POLICY BRIEF

CHINA AFRICA RESEARCH INITIATIVE

NO. 21 2017

Chinese medical teams in the DRC: A comparative case study

Xiaoxiao Jiang Kwete

POLICY POINTS

The CMT in the DRC faces unclear program logic, mismatched resources, and a lack of integration with the local hospital and providers. It can learn from the local MSF operation, which has clearer management structures, stronger supply chains, and more logistical support.

The CMTs should establish a longer-term profile and transition protocols to facilitate hand-overs between teams.

Against the backdrop of China's goal to further its relationship with the DRC, and the increasing global focus on improving health in vulnerable populations, the CMT should redefine its objective to center on improving the overall health of local communities.

SAIS JOHNS HOPKINS SCHOOL of ADVANCED INTERNATIONAL STUDIES

AFTER DECADES OF CIVIL UNREST AND ARMED CONFLICT, the health system in the Democratic Republic of Congo (DRC) is paralyzed. The country faces some of the highest rates of infant mortality, under-5 mortality, and maternal mortality in the world. In 2015, total health expenditure comprised only 3.6% of total gross domestic product, with half from government spending and the rest from external resources and official development assistance (ODA).

In 1963, China dispatched its first medical team to Algeria, setting the stage for China's "Development Assistance for Health" in African countries. This program has lasted several decades, with occasional disruption due to civil war in recipient countries and the Cultural Revolution period in China. Thus far, sending medical teams to local places remains China's major form of health-related foreign aid to African countries.

Each Chinese Medical Team (CMT) that is dispatched to Africa is sent from one province in China, forming a "buddy" system between provinces in China and states in Africa. The CMT in the DRC is from HeBei Province. In May 2012, the 15th deployment of the CMT to the DRC began its two-year mission in the Chinese-Congolese Friendship Hospital in Kinshasa. This team is the subject of the following analysis. Although the achievements of the CMT program are well documented by previous scholars, this brief focuses on the challenges the CMT faced in the DRC, and proposes recommendations for improvements in the future.

ANALYSIS: THE CHINESE MEDICAL TEAM IN THE DRC

THE 15TH CMT IN THE DRC HAD 18 MEMBERS, most of whom were physicians from different specialties with at least 10 years working experience in China. The CMT had its own internal administrative structure in which team members were asked to voluntarily assume administrative or coordinating roles for the team; sometimes members took more than one role for the team.

I examined the operations along five dimensions:

1. **Affiliation.** The hospital had its own steering committee, of which the CMT leader was not a member. The leader of the CMT had no management authority, but could play an "advisory role," as was described in the protocol between the two governments.

2. **Working conditions and schedule.** All CMT members, except the leader, the translator, and the chief, worked in the hospital 6 days a week, from 9am to 1pm. They lived together in a camp about 5 minutes from the hospital. Each medical team member had his or her own office; nobody shared an office with Congolese doctors.
3. **Fee structure.** The CMT did not charge patients for any medical consultations or laboratory tests and examinations. All fees for services provided by CMT members were charged by the hospital according to its standards and used at its will. In the hospital, there were two different pharmacies, one Chinese pharmacy and one Congolese pharmacy. The CMT pharmacist worked only in the Chinese pharmacy, together with another Congolese pharmacist. Patients needed to pay for the drugs received from the Chinese pharmacy at the price set by the Chinese Minister of Health—normally cheaper than local market price.
4. **Medical Device Management.** At least two batches of pharmaceutical products and medical devices had been donated from the CMT to the hospitals, yet these materials were mismanaged and often left under-utilized as a result. CMT members suspected that local doctors take the supplies for their own private use, while Congolese doctors suspected CMT members of selling them for profit.
5. **Financial Support.** Funding for the CMT came from three sources: the Minister of Health of China; the provincial Bureau of Health in HeBei Province; and the Minister of Commerce.

