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Social protection and crises in the Congo: From humanitarian aid to sustainable development

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Summary and acknowledgements

The two Congos have been through a number of crises, which have given rise to a whole host of humanitarian problems. Using the experiences of the two countries as a basis, the report considers to what extent and under what conditions the distribution of humanitarian aid contributes to the development of sustainable social protection.

In reality the impact of the crises on the statutory social security system has been extremely adverse, because the latter is at a loss how to cope with the new challenges and the present state of the management of the system does not facilitate the establishment of appropriate solutions.

The humanitarian agencies take action in isolated cases, with no overall strategy or vision for overcoming the crisis, and thus there is no interlinking of humanitarian aid and development. What will be the future role of NGOs and social security agencies in the development of sustainable systems of social protection?

In view of the widespread poverty that exists, the development of sustainable social protection systems depends not only on interlinking micro credit, micro enterprise and micro health insurance, but also on new social protection systems, in particular humanitarian social protection, which organizes allocations in kind to healthcare coverage, and temporary mutual health insurance, which covers individuals who do not yet have their own socio-occupational mutual health insurance.

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Abbreviations

ACF	Action contre la faim *(Action against Hunger)*
CFA	Coopération franco-africaine *(Franco-African Cooperation)*
CNS	Centre des nutrition et de supplémentation *(Food and Supplementation Centre)*
CRF	Caisse de Retraite des fonctionnaires *(Civil servants' pension fund)*
CSI	Centre de santé intégrée *(integrated health centre)*
EVP	Extended Vaccination Programme
FAO	Food and Agriculture Organisation
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
ILO	International Labour Organisation
IREC	International Rescue Committee
MSF	Médecins sans frontières *(Doctors without Frontiers)*
MOPAX	Mouvement pour la paix au Congo *(Movement for Peace in the Congo)* MSF
OCHA	Office for the Coordination of Humanitarian Affairs
NGO	Non-Governmental Organisation
PISE	Plan Intégré de Suivi et d'Evaluation *(Integrated Monitoring and Evaluation Plan)*
PNLS	Programme National Contre le SIDA *(National Programme to Fight AIDS)*
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNPF	United Nations Population Fund
VSV	Victims of Sexual Violence
WFP	World Food Programme
WHO	World Health Organisation

Introduction

The world is going through a very difficult period at the present time, and the African continent in particular is one of the regions most affected. New crises and post-conflict situations are arising regularly. The peoples concerned are suffering more and more and are becoming increasingly vulnerable through the destruction of the socio-economic fabric and as the result of numerous displacements. The countries in this subregion of Central Africa are identified as being the worst affected, and in particular the Republic of the Congo and the Democratic Republic of the Congo, both of which have endured at least two serious crises in less than ten years.

During the past few years in the two Congos pillaging and civil war have had serious consequences for the populations and have lead to a succession of humanitarian problems such as forced population displacements, forced expatriation, outbreaks and recurrences of epidemics, and so on.

Humanitarian programmes for these two countries have been launched with a view to relieving human suffering, advocating for the rights of the peoples affected and facilitating the implementation of sustainable solutions—within the context of crisis and post-conflict circumstances, and particularly in the field of social protection. They have additionally utilized a significant amount of humanitarian aid.

Using the experiences of the two Congos as a basis, this report will examine to what extent and under what conditions the distribution of humanitarian aid contributes to the development of sustainable social protection. Humanitarian aid is often distributed through (national and local) NGOs, which can bring a longer-term structure of social protection such as micro insurance. The broader issue will be that of determining the effect of humanitarian aid on the populations concerned in the period from 1996 to 2001 and formulating recommendations for the sustainability of what has already been achieved for development programmes in the Democratic Republic of the Congo, and the Republic of the Congo in particular.

The nature of the crises will therefore be examined as will the extent and composition of humanitarian aid. Attention will then turn to the effectiveness of that aid and the role of governments, social security agencies and NGOs. The impact of the crises on statutory social security prior to, during, and after the crises will be assessed, and the future role to be played by NGOs and social security agencies in the development of sustainable social security systems will be evaluated.

In view of this new challenge the classical approach of social protection—based on the institutional services contract—is proving to be inadequate if not inefficient. It will thus need to be adapted and efforts will have to be devoted to finding a new formula for social protection, particularly in the health field, which remains a recurrent need. The objective is to help the peoples concerned to evolve beyond selective and repetitive aid programmes, which generate dependence on welfare, towards a programme for sustained development in which individuals assume responsibility for themselves by transforming emergency aid into starting capital.

1. Nature of the crises and the impact of humanitarian aid

1.1 Crises

The Democratic Republic of the Congo and the Republic of the Congo have suffered a series of civil wars in the course of the past decade. In the case of the DR Congo there were the pillages of September 1991 and January 1993 followed by the war referred to as the liberation war (November 1996 to 17 May 1997), and a new armed conflict which has split the country in two has been ravaging country from 2 August 1998 to the present day.

This ongoing crisis began in 1980 with the recession, investors' lack of confidence in the Congolese economy, and the concomitant growing debt. From 1990 onwards the official suspension of bilateral international cooperation and the fact that the agencies of the United Nations opted for continuing minimum programmes had a disastrous effect on the Congolese economy. The very lengthy political transition—the most prolonged in Africa—interspersed with pillages had dramatic consequences for a socio-economic infrastructure that had already been destroyed by the mismanagement of the country. *(ILO 1999)*

In the case of the Republic of the Congo (Brazzaville), there has been a long period of instability marked by war that has torn apart the social fabric and has plunged the country into a situation of dire distress. The causes of this conflict can easily be traced to the internal power struggles behind which certain international interests—lured by oil and the other natural resources of the country—played an important role.

These conflicts came to a head in 1997 from what has come to be known as the war of 15June in Brazzaville. Tens of thousands of people were forced to leave the city abandoning their homes and their belongings, and many others were killed. The tensions reached a peak in September 1998 when armed gangs (militia), which were kept by certain political leaders, joined in the struggle for power. Confrontations between the various militias threw the country into a state of total confusion, destroying its infrastructures and thus forcing the entire population, which was left to its own devices, to seek refuge in the forests and the neighbouring countries. This chaos was compounded by ethnic strife.

These situations in the two Congos generated humanitarian problems, which took the form of forced immigration and population displacement, the abandoning and destruction of homes, the destruction of economic infrastructures, the cessation of school attendance, the enlisting of children in the armed forces, hunger and seed shortages, epidemics, war-wounded persons and job losses.

The fact is that the humanitarian problems identified in the Republic of the Congo and the Democratic Republic of the Congo in the period from 1996 to 2001 stem essentially from the civil wars which aggravated the existing economic crisis.

1.2 Humanitarian problems

1.2.1 Humanitarian issue

The humanitarian problems encountered are thus the consequence of the various types of crisis experienced by these two countries. The definition of the crises is relatively flexible, always referring to the difficult situations caused by many and varied factors such as economic crisis, war, violations of fundamental rights, natural disasters and hardship. Wars, for example, lead to the forced migration of populations towards borders of neighbouring countries, forced displacement within the national territory when people are obliged to leave their homes, new outbreaks of epidemics, hunger, child labour, etc. In the same line of thought, in addition to the problems mentioned above, natural disasters cause loss of homes (or dwellings), loss of jobs, outbreaks of epidemics, etc.

For the two Congos the situation of war has led to the forced migration of the populations to areas outside the conflict areas. The Congolese peoples have been obliged to leave their land and have found refuge either in the neighbouring regions within the country or outside the national borders. The first category of persons is referred to as "displaced persons" and the second category as "refugees". The total number of displaced persons and refugees has been estimated at 810,000 for the Republic of the Congo and 1,534,744 for the DR Congo, or an overall total of 2,344,744 for the two countries together.

a) The war-displaced

In the case of the Democratic Republic of the Congo there were 1,202,244 displaced persons within its own borders in January 2001. The following table gives a breakdown per province of these displaced populations in the DR Congo.

