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Advancing the Women, Peace and Security Agenda through Health System Reconstruction: The Case of the Catholic Church in the Nyankunde Health Zone, DR Congo

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Abstract: A consistent and longstanding focus of the Women, Peace and Security (WPS) agenda is the disproportionate impact of armed conflict upon the health of women, especially in resource poor countries characterized by weak and underfunded health systems. In such settings, faith-based actors often stand in the gap and offer basic continuity of care, but how well they succeed in meeting women's health needs is not widely known. This article offers a qualitative case study of how Catholic institutions have responded to these needs and supported health system reconstruction in a war-ridden health zone in the Democratic Republic of the Congo. Drawing upon interviews with Catholic administrators, nurses, midwives, and community health workers, it documents how Catholic health personnel, many of them women, have performed the unheralded work of rebuilding the local health system while also exposing challenges that hinder this work, including insufficient public investment, financial barriers for patients, and inadequate compensation and security for staff. It concludes that a greater commitment to health system reconstruction on the part of both states and faith communities is needed in order to advance the health dimensions of the WPS agenda going forward.

A CONSISTENT AND LONGSTANDING FOCUS OF THE WOMEN, Peace and Security (WPS) agenda is the disproportionate impact of armed conflict upon the health of women. War is widely known to cause elevated rates of gender-based violence, maternal mortality, and trauma, in addition to reducing women's access to the full range of health services. This impact is typically greater in resource poor countries where weak and underfunded health systems struggle to provide many of these services prior to the onset of war. In such settings, faith-based actors often stand in the gap and offer basic continuity of care through hospitals, health clinics, dispensaries, training programs, and more. Yet how

well these institutions succeed in meeting women's health needs, and to what degree they integrate their efforts into wider health system reconstruction, is not widely known.

This article offers a qualitative case study of how Catholic institutions have responded to women's health needs and supported health system reconstruction in a war-ridden health zone in the Democratic Republic of the Congo (DRC). Drawing upon interviews with Catholic administrators, nurses, midwives, and community health workers in the Nyankunde health zone, I document how Catholic health personnel, many of them women, have performed the unheralded work of rebuilding the local health system amidst chronic insecurity and state neglect.[1] In the process, I take stock of how this work has advanced women's health, helping to restore many of the system-wide functions (primary care, prenatal and other specialty care, vaccinations, etc.) that are essential to meeting the full range of women's needs. Such work illustrates how faith-based health organizations serve as partners not only in addressing the impact of war upon women but also in offering an important avenue for women's participation in this vital dimension of post-conflict peacebuilding. This case offers particular insight into some of the distinctive strengths that Catholic groups bring to this work, including the role of living base ecclesial communities in mobilizing grassroots participation in local health initiatives and the wider support of the church's international network of charitable institutions.

At the same time, this study exposes many of the challenges that continue to hinder this work, including a lack of public investment in the health system and the prevalence of user fee models of health financing that pose prohibitive barriers to impoverished patient populations. Health personnel remain grossly under-supported, particularly with respect to their compensation and safety, meaning that the women at the forefront of these initiatives often end up shouldering an undue burden of the rebuilding efforts. Such challenges demonstrate that a greater commitment to health system reconstruction on the part of both states and faith communities is needed in order to advance the health dimensions of the WPS agenda going forward.

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THE HEALTH OF WOMEN IN THE WPS AGENDA

Addressing the impact of armed conflict upon the health of women has been central to the WPS agenda going back to UNSCR 1325 (2000). UNSCR 1325 recognized the widespread use of sexual violence as a weapon of war and the importance of addressing the "special needs of women and girls during repatriation and resettlement and for rehabilitation, reintegration and post-conflict reconstruction."[2] One of the follow-up resolutions, UNSCR 2122 (2013), expanded the focus, urging Member States and UN entities "to ensure [that] humanitarian aid and funding includes provision for the full range of medical, legal, psychosocial and livelihood services to women affected by armed conflict and post-conflict situations."[3] The resolution further called for the strengthening of national institutions, including health systems, as well as civil society partnerships that redress the impact of war upon women's health.

Despite this commitment to addressing women's health, progress has been elusive. The 2015 Global Study on the implementation of UNSCR 1325 noted that the right to basic health care continued to be "out of reach or under assault for tens of millions of women and girls in conflict zones."[4] It pointed to rising attacks against health care facilities and personnel, continued high rates of malnutrition and disease among displaced women and girls, gender disparities in rates of war-related cases of HIV/AIDS, and gaps in psychosocial support and mental health.[5] It emphasized the particularly close relationship between armed conflict and maternal health: "Maternal mortality and morbidity are highest in crises-affected countries. Over half of the world's maternal deaths occur in conflict-affected and fragile states—and the majority of these are preventable."[6] The study also drew attention to other burdens that armed conflict places upon women, noting, "Households are transformed by conflict-related displacement, conscription and casualties, frequently leaving women as the head of the family in what are often deeply patriarchal societies."[7] In addition, the promotion of women's participation in strategies aimed at

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[2] United Nations Security Council Resolution 1325, UN Doc. S/RES/1325, October 31, 2000, documents.un.org/doc/undoc/gen/n00/720/18/pdf/n0072018.pdf.
[3] United Nations Security Council Resolution 2122, UN Doc. S/RES/2122, October 18, 2013, docs.un.org/en/S/RES/2122%20(2013).
[4] UN Women, *Preventing Conflict, Transforming Justice, Securing Peace: A Global Study on the Implementation of UN Security Council Resolution 1325* (UN Women, 2015), 74.
[5] UN Women, *Preventing Conflict*, 74–76.
[6] UN Women, *Preventing Conflict*, 77.
[7] UN Women, *Preventing Conflict*, 172.

mitigating these costs has been widely recognized but often neglected in practice.

