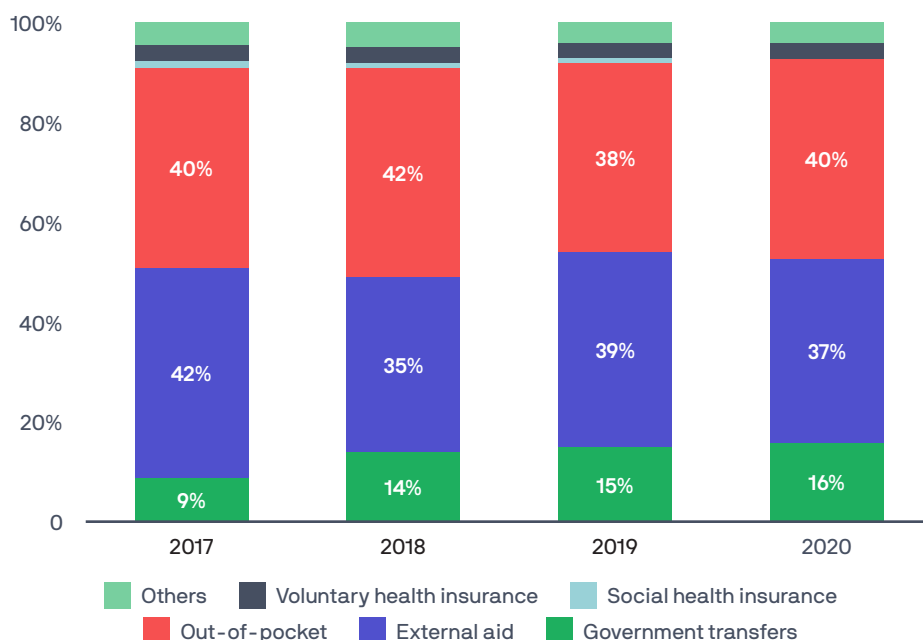
HIGHLIGHT

The low debt levels in DRC increase the public resource envelope hence a higher potential for financing health and immunization services. This is however limited by the low tax revenues.

A strengthened tax administration in DRC would help mobilize more resources for public goods such as health and immunization.

*Source: UN, Analysis by Consultant

FIGURE 2. Health financing sources



Source: WHO Global Health Expenditure Database, Analysis by Consultant

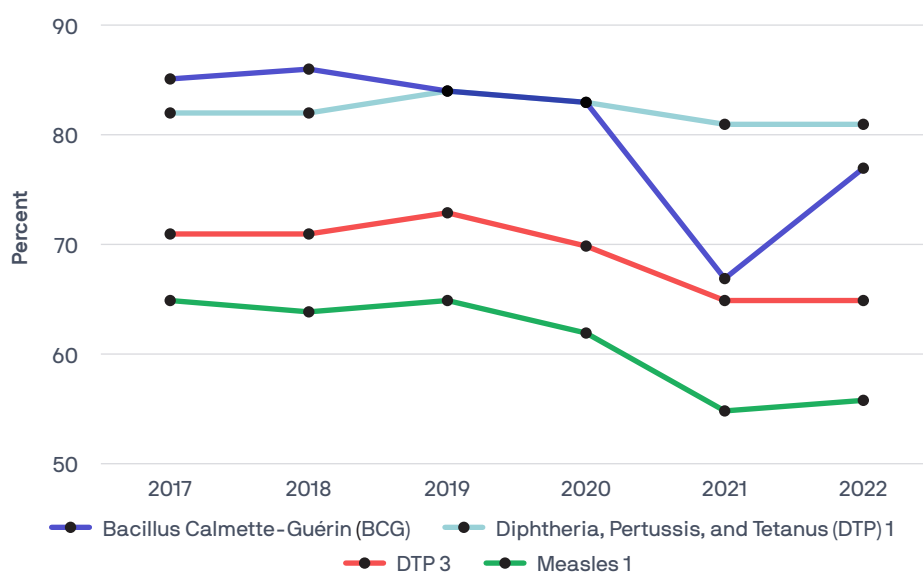
HIGHLIGHT

The high dependence on donor financing and out-of-pocket payments for health threatens sustainability of financing and increases the risk for financial hardship as households seek for health services, including immunization. Increased government funding for health is thus urgent and necessary to ensure sustainability and access to health services.

Immunization coverage

The national immunization coverage rates showed a declining trend between 2019 to 2022 particularly Diphtheria, Pertussis, and Tetanus (DTP) 3, Bacillus Calmette-Guérin (BCG), and Measles 1. This suggests a reduction in utilization of immunization services possibly due to contextual factors such as COVID-related restrictions, and ongoing conflict within DRC. Data on Measles 2 was not available since the vaccine was yet to be included in the national routine immunization schedule as of 2022.