Table 1: Breakdown of displaced persons in the DR Congo by province of origin (January 2001)

Provinces	Displaced persons		Provinces	Displaced persons	
	No.	%	Kinshasa	No.	%
North Kivu	640 000	52.2	Manieme	28 646	2.4
Katanga	303 504	25.2	P. Orientale	27 000	2.2
Equateur	82 455	6.9	Bas Congo	19 000	1.6
South Kivu	35 000	2.9	Bandundu	-	
East Kasaï	34 112	2.8		-	
West Kasaï	32 527	2.7			
Total			1 202 244		100 %

Source: Summary report on the situation of displaced persons in the DR Congo, ILO

In the DR Congo the most important flux of forced displaced persons comes from the eastern part of the country, and in particular North Kivu (52.2 per cent) and Katanga (25.2 per cent). The total number of displaced persons from the eastern provinces accounts for over half of the total number of victims of forced displacement in DR Congo: 80.3 per cent. Furthermore, of the 11 provinces in the DR Congo, Bandundo and Bas Congo are the only two that have not been affected by the humanitarian problem of displaced persons.

It transpires from the above that the victims of forced displacement are thus located in the provinces where there is no fighting. The need for emergency humanitarian assistance can thus be identified in the areas outside the conflict areas.

b) Refugees

In the DR Congo there are 332,500 refugees, people that were forced to flee their homeland for reasons of insecurity. The following table illustrates the refugee situation in terms of origin and how they are distributed over the host country, i.e. the DR Congo.

Table 2: Origin of immigrant refugees in the DR Congo

N°	Origin	Number of persons	N°	Origin	Number of persons
1	Rep. of the Congo	5 115	5	Rep. of Rwanda	46 235
2	Rep. of Angola	122 452	6	Rep. of Uganda	13 020
3	Enclave of Cabinda	53 008	7	Rep. of Burundi	19 760
4	Rep. of the Sudan	72 910			
Total					332 500

Source: Summary report on the situation of displaced persons in the RD Congo, ILO

According to Table 2, the Democratic Republic of the Congo is sheltering refugees from six bordering countries. The largest contingent of refugees is from the Republic of Angola (and its enclave of Cabinda), where there has been civil war for over a decade. The refugees from the Sudan form the second largest group, followed by Rwandans, Burundis, Ugandans and Congolese.

This situation is to be explained by a series of armed conflicts that are ravaging Central Africa for geopolitical, economic, ethnic and religious reasons. Furthermore, the fact that these refugees from seven countries are concentrated in the DR Congo is due to the geographic situation of the region. The DR Congo shares its borders with nine countries: in addition to the countries listed above, there is also the Central African Republic, Tanzania and Zambia. Apart from the Central African Republic and the Republic of the Congo, which are separated from the DR Congo by a river boundary (which is difficult to cross), the seven remaining countries share a border that is artificial and thus easy to cross at any time.

The humanitarian crisis in these countries is related to a large extent to the broader issue of displaced persons. In terms of the number of displaced persons and of the high degree of vulnerability typical of this category, the DR Congo and the Congo are high on the list after the Sudan with a combined total of approximately two million displaced persons and refugees.

1.2.2 Hardship and needs

a) Food security

Hunger and seed shortages can be described as a food insecurity problem typical of the victims of forced displacement and/or of persons who have returned to their homeland. This situation is due both to the exhaustion and the loss of food reserves and to the fact that agricultural production has ceased and all agricultural produce - even seeds - has been consumed. This is one of the problems caused by a state of emergency (natural disaster) or conflict.

Hunger is one of the most glaring humanitarian problems in the region of Central Africa. In both the Republic of the Congo and the DR Congo war and strife have exacerbated the food crisis, which, in addition to vulnerable persons such as the victims of the wars, is now affecting the other categories of the population which are indirectly concerned by the conflict, and in particular the inhabitants of the major urban areas. This is due to the fact that over half of the inhabitants of these countries (80 per cent in the case of the DR Congo) live in the hinterland, where agriculture is the main economic activity. In the DR Congo the most arable part of the country (the national granary), the Kindu region and the volcanic areas in the east, currently eludes government control. In view of the problem of insecurity that has separated producers from consumers, production is returning more and more to the form of self-subsistence farming.

It must be noted furthermore that, quite apart from the wars, agriculture in the Republic of the Congo is still a self-subsistence activity, where shortages are made up by the import of large quantities of foodstuffs resulting in an increase in commodity prices; those prices rose to unbearable levels for the majority of the populations after the last war.

At the socio-economic level, for instance, the inhabitants of Gbagnango village in the part of the basin situated in the Republic of the Congo (217 persons) still practise subsistence farming; agricultural production - sugar cane, banana and cassava - is geared entirely to their own consumption.

According to the document entitled *United Nations Plan for the Republic of the Congo*, 70 per cent of the Congolese who returned home were suffering from severe or acute malnutrition; 25 per cent to 30 per cent of the children less five years of age who returned were suffering from acute malnutrition. Hunger has played an important role in the process, weakening these people, who were already vulnerable, and considerably reducing their resistance to disease.

b) Health

Problems of epidemiological surveillance, etc. are a corollary of the very large number of war-displaced persons and refugees. The crisis has led to new outbreaks of diseases in both Congos such as poliomyelitis, hemorrhagic fever, tuberculosis and a high incidence of AIDS. Over the past few years these diseases have been the primary morbidity and mortality indicators.

As regards the prevalence of HIV/AIDS in the Democratic Republic of the Congo, it must be noted that the incidence rate was 5 per cent before the last two wars. It is now estimated to be

well above that level following the influx of large numbers of refugees from countries where the rate is very high. What is more, this situation is aggravated by the numerous cases of rape and sexual violence—of which women are the victims—which are perpetrated mainly by sero-positive soldiers from the neighbouring countries with a high incidence of HIV/AIDS. According to the *United Nations Plan for the Republic of the Congo*, AIDS is the primary cause of death in Brazzaville at 21.5 per cent.

Furthermore, in the Likouala region in the Congo, a marshy area with low population density, the influx of refugees has doubled the local population, but the district hospital and its health centres and health posts were already just managing to cope before this influx. In view of this new situation, the region has now been facing outbreaks of epidemics of diarrhoeal diseases such as cholera—particularly in 1999 and 2000—but it is also prone to regular flooding, which complicates the epidemiological problem. This affects refugees in particular, who do not have access to basic health care and are thus made even more vulnerable.

As regards the malaria situation, it must also be noted that the influx of refugees from malaria-infected areas (in East Africa), where there is resistance to the usual anti-malarial drugs, has aggravated the health situation in the DR Congo by introducing a parasite that is potentially resistant to these anti-malarials. Destabilisation can take the form of epidemics. In the city of Goma, for example, which had a population of approximately 500,000, there was an influx of a large number of refugees - over 1 million persons - from Rwanda in 1994.

c) Education

The disruption of school attendance and child labour must be added to the long list of problems connected with the series of conflicts in the two Congos. As a result of the wars and looting described above, school activities have been disrupted for two countries. In the conflict areas the school buildings that were not already destroyed were converted into accommodation either for soldiers or for refugees. The Government of the Republic of the Congo estimates that 1,714 schools are in need of rehabilitation.

The few schools remaining in operation soon found themselves without pupils due to the panic created by armed gangs, which were using the premises for rounding up young children to swell their ranks of armed militia by enlisting them by force. The Congolese government also states that the quality of education is steadily declining and that the school enrolment rate has been dropping since 1990. The fighting and mass displacements in the south of the Congo have led to the suspension of education services in that part of the country. Both pupils and teachers have been forced to flee the fighting, in which several schools have been destroyed, and the climate of disorder has promoted the looting of those remaining. According to the Directorate for Research and Planning of the Ministry of Primary, Secondary and Higher Education, which is responsible for scientific research in the Republic of the Congo, the total cost of the two wars in terms of infrastructures and equipment for the first five years of primary school and the intermediate and upper levels of secondary education that have been destroyed is estimated at approximately 22.8 billion CFA francs or approximately US$411.6 million. Furthermore, the exacerbation of the socio-economic crisis in DR the Congo and the Congo plus the problem of the disruption of school attendance have together propelled more school-age children into the labour world.

d) Employment

The wars and looting have further aggravated the employment situation, which was already precarious in both Congos. Despite their natural resources these countries are currently going

through a phase of very marked economic recession, which contrasts with the economic progress that was the fruit of globalisation.