The Global Study identified several obstacles impeding further progress in these areas, including a lack of coordination between government entities internally as well as civil society partners externally.[8] At the level of humanitarian response, it noted "the humanitarian system's collective failure to recognize the ability of local civil society organizations and women and girls to act as partners with valuable knowledge and experience," and called for more measures to empower women to participate in leadership, decision-making, and program design across all domains.[9] Beyond humanitarian measures, it reiterated that more "investment must be made in local health systems' ability to provide quality sexual and reproductive health and care for survivors and to put in place referral pathways to specialist care in all fragile settings."[10]

The priority of such measures has varied in the national action plans of Member States. The DRC has issued two national action plans, one in 2010 and a second in 2018. The first plan identified ten areas of intervention, including peace, security, HIV/AIDS, sexual violence, promotion and protection of women's rights, political inclusion, consolidation of the rule of law, regional and international cooperation, research, and evaluation.[11] The 2018 plan acknowledged that little progress had been made on most of these goals, pointing to continued under-representation of women in peacebuilding bodies, the security sector, and political leadership, in addition to chronic insecurity, alarming rates of sexual violence, and impunity for these offenses.

The 2018 plan prioritized four axes of action, broadly mirroring the four pillars of the WPS agenda: inclusion, prevention, protection, and recovery.[12] Under the axis of inclusion, the plan aimed to increase women's representation to 20 percent across a range of peace and security institutions. Under the axes of prevention and protection, the plan called for community-based mechanisms for early warning and peaceful resolution of conflict and strengthening the justice system to combat impunity for sexual violence. Finally, under the axis of recovery, it recommended "integrating the dimension of gender into the process of management and peaceful resolution of conflict" in

[8] UN Women, *Preventing Conflict*, 241–242, 268, 386, 416.
[9] UN Women, *Preventing Conflict*, 88.
[10] UN Women, *Preventing Conflict*, 400.
[11] See the discussion of the first plan in Ministry of Gender, Family, and Children, *National Action Plan for Implementing United Nations Security Council Resolution 1325 on Women, Peace, and Security, 2nd Generation* (Government of the Democratic Republic of the Congo, 2018), 15.
[12] Ministry of Gender, Family, and Children, *National Action Plan*, 19–23.

order "to accommodate the specific needs of women, young (and adolescent) women, and of marginalized groups (persons living with disability, indigenous peoples etc.), to increase their empowerment or to progress the equality of the sexes."[13]

Beyond this general appeal to accommodate the needs of women, however, the plan did not outline specific implementation strategies for addressing the impact of war upon women's health. It did not, for example, identify what modes of health delivery would best meet the full range of women's health needs, or how women's participation in such delivery mechanisms would be promoted.

Recent planning documents of the DRC's Ministry of Health (MOH) help to fill in some of the picture. The 2006 Health System Strengthening Plan, for example, noted that years of armed conflict had produced a situation in which the humanitarian health sector worked largely independently of the national health system, resulting in piecemeal, donor-dependent health interventions that focused upon acute needs rather than holistic, primary care.[14] It strongly advocated for a health system approach that would restore the integrated care of community health. Despite occasional appeals to maternal mortality, HIV infection rates, and other disproportionate impacts of war upon women, however, the MOH has not connected these priorities to the WPS agenda, missing a crucial opportunity to demonstrate why health system reconstruction matters specifically for meeting women's health needs. Kruk et al. capture the importance of health systems for these needs in this way:

> Averting maternal and neonatal deaths relies on elements of antenatal care, the availability of skilled birth attendants (i.e., doctors, nurses, midwives) and rapid referral for emergency obstetric care in the event of birth complications. Children suffering from conditions, such as malnutrition, require follow up visits and, when cases become severe, need to be referred to more specialized treatment. Mental illnesses, including depression and post-traumatic stress disorder, are chronic conditions. Treatment requires months or even years and requires specialized counseling skills and medicines. Health systems are needed to establish diagnosis and treatment for other chronic illness, reliable emergency services, and an integrated referral network.[15]

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[13] Ministry of Gender, Family, and Children, *National Action Plan*, 23.

[14] Ministère de la Santé, République Démocratique du Congo, *Stratégie de renforcement du système de santé* (juin 2006), 17–18.

[15] Margaret E. Kruk, Lynn P. Freedman, Grace A. Anglin, and Ronald J. Waldman, "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Post-Conflict Countries: A Theoretical Framework and Research Agenda," *Social Science and Medicine* 70, no. 1 (2010): 92, doi.org/10.1016/j.socscimed.2009.09.042.

These considerations attest to the need for greater coordination between government entities charged with implementing the WPS agenda; in the case of the DRC, this includes the Ministry of Gender, Family, and Children (which oversees the DRC's NAP) and the Ministry of Health (which coordinates health system reconstruction).

There is also a need for greater coordination between governments and civil society actors. While the DRC NAP underscores the general importance of civil society partnerships in meeting women's health needs, it neglects the contribution of faith-based health organizations (FBHOs). In the DRC, FBHOs operate "between 50 percent and 70 percent of health services" and half of all hospitals.[16] They also "co-manage around 40 percent of Congo's 515 health zones."[17] This is broadly representative of the role that faith-based health providers play in sub-Saharan Africa (SSA), which, depending upon the country, implement between 30 and 70 percent of health services.[18] As Schmid et al. observe, "It would not be an exaggeration to say that in SSA, FBOs are present and important, at a national and local level, and are sometimes the only functioning health service available in rural locations or areas of political crisis, or post-conflict."[19]

How are FBHOs assisting in the reconstruction of health systems that are central to women's health needs? And how are they serving as avenues of women's participation in such efforts? The following case study of the role of the Catholic Church in health system reconstruction in the Nyankunde health zone explores these questions. It illustrates the promise of FBHOs in addressing women's health-related needs and promoting their participation in mitigation strategies. As nurses, midwives, community health workers, educators, and leaders in ecclesial base communities, Catholic women have played an instrumental role in resurrecting the health system. At the same time, this case also reveals significant obstacles that continue to prevent such partnerships from more fully advancing the health-related aims of the WPS agenda.

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[16] Barbara Schimd, Jill Olivier, and James Cochrane, *The Contribution of Religious Entities to Health in Sub-Saharan Africa* (ARHAP, 2008), 60. See also Laura E. Seay, "Effective Responses: Protestants, Catholics, and the Provision of Health Care in the Post-War Kivus," *Review of African Political Economy* 40, no. 135 (2013): 83–97, doi.org/10.1080/03056244.2012.761601.

[17] Schmid, Olivier, and Cochrane, *The Contribution of Religious Entities*, 60.

[18] Jill Olivier et al., "Understanding the Roles of Faith-Based Health-Care Providers in Africa: Review of the Evidence with a Focus on Magnitude, Reach, Cost, and Satisfaction," *The Lancet* 386 (2015): 1767, doi.org/10.1016/S0140-6736(15)60251-3.