FIGURE 3. Immunization coverage trends

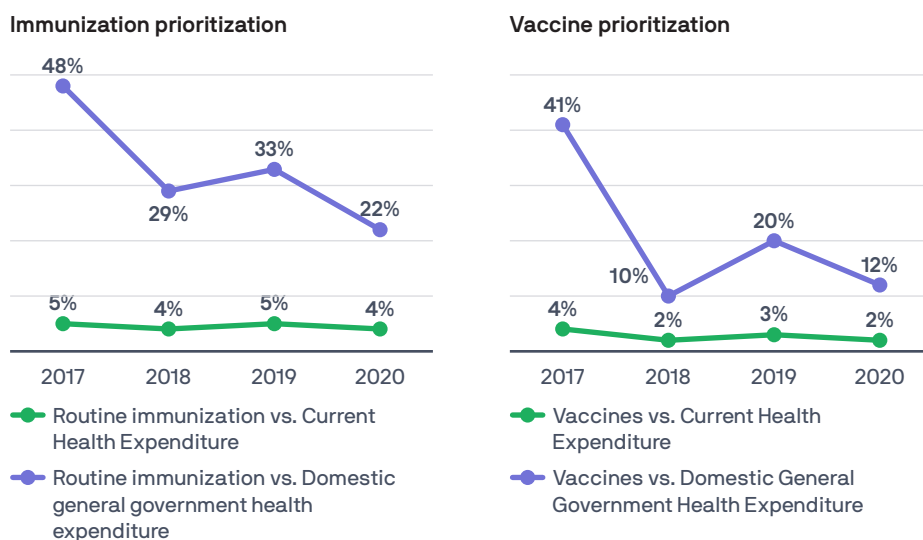


Source: WHO/UNICEF, Joint Reporting Form

Expenditures on Routine Immunization in DRC have been declining during the period of analysis. Immunization accounted for less than 5% of the Current Health

Expenditure; and between 22% and 48% of the Domestic General Government Health Expenditures between 2017 and 2020. Vaccine related expenditures while declining accounted for less than 4% of the CHE and declined from 41% to 10% of the Domestic General Government Expenditures. (Figure 4).

FIGURE 4. Prioritization of immunization and vaccines

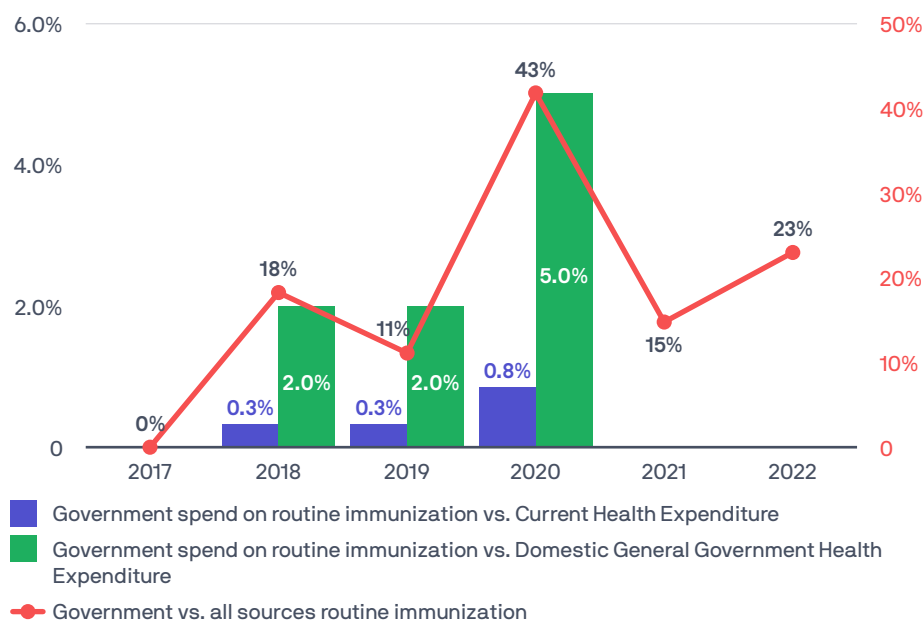


Source: WHO/UNICEF, Joint Reporting Form, Analysis by Consultant

Government funding as a source of immunization financing accounted for between 1% and 24% between 2017 and 2022. This accounted for less than 1% of Current Health Expenditures and less than 5% of the Domestic General Government Health Expenditure.

Government funding as a source of vaccine financing accounted for between 0% and 43% between 2017 and 2022. Though rising, this accounted for less than 1% of Current Health Expenditures and less than 6% of the Domestic General Government Health Expenditure (Figure 5).

FIGURE 5. Government prioritization of vaccines



Source: WHO/UNICEF, Joint Reporting Form, Analysis by Consultant

HIGHLIGHT

The declining prioritization of immunization financing by government in DRC threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

Factors affecting immunization financing

1. **Limited government funding and economic challenges:** Insufficient budget allocation for immunization programs in national healthcare budgets due to economic instability, poverty, and competing healthcare priorities.
2. **Dependency on external funding:** The reliance on external donors and international organizations for financial support for vaccine procurement and program implementation.
3. **Healthcare infrastructure and supply chain costs:** Expenses associated with building and maintaining healthcare facilities, vaccine procurement, storage, transportation, and distribution.
4. **Health insurance coverage and financial management:** Limited health insurance coverage for immunization costs and inefficient financial management systems within the healthcare sector.

Recommendations towards improving immunization financing

1. Increased government prioritization of Immunization

- Gradually increase the share of the healthcare budget allocated to immunization over time.
- Advocate for increased government investment in immunization programs as a critical public health intervention.
- Enhance coordination among government agencies and partners to optimize fund allocation and utilization.

2. Reduce dependency on external funding for health and immunization

- Develop a multi-year funding plan for immunization programs to secure predictable and sustained external support.

- Align immunization financing with national priorities and strategic plans.
- Strengthen government capacity to manage and implement immunization financing programs.

3. Health insurance coverage and financial management

- Expand health insurance coverage for immunization costs to reduce the financial burden on families.
- Strengthen financial management systems within the healthcare sector to ensure efficient and effective use of resources.
- Improve transparency and accountability in immunization financing to build trust and confidence among stakeholders.

References

GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. <https://www.gavi.org/types-support/sustainability/eligibility>

McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 12(2), 125–137. <https://doi.org/10.1017/S1744133116000414>