In the Democratic Republic of the Congo most production units have been shut down as the result of the aggravation of the crisis and the armed conflicts. Many people have thus found themselves in circumstances of dire poverty. The number of workers in the formal sector decreased by 55 per cent in the period from 1990 to 1996, whereas the population doubled in the period from 1975 to 1995.

The two pillages that occurred in the first half of the 1990s thus destroyed the economic infrastructures, plunging huge numbers of workers into unemployment and leading to the development of the informal sector. *(ILO 2000)*

The direct victims of the wars, the displaced persons and refugees, have also experienced job losses. This is a real humanitarian problem in that it places heads of families in a situation of indigence and dependence; they are on the verge of destitution and are thus living in circumstances of extreme poverty. *(ILO 2000)*

According to the *United Nations Plan for the Republic of the Congo*, the overall impression is one of massive unemployment. The estimated unemployment rate is close to 40 per cent. Of the some 965,000 young people between 15 and 35 years of age, less than 2 per cent have a job in the formal sector. In June 2000, six months after the signing of the peace agreements, the number of ex-combatants seeking to return to normal life and earn a living was estimated at 25,000. *(United Nations Plan, Brazzaville 2000)*

1.3 The humanitarian solutions

Médecins sans Frontières (MSF) considered it advisable after the conclusion of its activities in the Republic of the Congo in the year 2000 to maintain a presence in the country throughout 2001 with the agreement of the Congolese administration and health authorities. As a result of the ceasefire that was signed at the end of 1999, there is no longer a concentration of internally displaced persons requiring subsistence aid. Although the acute humanitarian crisis is over, the conflicts and displacements have left poverty, unemployment and the loss or destruction of resources in their wake. *(United Nations Plan, Brazzaville, 2000)*

According to the (1999) annual report of the Resident Coordinator in the DR Congo, the cooperation programmes set up by the various partners and specifically by those in the United Nations system were affected by events and government decisions particularly at the political and military level but also in the socio-economic and monetary field. *(UNDP, 1999)*

1.4 Impact of humanitarian aid

In the Democratic Republic of the Congo and the Republic of the Congo, the period from 1996 to 2001 was marked by a considerable flow of humanitarian aid. This aid came from various sources and was intended to bring relief to the populations that had suffered tremendous loss from the strife in these countries. It came from international sponsors and partners and also from several local charities. Three groups of actors were thus in contact—in addition to the two categories mentioned above there were also the recipients, the persons who had suffered loss or became

vulnerable as the result of the strife. Each of the partners played a specific role with regard to the humanitarian programme; the purpose here is to understand the impact of their assistance on the target groups.

a) Humanitarian action

In 1999, the populations that were victims of the crisis in DR Congo received humanitarian aid from external partners amounting to US$8.1 million. This financing in kind and in funds provided a means of

- eradicating the epidemic of Marburg hemorrhagic fever in the part of the country under rebel control, particularly in the city of Durba,
- organising national vaccination days in the same region for protection against poliomyelitis,
- providing equipment for medical training in Gemena (in the province of Equateur) and in Lodja in East Kasaï, and
- facilitating the organisation of state examinations, namely by ensuring the transfer of papers for some 10,000 candidates in Province Orientale and in North and South Kasaï. *(UNDP, 1999).*

As regards the activities registered by the OCHA, amounting to a value of $701,014, assistance was provided for a large number of the victims of the conflict: 620,000 displaced Congolese, 750,000 war victims—mainly wounded persons—and 70,000 children under five years of age, for a total of 1,440,000 persons. *(OCHA, 2000)*

There were approximately 332,500 refugees in the Democratic Republic of the Congo in 2000, whereas at the beginning of 2001 the number was estimated to be around 184,240—a decrease of 18.04 per cent. According to the November 2000 issue of the *Special Bulletin of the United Nations in the DR Congo*, the budget planned for the year 2000 was US$24,720,036 but, due to the financial crisis in the UNHCR, US$10 million were made available on 30 September 2000 with a component devoted entirely to social measures implementing projects concerning the most vulnerable groups including the elderly and disabled persons as well as other projects in aid of women and children.

b) The hopes of the displaced persons

(cf study: Employment and social protection: The hopes of the war-displaced in Brazzaville, ILO 2000)

As the result of the socio-political unrest in Brazzaville in 1998, the peace-loving populations of the capital found themselves far removed from their homes as they fled the combat areas. At the end of the hostilities almost all of these people were the victims of looting and thus lost all of the infrastructures that had enabled them to carry out their various activities. It is thus imperative that these displaced persons should not remain inwardly outraged by the lack of access to social services and occupational activities for any length of time, since this inward revolt would constitute a permanent threat to peace, particularly when it concerns persons of working age, most of whom are young people in the 15 to 35-year age group. The needs most frequently expressed by the displaced persons covered in the present study are as follows: financial aid (63 per cent), material aid (13.1 per cent), training (8 per cent), material and financial aid (5.8 per cent). As regards the social protection system, these displaced persons are victims of both exclusion and marginalisation.

c) *Development action combined with humanitarian aid:*
The example of an UNHCR project in Kinshasa (September 2000) (S. Ilunga et al. 2000)

Humanitarian action has included development components. As a case study, this example is a good illustration of the need expressed by the humanitarian agencies to design integrated programmes and create a link between humanitarian programmes and the needs regarding integration into economic life.

Within the framework of its aid programme to help urban refugees to achieve self-sufficiency, the UNHCR is implementing a programme with the collaboration of its operating partner, World Vision, to support income-generating activities by financing repayable micro credit schemes. World vision is responsible for launching the micro projects and providing training and extension services for the recipients.

This project falls within the field of the assistance for integrating the urban refugees in Kinshasa into the local community that has been deployed over the past few years in a socio-economic and political environment which is particularly difficult due to the systematic pillages which occurred at the beginning of the 1990s, the 96/97 liberation wars and the civil war which broke out in 1998 and is still continuing at the present time. These circumstances have had dramatic consequences for both the local populations and the refugees, and in particular for vulnerable persons such as single women who are heads of household, children, the disabled, and elderly persons living on their own.

As the result of the events of December 1998 in the Republic of the Congo, the number of asylum seekers in the DR Congo soared, particularly in Kinshasa. There are also very many Angolan refugees who have been living in the DR Congo for several years; most of them managed to become self-sufficient through the implementation of income-generating activities, but in view of the situation described above and of their low level of education they have found it difficult to manage these activities and make them sustainable. The settlement of the conflict by the agreements of May 1991 brought these Angolans the hope of returning to their country, but when the fighting flared up again after the elections in September 1992 the repatriation operations were unfortunately suspended. Most of the Angolan refugees had sold their assets and were preparing to leave when the situation deteriorated again. They thus found themselves in precarious circumstances—hence the need to implement this programme in order to help them to set themselves up again. There are currently 3,050 urban refugees recognised by the UNHCR in the city of Kinshasa; they are of several nationalities, mainly Angolans and Congolese with several Burundis, Rwandans and Cameroonians from 15 to 45 years of age, 20 per cent of whom are minors.

The objective of this project is to seek a sustainable solution for the refugees in the form of self-sufficiency by integrating them into the local community through the implementation of income-generating micro projects.

It has been observed after two years of operation that the target group is still a long way from achieving the self-sufficiency that was anticipated. With the agreement of its operating partner the UNHCR thus requested ILO expertise for evaluating the project and helping World Vision to achieve greater efficiency in the implementation of this programme.