The CMT providers usually see patients from one of three categories:

1. **Hospital Medical Staff.** The CMT provided free medical services to medical staff members including doctors and nurses in the hospital. All the drugs were also free of charge to them.
2. **Local Chinese and people affiliated with Chinese local industries.** The CMT was the primary choice for local Chinese. Sometimes they drove from far across the city to visit the CMT for medical consultation and treatment. The CMT also had informal contracts with local Chinese-owned companies.
3. **Local population.** Any patients who came to the hospital and asked directly to be seen by CMT doctors; some patients were referred to CMT members by local doctors, or CMT members were invited to jointly make treatment plans for complicated cases. Active CMT members also sometimes visited the offices of local doctors and voluntarily proposed to co-treat a patient or assume the work that other doctors refused to do.

In addition, CMT members were also expected to provide free services to officials in China's Embassy in the DRC, as well as Congolese government officials and other diplomatic personnel in DRC.

In observations and interviews with CMT members, they identified a number of challenges they faced in their daily operations, including language barriers, lack of logistics support, lack of access to patients in need etc. After further analysis, three underlying reasons were elucidated:

1. **Unclear program logic.** Every CMT member had different opinions regarding the objectives of the medical mission they served. When asked, "What is your target population," answers varied from local Chinese to high-officials in Congolese government to local communities.
2. **Mismatched resources.** Perhaps as a consequence of unclear program logic, the resources within the CMT program often did not align. For instance, some medical equipment could not be used due to lack of supporting materials or unreliable electricity supply.
3. **Lack of integration between the CMT and the hospital.** In the hospital, the CMT existed as an independent entity; CMT members were not supervised by the hospital administration, or vice versa. The majority

Chinese traditional medicine doctor consulting with a foreign diplomat, with the help of a translator, at the Sino-Chinese Friendship Hospital (Photo credit: Xiaoxiao Jiang)

of CMT doctors and Congolese doctors did not work together. This lack of integration was due in part to the fact that the protocol between the two countries contains no plans for integration. Each CMT leader was expected to negotiate with the hospital on a case-by-case basis to design the plans for the CMT to work in the hospital.

MSF IN THE DRC

MEDICINS SANS FRONTIERES (MSF), one of the world's largest medical relief organizations, has a similar model as the CMT program: they both send doctor teams and treat general health conditions of local people, rather than focus on disease-specific programs. However, MSF has a much larger impact and is far better known, while many people even in the global health arena have never heard of CMTs.

The DRC is MSF's largest operation in terms of staff numbers and funding. MSF started its program in DRC from 1981. As of 2010, there were 2,766 MSF staff members working in the DRC, providing more than one million medical consultations to local people, more than 10,000 operations, and assisting in over 19,200 births.

MSF has many outposts in the country, but we focus our comparison on their site in Niangara in Province Orientale. At the time of research, the project team consisted of 52 MSF staff, seven of whom were international expatriates and the rest were local community members.

We observed three main differences between MSF and the CMT:

1. **The MSF team dominated the management of the hospital and the supporting infrastructure.** MSF doctors worked together with local doctors that were affiliated with Ministry of Health of DRC government, but all of the MoH health workers fell under the supervision of a MSF staff member, usually one of the international expatiates. All of the medical services were provided free of charge to local people; all the pharmaceutical products and medical devices were provided by MSF. MSF also provided logistic support to ensure the proper running of the Niagara hospital, including ensuring water and electricity supply.
2. **MSF had a strong logistical back-up team**, with a nearby base that housed 30 logisticians whose work included providing temporary storage for materials, purchasing supplies, and fixing equipment. With this support, the Niangara program was able to ensure sufficient supplies and maintain properly running machines for daily functions.
3. **MSF maintained a good working relationship with local health administrations.** To ensure the supply chain of the international order of medical materials, MSF also kept a good relationship with the customs office. As a result, it took MSF 1-2 weeks to clear the medical materials through customs, while it took the CMT 5-6 months.