[19] Schmid, Olivier, and Cochrane, *The Contribution of Religious Entities*, 49.

THE NYANKUNDE HEALTH ZONE: A BRIEF BACKGROUND

The Nyankunde health zone covers 1,087 square miles and a population of roughly 107,000 in the northeastern province of Ituri.[20] The DRC adopted the health zone model in the 1980s after several pilot programs in community health succeeded in extending primary care to underserved rural populations.[21] At a time when community health approaches were gaining traction worldwide, culminating in the landmark Alma Ata Declaration, the DRC's health zone strategy quickly expanded under the leadership of a church-led initiative called *Santé Rurale* (SANRU).[22]

By this point, faith-based involvement in the DRC health sector was nothing new. Many faith-based health initiatives began under the auspices of mission organizations during the colonial era, when Belgian authorities relied largely upon nongovernmental actors to deliver health-care.[23] FBHOs remained active in Congo after independence, with leadership of most of these institutions passing to a new generation of

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[20] Équipe Cadre de la Zone de Santé de Nyankunde, "Conseil d'administration de la zone de santé de Nyankunde," PowerPoint presentation, Nyankunde, February 18, 2019.

[21] For more background on the health zone model, see Franklin C. Baer, "SANRU: Lessons Learned (1981–1991); A Report Prepared for USAID" (1992); Baer, "Establishing Public-Private Partnerships to Improve Health Services in Africa," in *Mennonites and Post-Colonial African Studies*, ed. John M. Janzen, Harold F. Miller, and John C. Yoder (Routledge, 2021), 169–181; and John M. Janzen, *Health in a Fragile State: Science, Sorcery, and Spirit in the Lower Congo* (University of Wisconsin Press, 2019), 109–144.

[22] In partnership with the Ministry of Health, SANRU was led by the medical office of the ECC (*L'Église du Christ au Congo*), an umbrella group for Protestant churches in the DRC. USAID was an important early partner in this initiative, helping to design and launch SANRU in the 1980s. As SANRU transitioned to an independent NGO in the 2010s, USAID remained involved alongside several other funders, including GAVI, the Bill and Melinda Gates Foundation, and the Global Fund to Fight Aids, Tuberculosis, and Malaria. In early 2025, the Trump administration withdrew USAID support for five SANRU programs; it resumed support for three of these in June 2025. For more on the SANRU-ECC relationship, see Janzen, *Health in a Fragile State*, 120–122. On the role of USAID support for SANRU, see Jane T. Bertrand, *Fifty Years of Family Planning in the Democratic Republic of the Congo* (Routledge, 2024), 94–108, 157–158, and SANRU, "Le Conseil d'Administration de SANRU Asbl annonce la relance de 3 projects USAID," June 25, 2025, sanru.org/actualites/49/le-conseil-dadministration-de-sanru-asbl-annonce-la-relance-de-3-projets-usaid.

[23] See Sokhieng Au, "Medical Orders: Catholic and Protestant Missionary Medicine in the Belgian Congo 1880–1940," *Low Countries Historical Review* 132, no. 1 (2017): 62–82, doi.org/10.18352/bmgn-lchr.10309; Sokhieng Au and Anne Cornet, "Medicine and Colonialism," in *Medical Histories of Belgium: New Narratives on Health, Care, and Citizenship in the Nineteenth and Twentieth Centuries*, ed. Joris Vandendriessche and Benoît Majerus (Manchester University Press, 2021), 99–133; and Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Duke University Press, 1999).

Congolese personnel. During the Mobutu regime (1965–1997), community health strategies initially aligned with the government's broader Zaireanization program, which promoted communal uplift and local empowerment, but years of government corruption eventually depleted funding for the health sector. This coincided with a shift in international donor policy towards structural adjustment and selective primary health care that prioritized cost-efficient interventions targeting specific diseases.[24] As governments withdrew from the health sector across the continent, faith-based providers again stepped into the gap, providing healthcare to underserved populations while wrestling with a system that increasingly privatized health and shifted its costs to patients themselves.[25]

Today, there are 515 health zones in the DRC. Each health zone includes a referral hospital and several health centers that are geographically distributed to ensure that patients do not have to travel far to access basic medical services.[26] Many of the health centers in the zone are administered by faith communities, including a Catholic center in Badiya, an Anglican center in Tekele, and three Brethren centers in Basunu, Kombokabo, and Sota. These centers are typically equipped to offer physical examinations, diagnostic tests, prescriptions, and maternity services ranging from prenatal care to assisted deliveries. They also oversee various public health projects such as vaccination campaigns, mosquito net distributions, and clean water sources. For such initiatives, the centers rely upon a team of volunteer community health workers known as *relais communautaires* (or RECOs), who serve as bridges between health centers and local residents.

If a patient requires more advanced attention, clinical staff refer them to the *Centre Médical Evangélique* (CME), a Protestant-run facility that serves as the general reference hospital for the zone. There patients can access emergency or specialized care such as C-sections and other surgeries, intensive care, or longer-term disease-specific care. Before the war, a staff composed of missionaries and Congolese health workers was trained in multiple specialties, from orthopedics and pediatrics to services for the deaf. The hospital's pharmacy supplied medications for the entire zone. CME also operated a large

[24] For background on these developments, see Matthew Basilico, Jonathan Weigel, Anjali Motgi, Jacob Bor, and Salmaan Keshavjee, "Health for All? Competing Theories and Geopolitics," in *Reimagining Global Health: An Introduction*, ed. Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico (University of California Press, 2013), 74–110.

[25] See Hunt, *Colonial Lexicon*, 285–287. For additional perspective on these dynamics, see Peter J. Brown, "Religion and Global Health," in *Religion as a Social Determinant of Public Health*, ed. Ellen L. Idler (Oxford University Press, 2014), 274–297.