Socio-economic impact of the micro project

It must be pointed out that of the 29 persons who stated that the programme had had an impact on their social life, 52 per cent said that it had brought improvement as regards food, 35 per cent considered that it had enabled them to pay the rent, 17 per cent reported that it had enabled them to pay for health care, and 10 per cent said that it had helped them to build up capital; the same proportion mentioned that they had gained autonomy thanks to the programme. One of the 29 persons reckoned that this programme had helped him to pay the water and electricity bill, and the same proportion considered that it had helped to constitute savings and/or cover transport expenses.

Table 3: Socio-economic impact of the micro project

Fields	Incidence	Percentage
Food	15	51.7
Housing	10	34.48
Schooling	10	34.48
Health	5	17.24
Water	1	3.45
Electricity	1	3.45
Savings	1	3.45
Capital	3	10.34
Autonomy	10	34.48
Transport	1	3.45

d) Social protection in crisis situations

The crisis that Republic of the Congo and the Democratic Republic of the Congo are going through has not spared their systems of social protection, and in particular the social security funds, with the result that the impact of the social protection agencies within the populations is virtually nil. The absence of social protection in this particularly difficult context has weakened the population of the DR Congo even further. That population is in fact listed as one of the poorest in Africa. It is extremely vulnerable.

In view of this situation the UNDP and the ILO have launched a project within the framework of the inter-agency programme for the reduction of poverty to strengthen social protection in the DR Congo. This project comprises two components: the rehabilitation of the National Social Security Institute (Institut National de Sécurité Sociale - INSS) and the extension of social protection to the informal sector in order to cover a larger number of people.

The second component that been a success (in this environment of crisis) has resulted in the establishment of a mutual benefit approach in health coverage. The first group of over 1,000 persons has thus had access to affordable basic health care since June 2000.

Furthermore, the Republic of the Congo, which is in the same situation as the DR Congo as regards social protection, is currently integrating the mutual benefit approach into health coverage in order to extend social protection to a larger number of persons. This has been made possible through the post-conflict aid of the World Bank with the collaboration of the UNDP and UNICEF.

e) Role of the NGOs

The NGOs have played a very important role in both Congos during this period of crisis, mainly in the form of participation in the identification of humanitarian problems, mobilisation of both human and logistic resources and technical support in the field. The following NGOs have carried out activities in the Republic of the Congo: ACF, IRC, ASU, MSF/F, CRS, AGRICONGO, Women's Committees working in the distribution field, Forum des Jeunes Entreprises (Forum of Young Enterprises), ADECOR, etc.

In the case of the DR Congo the following NGOs have been operating in the humanitarian field: Memisa, Caritas, ACF, Handicap International, OXFAM-Quebec, CRS, MSF-B, MDM, ECHO, HDW, World Vision, and private institutions - Spanish institutions in particular - cooperation for aid to developing countries, etc.

1.5 Impact of the crises on statutory social security

The social protection systems in both Congos are today in a state of mismanagement, from a decline in the number of jobs in the formal sector and a mismatch of the services supplied and actual needs. This is partly the result of the crises that these two countries are going through.

a) Prior to the crises

Before the crises of the 1990s, statutory social security in the DR Congo, for example, was already ailing due to the inappropriate application of the relevant legislation and to the mismatch of the structures of the INSS (National Social Security Institute) and the social protection system introduced in 1961.

It must be pointed out furthermore that the Congolese State organises special social protection schemes for the following categories of workers:

- Civil servants and servicemen
- Magistrates
- Court of Audit magistrates
- Personnel employed in higher education, universities and scientific research
- Members of Parliament
- Members of the Executive Council

Currently, the reality of coverage of social contingencies in the DR Congo is as follows. The INSS, the body that manages the general social security scheme in the country, covers only 1per cent of the workers of the sector within its competence, i.e. 562,852 workers. Furthermore, the persons who receive social benefits generally have to wait on average at least:

- Three years, one month and seven days to receive the initial payments in the provinces
- Five and one-half years for their first payment orders to be processed in the data-processing centre, which means that they have to wait even longer to receive their social benefits for the first time. *(ILO 1999)*

Civil servants and the remaining categories covered by the special schemes, on the other hand, are no longer covered by the Congolese state system.

In the Republic of the Congo, there are two social security funds at the institutional level: first, there is the Civil Servant Pension Fund (Caisse de Retraite des Fonctionnaires - CRF), whose function is to run the pension schemes for civil servants and comparable categories, to develop social and health action in aid of retired persons and their families, and to make the available funds profitable; and secondly, the National Social Security Fund (Caisse Nationale de Sécurité Sociale - CNSS), which is under the supervision of the Ministry of Labour and Social Security and which attends to the running of the scheme for civil service contract employees and workers in the private sector as well as their respective families.

Even before the wars, the reality of social coverage by these insurance bodies was inadequate. There were difficulties in the distribution of social security benefits; to quote an example, the CNSS was no longer able to pay benefits at regular intervals due to cash-flow problems; the major enterprises in the Congo have not been paying social contributions to the CNSS for over 10 years, and this is also the case with the State as an employer. The only risks covered on the basis of the regulations are maternity, employment injuries, disability, family allowances, old age and survivors. The risk of sickness is not covered. The informal sector and the liberal professions in the Congo are excluded from any form of social protection whatever. *(ILO 2000)*

It must be stated that the beneficiaries in both countries are aware of the situation and have expressed the need for reform of the system.

b) During the crises

In the Republic of the Congo, the distribution of social benefits was of course disrupted by the wars which led to the destruction of some of the buildings housing the bodies which managed the social protection system; this destruction concerned mainly documentation, accounting records and archives, the looting of work tools and the subsequent burning of the buildings. The social services deteriorated throughout the 1990s due to negligence, looting and destructive activities. *(United Nations Plan, Republic of the Congo, 2000)*

As regards the DR Congo, the impact of the crisis on the statutory institution is manifest; it is measured in terms of the daily lives of the population and the inability of the INSS to organise benefits effectively for the recipients. Becoming a pensioner or becoming disabled in the DR Congo is in fact the greatest misfortune that can befall an individual.

c) The appropriate solutions in situations of crisis

The institutional social security system does not have answers because it is not suited to providing solutions in crises. Besides, the present state of the management of the system, which already means that it is unable to fulfil its primary missions properly, does not facilitate the establishment of appropriate solutions to the crises. The macro-economic situation is so disastrous

and the situation so completely out of hand that the Governments resign themselves to resorting to humanitarian aid. The humanitarian agencies take emergency action in isolated cases - with no overall strategy or vision for overcoming the crisis that could open up prospects of development. There is thus no interlinking of humanitarian aid and development.

d) Economic context and the income situation with regard to the need for social protection

In the social security field one notes the low level of benefits compared to the real cost of living, i.e. US$1 per quarter for a pensioner in the DR Congo, whereas one overnight in a hotel costs US$160, which is equivalent to 40 years of benefits for a pensioner. This reflects the current socio-economic context in which purchasing power is becoming increasingly paltry compared to the actual cost of living.

The following two tables provide insight into the living conditions of the Congolese peoples (DR Congo), with particular regard to health care. (cf. study: Factors for assessing the social protection system in DR Congo, ILO 2001)

Table 5 provides a basis for understanding the situation of wages and salaries in the private sector of the Congolese economy. It will be noted that the monthly salaries of middle managers range from US$9.4 to 12.53; those of supervisors range from US$6.09 to 8.14, and the wages of non-classified labour amount to US$5; those of skilled labour range from US$3.42 to 3.95; those of semi-skilled labour from US$2.25 to US$2.97 and those of unskilled labour from US$1.44 to 1.92.

It must be noted in this context that the private sector in the DR Congo is not developed; it employs less persons than the public sector.

The present wage and salary scale was negotiated when the exchange rate for of the US dollar was 4 FC. Workers at the lowest grade (blue-collar workers) were paid the equivalent of US$65, and those in the top grade (middle managers, class 3) were paid the equivalent of US$564.2.

