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## Commentary

# Prioritizing Healthcare Delivery in a Conflict Zone

Comment on “TB/HIV Co-Infection Care in Conflict-Affected Settings: A Mapping of Health Facilities in the Goma Area, Democratic Republic of Congo”

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### Abstract

Nowhere are the barriers to a functional health infrastructure more clearly on display than in the Goma region of Democratic Republic of Congo. Kaboru *et al.* report poorly integrated services for HIV and TB in this war-torn region. Priorities in conflict zones include provision of security, shelter, food, clean water and prevention of sexual violence. In Goma, immediate health priorities include emergency treatment of cholera, malaria, respiratory illnesses, provision of maternal care, millions of measles vaccinations, and management of an ongoing rabies epidemic. It is a daunting task to determine an essential package of medical services in a setting where there are so many competing priorities, where opportunity costs are limited and epidemiologic information is scarce. Non-governmental agencies sometimes add to the challenge via an insidious reduction of state sovereignty and the creation of new levels of income inequality. Kaboru *et al.* have successfully highlighted many of the complexities of rebuilding and prioritizing healthcare in a conflict zone.

### Keywords

Congo, HIV, Tuberculosis, Conflict, Integrated Services, NGO, Mission Creep

In this journal Kaboru *et al.* present the results of a cross-sectional review of the provision of HIV/TB co-infection services in one of the most crisis-affected regions of Africa (1). They administered an unstructured questionnaire to staff in 80 facilities, which provide TB or HIV care in the Goma region of North Kivu in Eastern Democratic Republic of Congo (DRC). Within these selected health facilities, TB diagnostic and treatment services were more frequently provided than HIV care. Additionally they found that less than a third of facilities provided integrated TB and HIV care to co-infected patients. The authors call for the promotion of reforms to promote TB/HIV integrated care and for more urgent progress on HIV control because social instability in the area will create an accelerated incidence in HIV infections. Nowhere are the barriers to a functional health infrastructure more clearly on display than in this war-torn region. The authors are to be congratulated in

performing operational research and drawing attention to the difficulties of providing integrated medical services within one on the most unstable conflict settings in the world.

The city of Goma lies in the mineral rich province of North Kivu adjoining the Rwandan and Ugandan borders and has suffered the grave consequences of war, civil unrest and natural disaster over the last 20 years. Hundreds of thousands of Rwandan refugees crossed the border to Goma following the 1994 Rwandan genocide. During the second Congo war (1998–2002) the city became the siege capital of the Rally for Congolese Democracy rebel group. In 2002 the local Nyiragongo volcano erupted obliterating large parts of the city. Recent exacerbation of the war in North Kivu have led to the ingress of hundreds of thousands of internally displaced persons (IDPs) and a brief recent occupation of the city by the M23 rebel group. Almost a million (914,000) people were displaced throughout North Kivu in early 2013 and currently refugee camps around Goma house more than 160,000 IDP's (2). The United Nations peacekeeping forces (MONUSCO) and support services added a further 45,547 personnel to an already sizable population of expatriate personnel from over 100 international development and humanitarian organizations (3).

Humanitarian priorities have included provision of security, shelter, food, clean water and prevention of sexual violence. Immediate health priorities include emergency treatment of cholera, malaria, respiratory illnesses, provision of maternal care, provision of millions of measles vaccinations, and management of an ongoing rabies epidemic. Chronically inadequate health services are reflected by high infant mortality (148/1000 live births), chronic infant malnourishment (45%) and high maternal mortality (1289/100,000 births) (4). Under such appalling conditions it is not so surprising that integration of services has been a neglected component of such a dysfunctional health system.

In an environment of ongoing instability and large-scale population displacement, emergency healthcare delivery will continue to be the focus of international agencies and non-governmental organizations (NGOs). There is still violence in

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North Kivu and recent hostilities between Congolese troops and the M23 rebel army, remind us that the environment for building a stable health infrastructure is extremely precarious. However, future healthcare sustainability will require development of an administrative and health cadre with capacity to deliver a well-defined package of essential health services. The sub text of the article by Kaboru *et al.* is that TB/HIV integration should have been part of such an essential health delivery package. Current World Bank output indicators for primary health care providers in the DRC are number of new adult and child curative care consultations, faculty-based deliveries, hospital referrals, pregnant women vaccinated for tetanus, and achievement of immunization targets (4). In contrast, integration of HIV/TB services is high on the agenda of the International Union Against TB and Lung Disease (IUTLD), which has encouraged collaboration between the National TB and National AIDS programs and has supported an HIV care project for tuberculosis patients living with HIV/AIDS (ICH) in North Kivu from 2002 (5). Between 2008 and 2012, 13 pilot health clinics in the IUTLD program diagnosed a mean of 600 TB cases per clinic and tested 87% for HIV infection as an entry into HIV care.

It is a daunting task to determine an essential package of medical services in a setting where there are so many competing priorities, where opportunity costs are limited and epidemiologic information is scarce. Kaboru *et al.* suggested that TB and HIV risks were particularly high in the Goma area. The DRC has the 6<sup>th</sup> highest TB notification rate in the world (6) but there are little data on recent TB trends in North Kivu. The authors reported that HIV prevalence in TB cases in the 12 clinics performing testing was 9%, which is considerably lower than the national prevalence of 16% among TB cases tested for HIV (6). Antenatal HIV prevalence in DRC is estimated to be 1.3% but in Goma city in 2008–2009 prevalence was 7.5%, an increase from 5.4% that was reported in 2004 (7). In contrast, the antenatal prevalence in the surrounding rural areas was 1.1% in 2008–2009, which was a significant decline from a prevalence of between 3% and 7% reported in 2002–2003 (8). These discrepant trends in HIV prevalence illustrate that the relationship between conflict and HIV transmission is complex and is the result of multiple conflicting risks (9).

Additionally Kaboru *et al.* conclude that the public sector should remain the key provider of HIV and TB services in the Goma region but that currently may be nominal rather than intrinsic, given the influence of international humanitarian agencies. Indeed, international humanitarian and developmental

agencies of necessity focus on their own programs and targeted populations. However, these agencies pay little attention to the insidious reduction of sovereignty of the state and their impact on the local political economy. Kaboru *et al.* have successfully highlighted many of the challenging complexities of rebuilding and prioritizing healthcare in a conflict zone.

#### Ethical issues

Not applicable.

#### Competing interests

None.

#### Authors' contributions

RW was the leading author of this manuscript. ETR contributed to the analysis and reviewed the manuscript.

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