[26] Ministère de la Santé, République Démocratique du Congo, *Directives et guides d'élaboration du plan provincial de développement sanitaire* (Septembre 2006).

nursing school, the graduates of which staffed the neighboring health centers. A fleet of small airplanes operated by Mission Aviation Fellowship connected Nyankunde to the broader region, establishing the zone as one of the premier health networks in the country. It is no surprise that it was among the first selected for inclusion in the nascent health zone system in the 1980s.[27]

THE IMPACT OF WAR UPON WOMEN'S HEALTH IN THE NYANKUNDE HEALTH ZONE

Two decades later, this momentum ground to a halt. From 1996 to 2002, two major armed conflicts ravaged the DRC. The first led to the toppling of the longtime dictator Mobutu in 1997, and the second involved numerous African states, including Uganda and Rwanda, in a broader regional struggle over citizenship, minority rights, security, and access to Congo's lucrative natural resources.[28] These wars in turn prompted other local conflicts, including the 1999–2003 war in Ituri (where the Nyankunde health zone is located), laying the seeds for the chronic insecurity that continues in eastern Congo to this day.

In a series of epidemiological surveys, the International Rescue Committee estimated that 5.4 million people died from these wars, the deadliest since WWII.[29] The vast majority of these deaths were not battle-related, but the result of the indirect costs of war such as disease and malnutrition. Women have borne the greatest burden of these costs. According to the Congolese Ministry of Health, in 1985, the national maternal mortality rate in the DRC was 850 deaths per 100,000 live births; in 2001, at the height of the Second Congo War, it was 1,289 per 100,000 live births, one of the highest in the world.[30] War in the DRC has also produced some of the highest documented cases of gender-based violence on record, an issue brought to global attention by the gynecologist and Nobel laureate Dr. Denis Mukwege.[31]

Much war-related mortality and morbidity is a function of the destruction of healthcare facilities. The Nyankunde health zone is a case in point. In 2002, rebel groups attacked the village of Nyankunde, destroying the CME hospital and killing 1,200 people, including

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[27] Baer, "SANRU: Lessons Learned," 24.

[28] See Gérard Prunier, *Africa's World War: Congo, the Rwandan Genocide, and the Making of a Continental Catastrophe* (Oxford University Press, 2009), and Jason K. Stearns, *Dancing in the Glory of Monsters: The Collapse of the Congo and the Great War of Africa* (PublicAffairs, 2011).

[29] International Rescue Committee, *Mortality in the Democratic Republic of Congo: An Ongoing Crisis* (International Rescue Committee, 2007), ii.

[30] Ministère de la Santé, *Stratégie de renforcement du système de santé*, 20.

[31] See Denis Mukwege, *The Power of Women: A Doctor's Journey of Hope and Healing* (Flatiron Books, 2021).

numerous health personnel, in one of the worst attacks against healthcare in the war.[32] Two other health centers in the zone were destroyed and the remaining centers closed when staff were forced to flee. All told, an estimated 60,000 people died from direct violence during the Ituri conflict, most of them civilians.[33] Nearly 400,000 are estimated to have died from indirect health-related causes in Ituri, representing nearly one-tenth of all indirect deaths from war in the DRC.[34]

The war also claimed countless homes, schools, water sources, roads, and bridges, to say nothing of lost crops, livestock, and other possessions. Continued insecurity "obstructed the humanitarian community's access to sizeable areas of the region, effectively denying the provision of aid to the most vulnerable populations."[35] This shows that while the targeting of health facilities and personnel and the consequent discontinuation of health services represented significant sources of the indirect death toll, they were here hardly the only ones. War also destroyed the basic social conditions that make for health.

Since 2008, I have been conducting a long-term ethnographic project tracking the public health impact of war in the Nyankunde health zone. Over the course of this period, the war's disproportionate impact upon women has been plainly evident. "War has affected women the most," Charlotte Atim, the leader of a women's group at the Nyankunde Catholic parish told me. "We have suffered pillage, displacement, trauma. . . . We're menaced by the militias and the FARDC [the Congolese army]. . . . Men abandon their wives, leaving us with the children. We then have to provide for all their needs: food, clothing, their health needs, the health fees. It's not easy. Women are the greatest victims of war."[36]

Dr. Rémy Kumvuku, a longtime director of the health zone, described the war's impact upon women's maternal health. "Without access to medical services, there were a lot of home births. There were maternal deaths and post-partum infections due to the lack of

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[32] See Human Rights Watch, *Ituri: Covered in Blood; Ethnically Targeted Violence in Northeastern Congo* (July 2003), 30-35, and United Nations, *Special Report on Events in Ituri*, paras. 52-61, S/2004/573, July 16, 2004, docs.un.org/en/S/2004/573.

[33] United Nations, *Second Special Report of the Secretary-General on the United Nations Organization Mission in the Democratic Republic of the* Congo, para. 10, UN Doc. S/2003/566, May 27, 2003, docs.un.org/en/S/2003/566.

[34] Debarati Guha-Supir, "Conflict Related Excess Deaths," in *Expert Report on Reparations for the International Court of Justice, Case Concerning Armed Activities on the Territory of the Congo*, December 19, 2020, icj-cij.org/public/files/case-related/116/116-20201219-OTH-01-00-EN.pdf, 28.

[35] United Nations, S/2003/566, para. 10.

[36] Interview with the author, Nyankunde, April 6, 2025.

personnel."[37] Women, he explained, could not access pre-natal screenings, skilled birth attendants, or emergency obstetric procedures. Those who survived delivery often faced debilitating complications, including fistulas that could not be repaired until CME re-opened.

Even when health operations restarted, women continued to face barriers to care. The *Force de résistance patriotique en Ituri* (FRPI), an Ngiti armed group that held out of peace talks, remained active in the region for years, deterring many women from making the dangerous trip to the hospital. According to Dr. Michael Upio, who led the rebuilding efforts at CME, "Women would not come to the hospital because of security. Some had to walk twenty to thirty kilometers. They risked being raped or killed on the way."[38] Even the short trip to a local health center posed significant risks, as reflected in the following account from a resident of the village of Sedzabo:

> There was a woman who came at midnight, and there was a man who looked after security, like a security guard. We had to call him, because the soldiers here wouldn't let us pass, because they thought we might be militia. So we took the woman, who was pregnant (it was difficult for her even to walk), and we spent a lot of time negotiating with the soldiers, saying, "It is nighttime, can you let us pass?" And the soldiers were like, "We don't know if there are militia among you." We took a long time discussing, and the mother was suffering a lot. And the baby was almost coming. Fortunately, they allowed us to pass, and when we reached the health center, she immediately delivered. So what would have happened if the soldiers said, "No, don't pass"?[39]

During the early stages of rebuilding, a battalion of the UN's peacekeeping mission in the DRC (then known as MONUC) deployed to the region to provide protection for the surrounding villages. Although this was key to the restoration of the health zone's operations, the battalion proved agonizingly unresponsive to local needs and struggled to overcome widespread perceptions of inaction and passivity. Dr. Upio describes one such instance before his arrival when doctors were scarce and patients had to be referred to Bunia, an hour's drive by car:

> So [a nurse] told me they brought a pregnant woman from Marabo. He did an exam and said, "It's impossible. She needs a C-section." They had to inform the UN peacekeepers and the rest, to say, "We need an ambulance to take this woman to Bunia." It was in the

[37] Interview with the author, Nyankunde, July 26, 2015.
[38] Interview with the author, Nyankunde, July 27, 2015.
[39] Interview with the author, Sedzabo, May 27, 2019.