As table 4 shows, no state official from the Secretary General down to the usher has access to health care by contributing 10.7 per cent of monthly income to the statutory system (coverage per treatment)—hence the relevance of a mutual benefit system. Therefore, presently, in the pilot projects that the ILO Office in the Kinshasa area has developed the subscription is US$1.80 a month for a head of household and US$1.60 per dependent.

Within these two rates, the possibilities are as follows: Secretaries-General and Directors-General can join the scheme with one dependent each; Directors can only afford to join the scheme for themselves. From the Heads of Division down to the ushers no officials have any chance of access to treatment for a malaria attack; in order to obtain proper care it would be better to join a mutual benefit health insurance scheme, although this is still difficult for certain social classes. In the case of an usher, for example, 10.7 per cent of his monthly wage is equal to US$0.37; he needs US$5 in order to join the scheme even for only half of his family (head of household and two dependents), i.e. an additional US$4.63, or 11x10.7 per cent of his monthly income.

Table 4: Basic wages and salaries (public sector) in DR Congo (2001)

Grades	Basic wages/salaries in US$ per month
Secretary General	34.55
Director General	30.55
Director	19.44
Assistant Director	16.38
Head of Division	14.77
Chief of Bureau	9.66
Executive Officer - 1st class	7.73
Executive Officer - 2nd class	6.73
Member of office staff - 1st class	5.79
Member of office staff - 2nd class	4.43
Assistant official - 1st class	4.11
Assistant official - 2nd class	3.86
Usher	3.47

If one looks at how employees in private undertakings and their respective families view their accessibility to health care and at the system of payment per treatment, an episode of malaria, for example, costs US$3.8. In the categories from blue-collar workers to semi-skilled workers, no employee can bear the cost even when earning a full wage—yet it is the persons in this class who are most exposed to disease due to the poor social conditions in which they live. But with US$3.4 the head of household can pay his monthly subscription to a mutual benefit health insurance scheme as well as the subscription for one dependent for all primary health care in that month.

However, whenever there is a case of illness in the family one has to take action whatever the cost; since savings are becoming a luxury and illnesses occur more often than not just when there is no cash available, it would seem necessary and of advantage to anticipate.

Table 5 shows that with a contribution of 10.7 per cent of their monthly income even middle managers do not have access to care in the event of an episode of malaria; in order to obtain care of such an attack, they have to deduct funds from other expenditure items such as food or housing—with all the consequences that this entails.

e) Population faced with the need for health services: Cost per episode of common diseases

- The case of a child suffering from malaria for whom the following drugs are prescribed:

  - injectable quinine: 10 mg/kg/day for the first 2 days (100 FC per vial x 2 = 200 FC)
  - followed by tablets: 10 tablets of 250 mg DT (100 FC)
  - 1 litre of glucose serum (5 per cent solution) (350 FC)
  - 2 vials of vitamin C complex (20 FC)
  - 2 vials of Ascorvit (30 FC)

- 1 vial of Dipryone (15 FC)
- 1 scalp needle (15 FC)
- 1 5ml syringe (10 FC)

The total cost of all of these drugs and supplies totals 690,00 FC, or US$3.8 (slightly more than an usher's monthly income of US$3.47) without counting the consultation card and fees. Bearing in mind that the figures of the Ministry of Health show that a child under five years of age suffers from up to ten episodes of malaria a year, the illness totals 6,900 FC or US$38—provided that prices do not rise in the course of the year. An adult has at least three malaria attacks a year, and treatment for an adult is three times as expensive as treatment for a child, i.e. approximately US$114 a year.

An episode of diarrhoea costs an average of 850 FC or US$4.7, a figure which is higher than the monthly income of a 2nd class office staff member (10th grade in the civil service) for drugs alone, without counting the consultation certificate or fees or medical examinations. According to the Ministry of Health, a child of less than five years of age has an average of three to seven episodes a year.

The fact is that an important proportion of the Congolese labour force is left out of the classical system. Some of them make arrangements to join various mutual benefit associations (NGOs, limited companies, tontines, etc). The population openly rejects the way the INSS operates and how it achieves its social objectives.

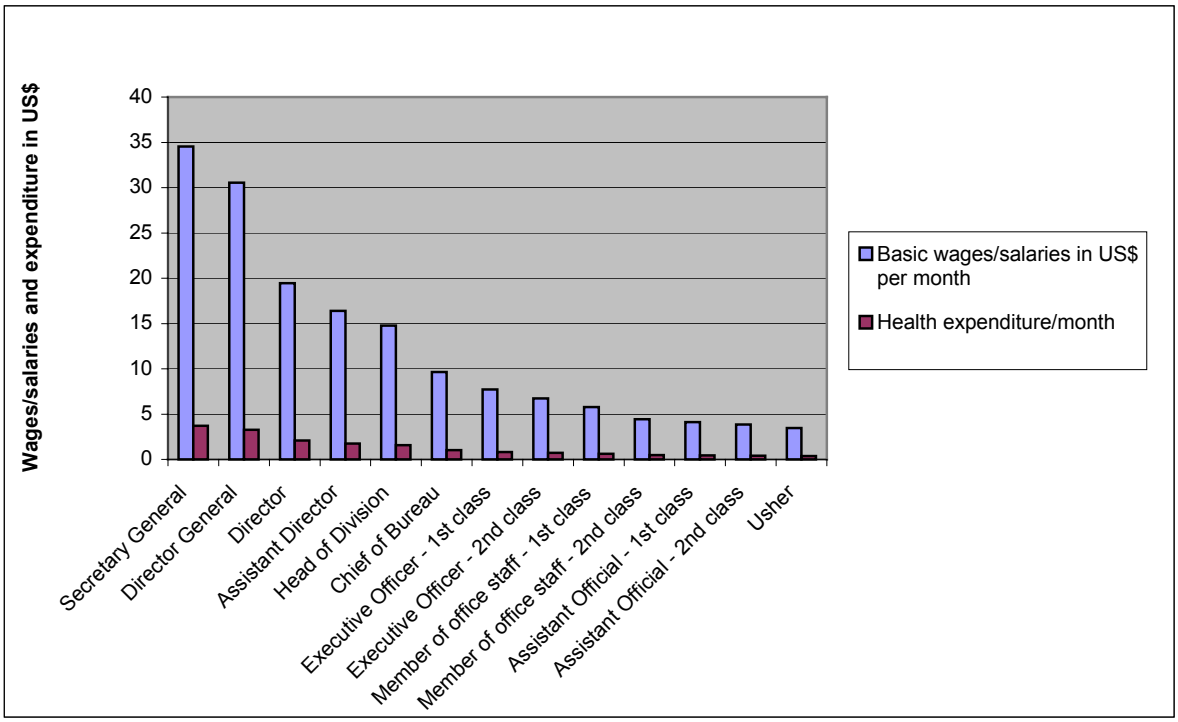
The macro-economic situation has obviously aggravated the state of social protection with the result that both the potential receivers of benefits and employers have lost confidence in the institution.

2. Prospects for developing sustainable systems of social protection in a context of crisis

In crisis and post-conflict situations, informal associations, community development structures, and NGOs show beyond doubt that the social protection impetus will not come from the State and statutory structures alone. There is a need to reorient and readapt social protection to developments and contingencies relevant to the situation in Africa.

Although it is a priority to adapt and seek a new formula for social protection, particularly in the health field, in order to respond to the requests of vulnerable populations or those which are victims of the crises, it would nevertheless seem difficult to apply the classical system of social protection to all components of the working population in every situation, particularly in a crisis and post-conflict period. Given the state of general and dire poverty of the populations it is essential to provide income support.

Graph 1: Basic wages and salaries (public sector) and the share devoted to health in the DR Congo (2001)



2.1 Interlinking of micro credit, micro enterprise and micro health insurance

(cf. study: Interlinking of micro credit, micro enterprise and micro health insurance, Gauthé, 2000)

The link between employment and social protection is not only real but is becoming increasingly relevant in the efforts to fight poverty. It is conceptually possible to establish a bridge between micro credit, micro enterprise and micro health insurance. Micro credit creates jobs and generates income and must thus be protected by health insurance. This means that micro credit alone cannot enable people to overcome poverty; education and social protection also play a vital role.

