

## 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.

## Chinese Medical Teams in the DRC: A Comparative Case Study

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THE DEMOCRATIC REPUBLIC OF CONGO (DRC) IS, BY AREA, the largest Sub-Saharan African country, with a population of almost 100 million people. At the end of 2018, the DRC went through its first peaceful transition of power since independence in 1960. While bright prospects await the country, years of conflict and civil unrest have left many challenges for various sectors. Although the DRC has some of the highest rates of infant mortality, under-5 mortality, and maternal mortality in the world as of 2015, total health expenditure comprised only 3.6 percent of 2015's total gross domestic product. Government spending accounted for half of the funding, while the rest came 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 disruptions due to civil war in recipient countries and the Cultural Revolution period in China. Thus far, sending Chinese Medical Teams (CMT) to work on the ground remains China's major form of health-related foreign aid to African countries.

Each CMT that is dispatched to Africa is sent from one Chinese province, 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 mission in the Chinese-Congolese Friendship Hospital in Kinshasa. This particular team and deployment is the subject of the following analysis.

### ANALYSIS: THE CHINESE MEDICAL TEAM IN THE DRC

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

We examined six dimensions of their operations:

- Affiliation:** The hospital has its own steering committee, of which the CMT leader is not a member. The leader of the CMT has no management authority,

\*Note: The content of this policy brief was updated in June 2019.

but can play an “advisory role,” as is described in the protocol between the two governments.

2. **Working conditions and schedule:** All CMT members, except the leader, the translator, and the chief, work in the hospital six days a week, from 9am to 1pm. They live together in a camp about five minutes’ drive from the hospital. Each medical team member has his or her own office; nobody shares an office with Congolese doctors.
3. **Fee structure:** The CMT does not charge patients for any medical consultations or laboratory tests and examinations. All fees for services provided by CMT members are charged by the hospital according to their standards and used at their will.
4. **Pharmacies:** In the hospital, there are two different pharmacies, one Chinese pharmacy and one Congolese pharmacy. The CMT pharmacist works only in the Chinese pharmacy, together with another Congolese pharmacist. Patients need to pay for the drugs received from the Chinese pharmacy at the price set by Chinese Minister of Health—normally cheaper than local market price. Total revenue from the Chinese pharmacy is reported back to the Chinese Minister of Health every two years, with 30 percent sent back to China for further medication purchases and 70 percent donated to the hospital.
5. **Medical Device Management:** At least two batches of pharmaceutical products and medical devices have been donated by the CMT to the hospitals, yet these materials are mismanaged and often left un-used as a result. Misunderstandings and mistrust were thus born out of the lack of transparency into the use of donated materials. Interpersonal bonds between the two sides were impacted as CMT members suspected that local doctors were taking the supplies for their own private use, while Congolese doctors suspected CMT members of selling materials for personal profit. Neither suspicions were true as we describe in detail below.
6. **Financial Support:** funding for the CMT comes from three sources: 1) Minister of Health of China; 2) provincial Bureau of Health in HeBei Province; and 3) Minister of Commerce.

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

1. **Hospital Medical Staff:** the CMT provides free medical services to medical staff members including doctors and nurses in the hospital. All the drugs are also free of charge to them.
2. **Local Chinese and people affiliated with Chinese local industries:** The CMT is the primary choice for local Chinese. Sometimes they drive from far across the city to visit the CMT for medical consultation and treatment. The CMT also has informal contracts with local Chinese-owned companies.
3. **Local population:** Any patients who come to hospitals and directly ask to be seen by CMT doctors; those usually include family members of the hospital staff members, and patients who have been seen before by CMT members. In addition, some patients are referred to CMT members by local doctors, or CMT members are invited to jointly make treatment plans for complicated cases. Active CMT members also sometimes visit the offices of local doctors and voluntarily propose to co-treat a patient or assume the work that other doctors refuse to do.
4. In addition, CMT members are 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.

#### MAJOR CHALLENGES

1. **Unclear program logic model:** every CMT member has different opinions regarding the objectives of the medical mission they serve. 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 do not align. For instance, some medical equipment cannot 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 exists as an independent entity; CMT members are not supervised by the hospital administration, or vice versa. The majority of CMT doctors and Congolese doctors do not work

together. This lack of integration is due in part to the fact that the protocol between the two countries contains no plans for integration. Each CMT leader is expected to negotiate with the hospital on a case-by-case basis to design the plans for the CMT to work in a hospital.

### MEDICINS SANS FRONTIERES 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 local people's general health conditions, 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 the DRC in 1981. As of 2010, there were 2,766 MSF staff members working in the DRC, providing more than 1,000,000 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 with their Niangara site in Province Orientale. The project team consists of 52 MSF staff, seven of whom are international expatriates and the rest are local community members.

### THREE MAIN DIFFERENCES BETWEEN MSF AND THE CMT:

1. **The MSF team dominates the management of the hospital and the supporting infrastructure.** MSF doctors work together with local doctors that are affiliated with the DRC government's Ministry of Health (MoH), but all of the MoH health workers fall under the supervision of an MSF staff member, usually one of the international expatriates. All of the medical services are provided free of charge to local people and all the pharmaceutical products and medical devices are provided by MSF. MSF also provides logistics support to ensure the proper running of the Niangara hospital, including ensuring water and electricity supply.
2. **MSF has a strong logistical back-up team,** with a nearby base that houses 30 logisticians whose work includes providing temporary storage for materials, purchasing supplies, and fixing equipment. With

this support, the Niangara program is able to ensure sufficient supplies and maintain properly running machines for daily functions.

3. **MSF maintains a good working relationship with local health administrations.** To ensure the supply chain of medical materials ordered from abroad, MSF also keeps a good relationship with the customs office. As a result, it takes the MSF one to two weeks to clear medical materials out of customs, while that process for the CMT lasts from five to six 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 the DRC; the cooperation between the CMT program and local health administration agencies will be influenced by the DRC government's diplomatic relationship with the Chinese government. Also, any modification to the CMT program will first have to consider the political consequences before its health outcome or other effectiveness measure.
3. **The biggest criticism of MSF's model is its lack of sustainability, but this is essentially by design.** MSF regards themselves as "fire fighters" rather than "rebuilders". They appear in places with urgent need, and retreat when situations are stabilized to a certain extent, according to their own standard. The focus of MSF in the DRC is "Emergency Medical Relief", but not "Health System Strengthening". While the CMT can learn from the successful experience of MSF's effective delivery of health care service, it should always bear in mind that the goal of CMT is 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. **Negotiate the CMT protocol with the Congolese Ministry of Health every two years.** Previous negotiations have not aligned the Congolese Government's requests and China's capabilities. Conducting the negotiations between the DRC's Ministry of Health and the Chinese Health Counselor will help ensure that both sides' expectations are met.
2. **Provide administrative support to help the CMT solve problems that fall outside daily operations.** The Chinese Health Counselor can mobilize political resources and communicate with local health administrators as a representative of the CMT.
3. **Establish a long-term program profile in the DRC, ensuring a smooth and stable transition between different shifts of the CMT program.** Currently, there

is no formal transition time between the last CMT team and the next CMT team, and there is no official handover from one leader to the next. The leader of the 15th CMT had to start from scratch.

4. **Redefine the program objective and mission statement of the CMT in the 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 vulnerable populations, we strongly recommend that the objective of the CMT should be refocused on improving the overall health condition of people in African countries. ★

## AUTHOR

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