> afternoon, around 4 or 5 p.m. The road from Nyankunde to Bunia wasn't safe. The militia could come and attack anytime. It was only the peacekeepers who could escort the ambulance on the road. "We told the people to come, but as it was in the evening, the peacekeepers had to ask for the clearance from Bunia, and Bunia had to ask for clearance from the UN headquarters in Kinshasa." The escort did not arrive until the next morning. The UN came to the hospital and asked, "Where is the woman?" She was there dead, and the child was also dead. They weren't able to do anything.[40]

While Dr. Upio's arrival enabled CME to resume C-section procedures on site, it has taken years to restore other basic services. David Chulu directs the CME laboratory. When he began in 2007, the lab had one microscope that barely functioned and a hand-operated centrifuge. Electricity was limited and his team had to rely upon a generator for any cases at night, sometimes working by flashlight. "We couldn't run many tests. We could do hemoglobin, a rapid test for malaria, stool samples for intestinal infections, that sort of thing. We could also do blood transfusions, but we couldn't do many tests for the transfusions."[41] Malaria, he pointed out, causes anemia, which in turn requires transfusions. It can cause numerous other complications for pregnant women and fetuses. Without the ability to test blood, the whole treatment process is put on hold. "We also needed to screen for HIV, Hep B, Hep C, syphilis, and for things like trypanosomiasis. We needed to do the cross-matching and compatibility tests. Initially we couldn't do these, so we were very limited." The hospital also did not have a blood bank, so finding donors was a problem. Some nurses took to donating their own blood as a stopgap measure.

Reviving public health measures that require intensive infrastructural rehabilitation has taken even longer. Dr. Upio describes the difference between tackling malaria and water-borne diseases:

> You can change the malaria situation in a couple of months, just with the mosquito nets. They are very effective. But diarrhea, that's difficult because it requires clean water, and not only clean water, but you need to change people's habits. So it's a long-term result that will be affected by the war. Before the war, you might have started a program and reached 70 percent of the goal. The war comes, wipes it out, and you are back to zero. It will take you ten more years to put in all the water sources, to change the people's habits regarding boiling and drinking the water, and to maintain your source. It will go very slowly.

[40] Interview with the author, Nyankunde, May 24, 2019.
[41] Interview with the author, Nyankunde, April 4, 2025.

> To cover the whole health zone takes time. This will be seriously affected by the war.[42]

War has also impacted non-communicable diseases (NCDs) such as diabetes, cancer, and heart conditions. This impact is often less discernible because the effects play out over a longer period of time. "Patients don't die in the middle of the war," Dr. Upio observes, "but by the time the war finishes, they start dying. Like right now, the hospital is full of people with renal failure, losing their sight, suffering stroke and paralysis, experiencing heart failure—all complications from hypertension and diabetes. We see it every day."[43]

He told me the story of a two-year old girl in a coma. They suspected she had meningitis or malaria, but when Dr. Upio performed the exam, he noticed she did not have a fever. He checked her glucose level; instead of being low, it was very high, a sure sign of type-1 diabetes, which meant she would need insulin for life. The hospital stocked insulin for emergencies, and Dr. Upio gave her some. She woke up. He told the girl's mother she would need regular insulin going forward. The child survived, but later experienced kidney failure. "She's on and off with the treatment; they buy insulin, they have it for a week, then go back off."[44] They simply could not afford to stay on.

Thus, while the Ituri war formally ended two decades ago, its impact upon the health of women and girls continues to play out daily.

THE ROLE OF THE CATHOLIC CHURCH IN THE RECONSTRUCTION OF THE NYANKUNDE HEALTH ZONE

The Catholic Church has long exercised an important role in the Nyankunde health zone. It operates a health center in Badiya, and Catholic nurses, midwives, and health workers staff many of the other centers in the zone. Today, Catholics represent roughly a quarter of employees at the Protestant-run CME hospital, a reflection of the ecumenical spirit of much health activity in the zone. Catholics also serve in leadership posts in health planning committees and the health zone office. Moreover, Caritas Internationalis is a major funder of the health centers, and other international Catholic NGOs such as Catholic Relief Services have provided long-term support for local health system reconstruction.

The village of Badiya serves as the epicenter of much Catholic life in the area. It is the home of the diocesan cathedral, a team of local

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[42] Interview with the author, Nyankunde, July 27, 2015.
[43] Interview with the author, Nyankunde, July 27, 2015.
[44] Interview with the author, Nyankunde, May 29, 2019.

priests, and the Congregation of the Sister Servants of Jesus, a religious order founded in the 1930s. The sisters operate a local school and assist in the Badiya health clinic.

Sister Esperance Nyamungu, a teacher in the school, arrived in Badiya five years ago, just as the region was experiencing a resurgence of armed conflict. She and the sisters provided safe haven for people fleeing the violence. She has since become an advocate for women's issues, most recently as lead organizer for a series of workshops engaging the 2025 International Women's Day theme: "For All Women and Girls: Rights, Equality and Empowerment." These workshops have drawn hundreds of women. "The Church cannot be silent," she says. "We must sympathize with other women who suffer in Ituri. . . . We must have an awareness of the sacredness of these women and push for what is missing. We must say to society: come back to the right path. The Church can orient and guide this work for the good of all."[45]

In the area of women's war-related health needs, Catholic women are orienting and guiding this work in several ways. "Women represent the majority of personnel in the health system," says Chandikana Sumbauna, a Catholic nurse in the Marabo health center. Of the eleven employees at the center, all but one are women, and many of them are Catholic.[46] Catholic women are strongly represented in several other clinics in the zone as well. As midwives and nurses, they are directly involved in restoring a range of services necessary for women's health, from pre-natal care and deliveries to primary care. After recent insecurity forced most of the personnel at the Badiya health center to relocate elsewhere, Charlotte Dualina, a Catholic midwife, stayed. She performs nearly two dozen deliveries per month, often receiving calls in the middle of the night and assisting with several deliveries at once. Without a regular government salary and with few supplies, she has ensured women do not have to walk ten kilometers to CME to access these services.