Illness is one of the primary reasons for the non-repayment of loans. Efforts to identify favourable factors must form the first stage of a strategy for relating and activating this triad from the point of view of the community and mutual benefit. The major challenge of the structures which come under these three components is to sustain their action—hence the need for training.

Table 5: Basic wages and salaries in the private (commercial) sector and the share allocated to health in the DR Congo (1999 to January 2001)

Grades	Basic wages/ salaries in US$	Health expenditure
Labour		
- Blue-collar	1,44	0.15
- Free	1,67	0.18
- Skilled	1,92	0.20
Semi-skilled labour		
- 1st class	2,25	0.24
- 2nd class	2,57	0.27
- 3rd class	2,97	0.27
Skilled labour		
- 1st class	3,42	0.36
- 2nd class	3,95	0.42
Non-classified labour	4,55	0.48
Supervisory staff		
- 1st class	6,09	0.65
- 2nd class	7,04	0.75
- 3rd class	8,14	0.87
Middle managers		
- 1st class	9,4	1.06
- 2nd class	10,08	1.16
- 3rd class	12,53	1.34
Senior managers		
- 1st class	-	-
- 2nd class	-	-

Source: Agreement between employers and trade unions (June 1999)

Micro credit is identified as a minor external financial contribution that is granted to a person launching a micro project to help them get started. This interlinking of micro credit and micro project has been the strategy pursued for several years by credit structures and development NGOs, the objective being to make low-cost services readily available to small economic operators, as the fundamental factor for creating mutual benefit savings and credit institutions. Several micro finance structures are on the road to financial autonomy, and the aim will be to support them in terms of capacity-building for the leaders and managers and to establish monitoring systems. Needless to say, the establishment of a computerised system will greatly contribute to achieving this objective of securing funds. Several groups of persons are left out by traditional banking systems, and there is thus a real need. Although their aim is to reduce poverty, mutual credit institutions do not pretend to curb it completely, but they do alleviate it to a large extent since they constitute an important economic lever that creates jobs.

Micro health insurance is the formal expression of traditional solidarity; it is of community and anticipatory value. Since the interlinking of micro health insurance and micro credit is an innovatory approach, factors promoting the establishment of a micro health insurance scheme within a micro credit structure must be determined in order to ensure feasibility. Micro health insurance is in actual fact a guarantee for micro credit.

2.2 Future role of NGOs, community development structures and United Nations agencies

In a crisis and post-conflict situation humanitarian problems are the priority issue. The aim will be to combine this humanitarian aid with support for development co-operation schemes—including the support of the United Nations system—with a view to organising health care coverage by means of sustainable systems. But the sine qua non for organising humanitarian social protection is humanitarian work. In short, it is both possible and desirable to organise the link between humanitarian programmes and development programmes. Once this link is established a distinction can be made between a social assistance programme for which there is no *institutional services agreement* and an *institutional services agreement* for work of public benefit which can be paid for either in kind or in cash. This connection or this link between humanitarian work and humanitarian protection is part of an empowerment approach that excludes any form of dependence on welfare. The plan is thus to include prospects for sustainability at the beginning of the humanitarian process or programme by means of income-generating activities and by organising mutual health insurance schemes in order to help the recipients of the assistance programme to evolve beyond their situation of assistance or abject poverty.

a) Humanitarian social protection: a solution to a crisis situation
(cf. Humanitarian mutual social protection insurance, ILO 2000)

The target groups here are populations that are vulnerable or have suffered great damage as the victims of an economic crisis, natural disaster or war. They have no jobs and no income. These populations including young people are devoid of any financial means for the time being and have no access to any appropriate and sustainable system of social protection. They are on the verge of destitution and are thus living in circumstances of extreme poverty.

To begin with, the programmes will be based on a programme of assistance for persons who agree to commit themselves to a process of reintegration into the economy. This is a form of humanitarian social protection that covers health care as a priority. This basic health coverage aims

to provide primary or essential health care for the target group. The level of services is different from those of the decentralised contributory system, which is intended for micro entrepreneurs or wage and salary earners. In view of the vulnerability of the target group, sponsors finance humanitarian programmes that assure contributions. It is contributory and based on the concept of social protection in return for humanitarian work.

The aim will be to organise allocations in kind which are made available by the United Nations agencies within a system based on both exchange and cooperation agreements with the various health groupings with a view to establishing a system of healthcare coverage. In this mutual benefit system people will be affiliated under predetermined conditions, and allocations in nature and in cash will be converted and managed.

The allocations will normally be managed by the mutual health insurance scheme. Evaluation of their market value will provide a means of interesting partners and providers in joining the scheme. In more concrete terms, the care providers will be the main partners. The aim will be to conduct negotiations in order to provide incentives for these health centres with regard to the initial allocations.

This system is based essentially on health care for resource-poor persons, but it also integrates the general process of action with a view to their becoming integrated into the economy. The first level of this mechanism, which is known as humanitarian health insurance, provides basic health care services. The second level, which is participatory and contributory, can be accessed soon afterwards by first-level beneficiaries if they start up an activity- generating income. In other words, the former destitute remain the potential mutual benefit clients of the health centres and will contribute in the future to the financing of health care costs. This argument, which is an incentive for health centres to collaborate, can be complemented by the possibility for these health centres to be strengthened more generally through the support which they will be able to obtain either from the government or from international cooperation to enhance their capacities for providing care.

In this context humanitarian work is based on remuneration in kind, provisions, seeds, tools, medicines, etc. The aim will be to organise the target group—in particular populations that are vulnerable or have suffered damage as the victims of crisis—in communities of workers who perform work that is of benefit to the community:

- The work context is defined through the establishment of a community organisation that is a preliminary to operating structures and to humanitarian dialogue with the authorities.
- Thus, in the health care context, the allocations in kind will be granted to the community rather than to the individual.
- The mission of the community is to guarantee that the products are used properly and to organise the sustainability of the allocations and subsequently the recovery of costs.
- Through this mutual health insurance scheme the community will sign an agreement with the health centres based on the market value of the outputs of the remuneration of community work.

There is in fact a link and synergism between humanitarian programmes and development programmes. For any humanitarian programme comprises an employment component which is integrated into the emergency programmes. In development programmes the employment component is integrated into the macro-economic context.

It is thus advisable to plan ways and means of making the scheme sustainable from the outset of the humanitarian process or programme through income-generating activities in order to organise a strategy for evolving beyond the humanitarian programme. An information, guidance and training programme will thus be planned for that purpose, the precondition for access to the training programme being that the availability of micro credit be ensured. Although it is necessary to grant micro credit, these loans will not suffice to help the target group overcome its poverty or vulnerability.

The link between employment and social protection thus is not only real but is also becoming increasingly relevant in the action to fight poverty. The aim in this context will be to establish a bridge between micro credit and micro health insurance involving income-generating activities. Through humanitarian work the populations that are vulnerable or are the victims of crises and which have been grouped in humanitarian health insurance schemes will thus progress to a higher level of social protection through the development of income-generating activities. The persons receiving credit will be required to take out insurance against the risk of sickness with a mutual health insurance scheme of their choice. This will constitute a guarantee for the repayment of the loans. Furthermore, this insurance remains compulsory throughout the period of repayment, the objective being to protect the micro entrepreneurs and their activities as well as the sums that have been lent. During the period of repayment and thus of compulsory affiliation in a mutual health scheme a programme of education in social protection will be run in the hope that people will choose to stay in the social protection system. Appropriate regulations will no doubt be necessary in order to guarantee that people remain affiliated.

b) Classical mutual insurance schemes in development programmes

In a classical environment where there are no urgent humanitarian problems the establishment of mutual health insurance schemes is part of the process for reforming and extending social protection to a larger number of persons, particularly in development programmes. Mutual health insurance or micro health insurance is a form of decentralised social protection, which organises health coverage for persons who wish to cover themselves against the risk of sickness. It has the fundamental advantage of making quality health care affordable and geographically accessible in a difficult macro-economic environment through the flexibility and relevance of its operating mechanisms and strategies.