IMPLICATIONS

THE CMT PROGRAM COULD LEARN a lot from the MSF model, but there are also some fundamental differences in the two organizational structures:

1. **MSF is an international organization.** It has a much bigger volunteer pool to choose from. It is much easier to select volunteers with proficient French speaking skills, cross-cultural understanding and devotion to their mission.
2. **MSF takes a politically neutral stance.** It enables them to always focus on "medical emergency relief" regardless of any political climate changes. In contrast, CMT is inevitably influenced by the bilateral relationship between China and DRC; the cooperation between CMT program and local health administration agencies will be influenced by the diplomatic relationship of DRC government to China government. Also, any modification to the CMT program will have to consider the political consequences before it considers its health outcome or other effectiveness.
3. **The biggest criticism of MSF's model is its lack of sustainability, but this is essentially by design.** MSF regards itself as "fire fighters" rather than "rebuilders". They appear in places with urgent need, and retreat when the situation are stabilized (by their own definition). The focus of MSF in the DRC is "Emergency Medical Relief," not health system strengthening. While the CMT can learn from MSF's model of successful and effective delivery of health care, it must also remember that its goal extends beyond humanitarian emergency relief.

RECOMMENDATIONS

DESPITE THE FUNDAMENTAL differences between MSF and the CMT program, this case study offers four recommendations for the CMT in the DRC, as well as for China's Aid for Health program more generally.

1. **Establish a "Heath Counselor" position in China's Embassy in the DRC.** With regards to the CMT, the work of the health counselor might include negotiating with the Congolese Ministry of Health a protocol for the CMT program every two years; providing administrative support and helping the CMT solve problems that fall outside of daily operations and require higher-level support and resources; establishing a longer-term program profile in DRC, ensuring smooth and stable transitions between different shifts of the CMT program; serving as the representative of China's Aid for Health in the DRC; and establishing a regular contact system with local health administrations and with other donor countries in order to increase the impact of China's aid programs.
2. **Redefine the program objective and mission statement of the CMT in DRC.** The fundamental objective of the CMT is to further China-DRC relations, which is the common objective for all bilateral aid agencies. However, there are different approaches to achieving this aim: it could be achieved through health system strengthening projects, emergency relief efforts, or by providing health services to high level officials within the government. With increasing global focus on serving vulnerable populations, the objective of the CMT should be refocused on improving the overall health condition of people in African countries.
3. **Redistribute funding for Aid for Health programs, increasing the amount allocated for non-medical support.** Much of the funding for the CMT profiled in this report was spent on salaries, as well as an initial purchase of medications and medical devices. Funding should be re-appropriated to provide other support, such as building a supply chain or improving access for local patients to the CMT.
4. **Increase cooperation with the Congolese government.** In order to increase the impact of China's medical diplomacy, there should be close and regular contact with local health administrators. ★

AUTHOR

XIAOXIAO JIANG KWETE is a research associate at Harvard T.H. Chan School of Public Health and a member of the China-Harvard-Africa Network. She is also the co-founder and COO of Expat Inc, a technology company dedicated to providing affordable and accessible artificial intelligence technology for all, in areas including healthcare, financial literacy, and education. The research presented in this article was sponsored by Harvard's Committee on African Studies.

THE SAIS CHINA-AFRICA RESEARCH INITIATIVE at the Johns Hopkins University School of Advanced International Studies (SAIS) in Washington, D.C. was launched in 2014. Our mission is to promote research, conduct evidence- based analysis, foster collaboration, and train future leaders to better understand the economic and political dimensions of China-Africa relations and their implications for human security and global development.

SAIS China-Africa Research Initiative
1717 Massachusetts Ave NW, Suite 733
Washington, DC 20036
www.sais-cari.org
Email: sais-cari@jhu.edu

Support for this policy brief was provided by a grant from Carnegie Corporation of New York. Carnegie Corporation of New York is a philanthropic foundation created by Andrew Carnegie in 1911 to do "real and permanent good in this world."