Catholic women have also supported the war-related needs of women in their capacity as *relais communautaires* (RECOs). As mentioned above, RECOs are community health workers who serve as bridges between the health centers and local residents. The role of community health workers in ensuring primary health care and effective drug treatments has received increasing attention in recent years. Partners in Health, the organization co-founded by Paul Farmer, has highlighted the importance of community health workers in achieving successful outcomes for multi-drug resistant tuberculosis

[45] Interview with the author, Nyankunde, April 6, 2025.
[46] Interview with the author, Marabo, April 4, 2025.

and antiretroviral adherence for patients with HIV/AIDS.[47] As their local name in Haiti (*accompagnateurs*) suggests, community health workers provide the often-missing glue in a successful community health system, accompanying a person in his or her ongoing journey towards recovery and well-being. James F. Keenan, SJ, has noted the term's rich resonance with Pope Francis's emphasis upon accompaniment as emblematic of Christian discipleship.[48] The French term *relais communautaires* captures how health workers are both relayers of information and the "relays" that help to constitute the communal relationships upon which well-being depends.

When war fractures these relationships, the role of RECOs becomes all the more important. In the Nyankunde health zone, one of their early post-war roles included enlisting community support in the rebuilding of the health centers. "When we first started, we were working from a very small house," remembers Rogeline Mobabo, a leader in her local parish who serves as a RECO in Marabo.[49] Medair, an NGO assisting with infrastructure projects, offered to rehabilitate the center, but the RECOs insisted upon getting buy-in from the local community. "Our role was to explain to the community why we needed a good building for the health center and that their contribution was very important." The RECOs succeeded in rebuilding the Marabo center, and soon after, most of the other health centers in the zone.

RECOs have also helped to restore a number of public health programs. Sengi Bonza, the head of the zone's vaccination program, explains that prior to the war, the zone had achieved nearly 80 percent coverage of seven vaccines that immunized against diseases such as TB, diphtheria, tetanus, yellow fever, and polio. "It must have dropped to 35 or 40 percent because many people fled and couldn't complete the appropriate vaccination regimen for it to be effective," he says.[50] In partnership with the World Health Organization and UNICEF, RECOs organized several successful vaccine campaigns. They have also helped to install solar-powered refrigerators so they can store vaccines on site at the health centers. Coverage rates are trending upwards again. In addition to vaccines, RECOs have distributed mosquito nets, restored water sources, and raised awareness about the

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[47] Peter Drobac, Matthew Basilico, Luke Messac, David Walton, and Paul Farmer, "Building an Effective Rural Health Delivery Model in Haiti and Rwanda," in *Reimagining Global Health: An Introduction*, ed. Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico (University of California Press, 2013), 133–183.

[48] James F. Keenan, "From *Amoris Laetitia* to Ebola: Accompaniment as a Model for Medical and Pastoral Care," in *A Prophet to the Peoples: Paul Farmer's Witness and Theological Ethics*, ed. Jennie Weiss Block, M. Therese Lysaught, and Alexandre A. Martins (Pickwick Publications, 2023), 202–218.

[49] Interview with the author, Marabo, May 21, 2019.

[50] Interview with the author, Nyankunde, July 27, 2015.

building blocks of nutrition. Matotina Nyaganan, a Catholic RECO in Badiya, observes, "Sometimes the mothers say, 'We don't have those kinds of nutrients.' But then I say, 'Let's just go to the garden and we can identify them. They are all there.'"[51]

The value of RECOs in coordinating large public health measures was in full evidence during the 2018–19 Ebola outbreak. Countries emerging from armed conflict and struggling to rebuild their health systems are at significantly greater risk of such outbreaks, as witnessed by the 2013–16 Ebola pandemic in West Africa.[52] In Marabo, there were twenty-six RECOs who participated in the Ebola response, each responsible for raising awareness in a forty-home catchment area. They educated neighbors on how Ebola spreads and dispelled rumors and misinformation, often at great personal risk. Mobabo recalls, "When MSF set up a triage center, people started saying, 'Ah, they have brought Ebola into our community.'"[53] In one instance, she was cornered by several neighbors, accused of inventing the danger and profiting at their expense. "We had to work hard to convince people even to wash hands. We worked day and night mobilizing people. Everyone eventually became convinced about Ebola." In the end, the zone only registered a few positive cases, containing the outbreak more effectively than other nearby zones.

Living Base Ecclesial Communities and Women's Health

In addition to direct participation in the health system, Catholic women are actively engaged in responding to women's health needs through other channels, including the *communautés ecclesiales vivantes de base* (CEVB), or living base ecclesial communities. Widely known in Latin America, base communities have exercised an important role in African Catholic life since the 1960s.[54] According to J.J. Carney, their promotion has been a priority of the Catholic bishops in Congo: "Building on Vatican II's people of God ecclesiology, the bishops called for the Catholic Church to become a 'church of the poor' and move 'near to the Congolese people,' forming lay-led communities that would reflect an engaged, adult Christian faith and not simply a 'religiously instructed' population."[55] Gender equality was central to

[51] Interview with the author, Badiya, May 22, 2019.
[52] See Paul Farmer, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History* (Farrar, Straus and Giroux, 2020).
[53] Interview with the author, Marabo, May 21, 2019.
[54] J.J. Carney, "The People Who Do All Things Together: Living Base Ecclesial Communities in the Democratic Republic of the Congo," *Theological Studies* 85, no. 2 (2024): 267, doi.org/10.1177/00405639241237474.
[55] Carney, "The People Who Do All Things Together," 269–270.

this vision, and women have found in these communities an important pathway to empowerment in parish life.[56]