Solidarity forms the essential foundation of this system, requiring that each member pays their contribution irrespective of the personal risk of falling ill and that all members benefit from the same services in the event of illness. It is thus a form of solidarity between the sick and the healthy, in short between the various members of the mutual health insurance scheme.

This scheme is managed by its members. The beneficiaries of the mutual health insurance thus take part in the running of their association, and this participation is democratic. Democratic participation in a mutual health insurance scheme is a principle that implies that all of the members of the association have the same rights and obligations. They are entitled to take part in the various decision-making bodies such as the General Assembly, the Board of Administration, the Executive Committee and the Supervisory Board. This principle constitutes a factor of confidence for the implementation of the contributory system, the very essence of mutual health insurance.

Example of the mutual health insurance scheme for teachers in the Catholic schools in Kinshasa (Museckin)

This project brought about the establishment of the mutual health insurance scheme for teachers in the Catholic schools in Kinshasa, the MUSECKIN, in June 2000. The agreement concluded between the mutual insurance scheme and the care providers organises a system of pre-payment of a lump sum for the care to be provided. In accordance with the law of supply and demand, the above agreement covers essential care—minor and relatively minor surgery involving in-patient care for up to ten days. Since June 2000 the members of the MUSECKIN, who are scattered over the city of Kinshasa, have started to receive quality care in 32 health centres and one referral hospital by virtue of a small monthly contribution of US$1.80 for the beneficiary and US$1.60 for each dependent.

The evaluation report drawn up in December 2000 shows clearly that the teachers are committed and determined to continue the experience of community healthcare coverage. The report also shows that contributions to the MUSECKIN are being paid regularly and that the contributions account shows a credit balance. It is observed furthermore that after one year of operations the MUSECKIN has been building up a reserve of US$300 a month since April 2001. Despite the fact that the salary level of Congolese teachers is low and despite the constant devaluation of the national currency, the number of members and dependents is steadily rising. The membership grew from 672 beneficiaries in June 2000—209 of whom were heads of household and 463 were dependents—to almost 1,500 persons to be covered in June 2001.

The members of the MUSECKIN are extremely satisfied with this experience, particularly during the summer vacation, when they do not receive certain bonuses. They are having fewer and fewer health problems. No more unwelcome surprises regarding the thorny question of how to finance care in a particularly difficult context. Regular attendance at work is guaranteed. Furthermore, the healthcare providers welcome the mutual health insurance initiative in view of the fact that it can mobilise resources for the health centres, which can thus have liquid assets at their disposal and plan the management of services and stocks of drugs in advance. The solvency which mutual health insurance ensures these centres is a guarantee for their development in both qualitative and quantitative terms.

c) Temporary mutual insurance for promoting national health coverage

(cf. study: Temporary mutual insurance, Gbossa et al. 2000)

The strategy that the ILO has been pursuing for several years to develop mutual health insurance schemes is based on the grouping of the members of various occupational associations. It uses inter-occupational solidarity and the principles of mutual benefit as a basis for its efforts to fight the problems inherent in the covering and financing of health care.

The success of this new approach to social protection is attracting growing interest amongst the members of the general public, governments and the many different bilateral and multilateral cooperation partners. Indeed this situation has given rise to many requests for technical support with a view to setting up mutual health insurance schemes for various categories of the population.

Given the practical difficulties which could conceivably arise in meeting these requests rapidly using the associative and community approach, the question that arises is “What strategy

should be established in order to respond effectively and efficiently to the needs of small heterogeneous groups, individual micro entrepreneurs, third persons evolving in liberal professions, and certain wage and salary earners who are prepared to protect themselves against the risk of sickness in line with the above-mentioned approach?".

Temporary mutual health insurance is a new form of affiliation whose specific mission is:

- to open up access to care in line with the mutual benefit approach for anyone who is able to contribute regularly to a health care scheme;
- to enable the State increase the effectiveness of its policy on healthcare coverage for the population through regulations which take account of the mutual benefit approach;
- to promote the role of the State in the new approach to provident schemes for health care by attributing to it the function of coordinating temporary mutual insurance.

Temporary mutual insurance is thus a component of the overall strategy of health insurance schemes, its objective being to provide health coverage for persons who belong to occupational groups or associations and who are unable to prove that they are affiliated to a mutual insurance scheme of their choice. Its mission is to promote the development and extension of mutual health insurance schemes with a view to covering a larger number of persons rapidly. It derives its name from the temporary aspect of its mission.

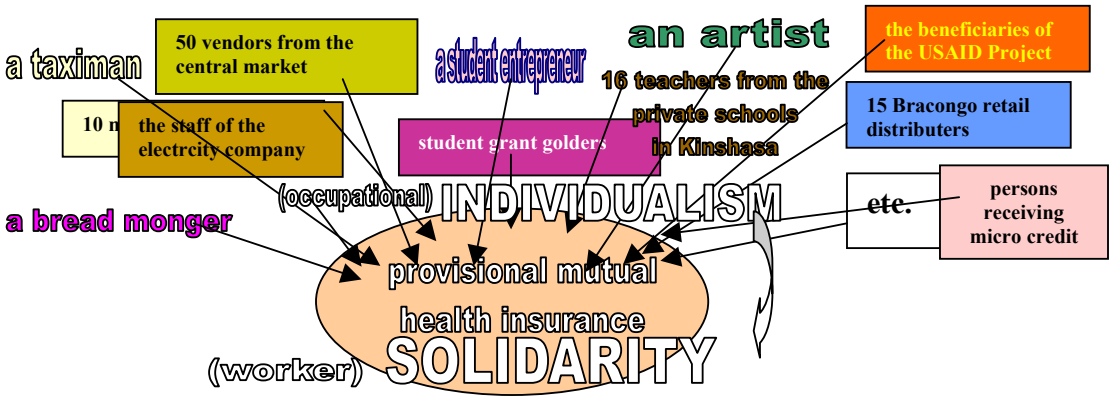
Temporary mutual health insurance is non-profit-making. Its objective is social—that of rapidly and temporarily covering the medical care of all persons who carry out an income-generating activity.

Temporary mutual health insurance concerns the category of persons whose occupational associations do not yet have any specific mutual health insurance schemes as well as individual micro entrepreneurs and any persons who are able to contribute but who have not yet exercised autonomy in the free choice of a mutual insurance scheme.

Temporary mutual insurance can be compared to a nursery or a system of transplantation; it operates on the same principle as that of crop reproduction. Just like seeds, persons are placed temporarily in a heterogeneous structure so that aptitudes conducive to the establishment of homogeneous structures or groups can be developed. They are then transferred or transplanted, so to speak, to definitive structures for permanent health coverage.

Seen from this point of view, temporary mutual insurance is a strategy for reducing the waiting periods for persons from occupational organisations, which are not involved in the existing community and associative mutual insurance schemes. Through the establishment of temporary mutual health insurance persons who have not hitherto been covered—in exercising their freedom of choice in joining an insurance scheme—are forced to protect themselves against the risk of sickness. Until such time they exercise freedom of choice in affiliating to mutual health insurance schemes specific to their respective occupations. The objective is of course social but also economic, since it is a question of guaranteeing the repayment of micro credit where these persons have received such loans.

Figure 2: Membership prior to the establishment of specific mutual insurances for the individual groups



At the national level the creation of temporary health insurance within the framework of the provident health system enables the State to:

- reorganise health policy;
- create additional sources of funding for promoting health;
- promote and facilitate the creation of health centres and mutual health insurance schemes;
- introduce a robust national health policy for training medical personnel;
- promote synergism between community development and national development.

Like the classical mutual insurance systems, temporary mutual insurance is a structure with democratic and autonomous management which is entrusted to a private body or an NGO—with the one specific feature that it belongs to the State. Since it is a strategic structure for promoting the country's health policy, and in view of the heterogeneous nature of its field of application, temporary mutual health insurance is under direct State supervision with the reservation of non-interference in the conducting of its day-to-day activities. The organs of the temporary mutual health insurance schemes are thus the Assembly General, the Board of Administration, the Management Board, the Technical Committee and the Supervisory Board.