Known in Ituri as *shirika* communities, these groups typically gather once a week for hymns, Bible study, prayer, and discussion of community needs. One early morning in April 2025, I attended the St. Augustine *shirika* service in Marabo. About seventy people, most of them women, assembled in a small building, taking their seats on rows of long wooden benches. After a procession and hymn, the catechist reflected upon the reading, the upcoming gospel lesson for Palm Sunday. "People participate in *shirika* to share the word of God so they can understand what they hear in the church," one participant later shared.[57] Another added, "This is where we apply the word of God."[58] Albert Tebabo, a catechist, said that for him, *shirika* is "the assembly of the faithful that prays together and collaborates on ideas for development."[59] As Charlotte Dualina in Badiya put it simply, "It's the action branch of the church."[60]

While the role of base communities in generating social and political activism is well known, their role in promoting health is less recognized. Health is a clear priority in the St. Augustine *shirika* community. During the discussion of community needs, members made an inventory of who was sick and planned food distributions for those who were hospitalized at CME. In Marabo and other villages in the health zone, RECOs partner closely with *shirika* groups, and many women participate in both capacities. Rogeline Mobabo, the RECO in Marabo mentioned above, serves as one of the leaders of the St. Augustine *shirika* community. She frequently provides updates on public health campaigns and offers short health lessons during the discussion portion of the service. Mobabo says she seeks to be an "engaged Catholic," someone "who knows the word of God by doing it."[61] She cites Matthew 25 and its vision of Christ as present in all who suffer, observing, "If we do it for them, we do it unto Christ."

In her dual role as RECO and *shirika* leader, Mobabo has also become a trusted confidante for a number of women's health issues, including gender-based violence. She notes that it is not just soldiers and militia who commit these violations. "It's people in the villages who do this too. The militia activity creates an environment in which these abuses can occur." She says survivors experience social ostracization, trauma, and abandonment by their husbands. Mobabo

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[56] Carney, "The People Who Do All Things Together," 271.
[57] Interview with the author, Marabo, April 7, 2025.
[58] Interview with the author, Marabo, April 7, 2025.
[59] Interview with the author, Nyankunde, April 8, 2025.
[60] Interview with the author, Badiya, April 3, 2025.
[61] Interview with the author, Marabo, April 4, 2019.

coordinates support services for them, connecting women to the Marabo health center and local government investigators.

During my visit, Mobabo took me to a microenterprise center that she and others started to provide additional opportunities for survivors in the community. After picking up flour from a local market, Mobabo added it to a large bowl, along with some water, yeast and salt. She mixed the ingredients until the dough came together and passed it to several young girls who kneaded it on a nearby table. After letting the dough rest, they shaped small rolls to rise in tins and placed them in the wood-fired oven. The intoxicating smell of the fresh loaves wafted into the air, and about a half hour later, they turned them on to the table, brushed vegetable oil on top, and took them to the market. They repeated the same process in the afternoon.

Rachel Lingachalo, one of the bakery's co-owners, explained its origins. "We had children here, some orphaned from rape and coming out of a violent situation, and we created this place to care for them."[62] She emphasized the therapeutic dimension of the baking process. "Baking helps alleviate stress and trauma. Kneading the dough is important in this respect. It focuses attention on the work—on the present, not the past. This is why we knead by hand, not by machine. It makes you strong. It gives you hope."

She then shared how her Catholic faith informs her work. "The Bible says love your neighbor as yourself, and this includes anyone who suffers." Reflecting upon the scriptures that have inspired her, she mentioned Dorcas from the book of Acts, who is described as "full of good works and acts of charity" (9:36). Dorcas, Rachel explained, made garments and gave them to the needy, including widows. "Dorcas helped other women. Who would Dorcas help today? We're applying the same idea to these women and girls."

Assessing the Role of Faith-Based Actors in Health System Reconstruction

The case of the Catholic Church's involvement in the rebuilding of the Nyankunde health zone illustrates how faith-based actors help advance important health-related dimensions of the WPS agenda. As we have seen, FBHOs offer a direct avenue not only for addressing many of the health needs of women impacted by war, but also for empowering women to participate in these efforts as nurses, midwives, community health workers, and members of supporting communities such as *shirika* groups.

[62] Interview with the author, Marabo, April 7, 2025.

The African Religious Health Assets Programme (ARHAP) has developed the concept of religious health assets to capture the ways that FBHOs contribute to health delivery.[63] Among these are "the role of personal values on institutional policies and on health outcomes at various scales," "the trust that communities have in religious leaders," and "the ability of faith leaders to tap into the commitment of their religious communities and to mobilize volunteers for a range of grass-roots health-related needs."[64] ARHAP also notes that health workers in FBHOs are often motivated by a strong sense of mission or vocation, which deepens their commitment to their work.[65] Moreover, FBHOs frequently draw upon a wide network of domestic and international support in sustaining their operations when other sources are inadequate or unavailable.[66]

We can see several of these assets on display in the Nyankunde health zone. Catholic health workers bring a strong sense of vocation to their work. Whether it is the inspiration of scripture (e.g. Christ's identification with those who suffer, the charitable works of Dorcas) or broader theological ideas (being an "engaged Catholic," applying the gospel to daily life), their Catholic faith provides motivation for staying the course in the face of chronic insecurity, displacement, and state absenteeism. When I asked Faustin Tscheda, the administrator of the Badiya health center, why he remains invested in this work, he responded, "We have sworn to serve the sick. That's our vocation. For Catholics, it is part of our faith. You dedicate your life to helping others. So I must stick with it. Many people work for money, and sometimes, when there is no money, they leave. But we are still here because of the vocation."[67]

This case has illustrated some of the distinctive strengths that Catholic groups bring to this work. We have seen how living base ecclesial communities such as the St. Augustine *shirika* community play a significant role in mobilizing grassroots support for health center initiatives. Their development projects, including the micro-enterprise center described above, help to address the deeper social determinants of health, including employment, income, food access, and communal belonging. The overall operation of the health zone has benefited from the institutional stability of the Catholic Church, which offers an extensive support network that includes local parishes,

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[63] Schimd, Olivier, and Cochrane, *The Contribution of Religious Entities*, 36. See also Susan R. Holman's discussion of ARHAP in *Beholden*: *Religion, Global Health, and Human Rights* (Oxford University Press, 2015), 125–161.
[64] Schimd, Olivier, and Cochrane, *The Contribution of Religious Entities*, 36.
[65] Schimd, Olivier, and Cochrane, *The Contribution of Religious Entities*, 85.
[66] Schimd, Olivier, and Cochrane, *The Contribution of Religious Entities*, 85.
[67] Interview with the author, Badiya, May 22, 2019.

religious orders such as the Congregation of the Sister Servants of Jesus, and funding and additional assistance from Caritas and Catholic Relief Services. The commitment of Catholic health workers to providing holistic, integrated healthcare within the health zone system, including their strong representation among RECOs, is critical to ensuring the regular follow-up, referrals, and specialized care that is necessary in meeting the health needs of women.