The heterogeneous nature of the persons to be covered by the temporary mutual insurance arrangement necessarily calls for harmonisation as regards the periodicity of collection and the level of contributions. Thus with a view to generating solidarity everyone has to contribute equally for the same types of benefits.

As regards periodicity, a certain degree of flexibility is recommended so that wage and salary earners and other workers whose activities are not subject to climatic hazards can contribute on a monthly basis, whereas a system of pre-payment during the high season is recommended for categories of seasonal workers (such as market gardeners).

The benefits organised in the temporary mutual health schemes are essential benefits which correspond to the average ability to pay contributions of all of the persons concerned. Benefits

appropriate to each group will be organised in the specific mutual insurance funds which will be set up in due course.

The establishment of temporary mutual health insurance involves a number of prerequisites on the part of the State, which will have to:

- integrate the temporary mutual insurance strategy into national health policy;
- make health protection compulsory for workers throughout the country;
- set up a programme of permanent awareness campaigns and extension services;
- protect the mutual insurance scheme with appropriate regulations;
- guarantee the autonomous management of the temporary mutual health insurance;
- encourage the development of specific mutual insurance funds.

Temporary mutual insurance is proving to be a complementary tool for improving the health policies of African countries, which are having to contend with many different development problems. With this approach the African States have the possibility to provide satisfactory solutions to the health problems that arise in all social strata.

Since this system is conducive to synergism between community development and national development, the mutual health insurance schemes are requesting that all health partners be involved (through the temporary mutual health insurance)—the State, the beneficiaries and the providers of health services. It is a system of general delegation of responsibility in order to cover the entire population.

2.3 Future role of social security agencies

Most social protection systems in Africa are currently in crisis due to mismanagement, a decrease in the number of jobs in the formal sector and a mismatch of the services provided. The absence of prospects and appropriate solutions to the social needs of persons who are not covered by the official system are proving to have a crippling effect on the rehabilitation of social security funds in Africa

a) Rehabilitation

The inventory of social protection systems in the two Congos has induced both countries to request technical support from the ILO for rehabilitating their social security funds and extending the social protection system to cover as many people as possible, particularly workers in the informal sector.

The technical co-operation measures taken by the ILO thus inevitably involve a programme for restructuring the existing systems and establishing mutual health insurance schemes.

Essentially, the social protection systems in both countries are in need of in-depth reform. The reform programme to be implemented should thus be based on the relevance of the services provided in the social protection field. This can be ensured both by taking account of the real needs of the various categories to be covered and by organising modern management of the social protection systems. It goes without saying that the consensus which has been reached on the general state of affairs must be translated into a consensus on the action to be taken within the

framework of collaboration between the governments and the ILO—which is no easy task, since these rehabilitation programmes come up against long-established interests and acquired rights.

b) Reinsurance

In some respects, the consolidation of mutual health insurance activities requires that a link be created with the public or private institutional health system in order to guard against certain risks that are considered to be very costly. In order to cover itself against certain major risks such as chronic diseases a mutual health insurance fund can reinsure with the classical insurance and social protection institutions. This constitutes a guarantee for its solvability in respect of the health centres and ensures the continuity of activities at the same time. This is the technique of reinsurance for a higher level of benefits.

The reinsurance technique within a mutual health insurance system is made possible by establishing a partnership between the mutual health insurance scheme and the other social protection mechanisms such as the rehabilitated and reformed social security funds, private insurance companies, the network of mutual health insurance schemes, or even transit mutual insurance schemes.

What is required of mutual health insurance schemes with a view to reinsurance is that they propose the possibility for members with chronic diseases to consider paying an extra contribution in order to cover those diseases properly. This possibility will enable them to obtain a higher level of benefits more or less adapted to their circumstances. The application of the policy of reinsurance in collaboration with the other social protection mechanisms will thus enable mutual health insurance schemes themselves to guard against any unexpected expenditure which could be caused by a high incidence of chronic disease. They will thus share this obvious risk with other insurance companies. This strategy will be adopted as the mutual insurance activities develop.

The establishment of reinsurance systems can be strengthened through the inflow of funds from the mobilisation of the savings of mutual health insurance schemes. The waiting periods which remain compulsory in the operating mechanisms of mutual health insurances and which facilitate the forming of a reserve can help to mobilise financial resources which could be invested but which could also be used for reinsurance services. The development of reinsurance opens up prospects for social security funds, which can make provision for this service in their reform programmes.

Conclusions

In the course of the last decade, the Republic of the Congo and the Democratic Republic of the Congo have been the recipients of humanitarian programmes as the consequence of the conflicts which punctuated the political and economic development of these two Central African countries. These programmes played an important role in alleviating the suffering of the populations that were victims of the crises and in restoring peace and dignity.

Given the nature and extent of this humanitarian aid, it is legitimate to examine its impact on the Congolese peoples and its contribution to the emergence of a new restructuring of the socioeconomic fabric and also to devote thought to how these situations of crisis can be taken as a point of departure for organising and elaborating new forms of social protection which will be sustainable.

Throughout, the intervention of the NGOs, United Nations agencies and governments, the mechanism for distributing aid is based both on partnership and on collaboration between the various partners operating in the field. This collaboration is visible in concrete form in the role played by the United Nations agency, OCHA. However, since the mandate of this organisation is limited to coordinating humanitarian aid, the question "What solution is to be found for post-aid development and for sustaining the action that has been carried out during this period?" remains to be answered.

Although the objective of providing emergency aid for needy people must not suffer from trial and error, strategies for integrating people into the economy must be devised and implemented by creating jobs and providing training and social protection in an integrated manner. This approach would help recipients to evolve beyond the dependency on welfare inherent in humanitarian programmes and empower them in a programme for development.

The aim will be to create a link and synergism between humanitarian programmes and development programmes in which the employment component facilitates the individual's gradual transition from the level of humanitarian assistance to that of micro entrepreneur. These two levels are part of the macro-economic framework and help to resolve the problem of sustainable employment, particularly for young people—hence the importance of information and training in these various humanitarian programmes.

Although it is necessary to provide humanitarian aid, this aid is not sufficient to help people overcome their poverty or become less vulnerable. From this point of view the sustainability of the activities that have been launched in the humanitarian programmes can be organised around the link between employment and social protection, an approach of relevance in the efforts to fight poverty.

This means that guaranteeing the employment and protection of the individual must be part of the objective for both the short and the long term, particularly since the application of the triad of micro enterprise sustained by micro credit, training, and micro health insurance brings advantages both for the economy as a whole and in the health field.

The micro health insurance system that has gradually been introduced in the two Congos can constitute a natural experience on a large scale. It was observed in the evaluation carried out by the ILO in the pilot project to provide mutual health insurance for the teachers of the Catholic schools in Kinshasa that there was substantial development in the utilisation of the health centres in Kinshasa. This occurred without prejudice to the financial balance of these health centres, which would have been caused by abuse of the system connected with a sudden increase in the overall consumption of health care. What was noted was rather the redistribution of health resources in the various health centres registered in the mutual benefit network, which provided a means of increasing the amount of preventive care provided and providing better access to care for the beneficiaries.

One can extrapolate by supposing that the productivity of the beneficiaries is increased when a mutual benefit system is introduced due to the large-scale mobilisation of workers in the formal and informal sectors or to an improved state of health (and a lower rate of absenteeism), or to both factors. It thus is not utopian to consider developing the statutory systems through new

mechanisms identified in the micro health insurance schemes such as the reinsurance component for covering chronic diseases.

The information drawn from the experience gained in other countries clearly shows that a system of social security that is adapted to the new circumstances can bring advantages on two levels, improving both the health and employment situation and the economy as a whole.

Annex 1: Administrative map of the Republic of the Congo

Annex 2: Administrative map of the Democratic Republic of the Congo

Annex 3: Selected references

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