If the involvement of the Catholic Church in the Nyankunde health zone demonstrates how FBHOs perform essential work in advancing priorities central to the WPS agenda, and some of the particular strengths of Catholic contributions, this case also offers a window into some lessons that are worth heeding if such partnerships are to be more effective going forward.

First, as touched upon above, the involvement of faith-based actors in the Congolese health sector has advanced over the past several decades against a steady backdrop of state withdrawal. According to Waldman, "From 2000–02, less than 1 percent of the [DRC's] total budget was devoted to the health sector."[68] While this number increased to 10.8 percent by 2020, Jane Bertrand notes that it only represented 4.0 percent of GDP, and actual spending is far below budgeted amounts.[69] To this day, almost all health-related activities in Congo are donor-dependent and "[t]he DRC government spends less than one-tenth the average of the rest of sub-Saharan countries on health."[70]

In the Nyankunde health zone, the lack of government buy-in is palpable at many levels. Employees at the health centers and CME hospital are considered government workers and entitled to a state salary (known as a *prime de risque*), but due to bureaucratic dysfunction and backlogs in the registration system, these employees rarely receive it. The salary they do receive (known as a *prime locale*) comes directly from the health facilities. These salaries fluctuate depending upon monthly revenue, which apart from donor funds, is generated through user fees that patients pay. For FBHOs, the practice of charging user fees exposes what Peter J. Brown identifies as a "tension between their religious foundations and their financial requirements" in that "user fees, even minimal ones, can make medical care inaccessible to the poorest people."[71] Waldman echoes the point,

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[68] Ron Waldman, *Health in Fragile States, Country Case Study: Democratic Republic of the Congo* (Basic Support for Institutionalizing Child Survival [BASICS] for the United States Agency for International Development [USAID], 2006), 10n4.
[69] Bertrand, *Fifty Years of Family Planning in the Democratic Republic of the Congo*, 296.
[70] Bertrand, *Fifty Years of Family Planning in the Democratic Republic of the Congo*, 292, 296.
[71] Brown, "Religion and Global Health," 286–287.

"The cost of emergency procedures, such as Cesarean section, may be exorbitant—$60 or more in areas where 80 percent or more of the population earns less than $0.20 per day. Paying for health care can, in fact, be a cause of poverty. Several studies have shown close correlations between user fees and utilization rates, with the latter increasing as fees are lowered and decreasing when they are raised."[72]

Given that many patients cannot pay these fees, health facilities constantly struggle to make ends meet, and the salary fallout is usually gendered: while physicians (an overwhelmingly male-dominated profession in the health zone) tend to receive their *prime locale* on schedule, many of those in the female-dominant professions such as nursing and midwifery do not. This can cause these workers to look elsewhere for employment, including the more stable NGOs in urban centers, depleting rural health centers of a key part of the workforce. Financial support from such groups as Caritas helps, but for the women who remain, the lack of regular pay stands in stark contrast to the outsized role they play in sustaining the health system.

There have been some attempts to redress these inequities, but they represent mostly stopgap measures. The European Union, for example, provides funds that partially cover the health fees for women's health services (including C-sections), and this has helped CME and the health centers meet some of their operating costs.[73] Recent years have also seen an increase in *mutuelles de santé*, which are health insurance cooperatives that, for a modest annual fee, cover primary care expenses for members. The Catholic Church has pioneered the use of *mutuelles* in South Kivu, and CME started a *mutuelle* called *Musanya* for the Nyankunde health zone.[74] At one point, *Musanya*'s membership numbered in the thousands, but it took only one spike insecurity between 2020–21 for other livelihood costs to increase and drain many

[72] Waldman, *Health in Fragile States*, 22.

[73] The European Union has supported health initiatives in Ituri over the course of several funding cycles, including the 2007–2013 Programme d'appui au plan national de développement sanitaire (PAPNDS), the 2014–2020 Programme de renforcement de l'offre et développement de l'accès aux soins de santé en RDC (PRODS), and most recently, the 2021–2027 Instrument de voisinage, de coopération au développement et de cooperation internationale (IVCDCI). For further discussion, see Eric Tchouaket, Hermes Karemere, Drissa Sia, and Woolf Kapiteni, "An Analysis of the Social Impacts of a Health System Strengthening Program Based on Purchasing Health Services," *Journal of Epidemiology and Global Health*, 13 (2023): 751–773, doi.org/10.1007/s44197-023-00147-8.

[74] On the role of the Catholic Church in organizing *mutuelles* in South Kivu, see Bwimana Aembe, "Networked Health Sector Governance and State-building Legitimacy in Conflict-affected Fragile States: The Variable Impact of Non-State Provision of Public Health Services in Eastern Democratic Republic of Congo" (PhD diss., Wageningen University, 2017), 128–150.

households of even the minimal funds to cover membership fees, leading the cooperative to dissolve.

Neighboring countries such as Rwanda have required their citizens to enroll in *mutuelles*, and momentum is building in the DRC towards a universal health care policy.[75] It is too early to tell if this policy will be matched by the requisite government budgeting and spending that universal health care access and equitable health sector service provision demand. Much of the government's capacity to increase health spending will depend upon whether it can generate more tax revenue from lucrative industries that remain dominated by foreign investors.[76] A 2025 World Bank report noted that tax concessions are "highly concentrated in industrial, mining, and oil sectors, accounting for over 75 percent of total forgone revenue."[77] It recommended that the DRC "prioritize expenditure on essential services and infrastructure investments" and "broaden the tax base and improve tax collection efficiency."[78]

Returning to the issue of remuneration, with the growing recognition of the importance of community health workers to primary care, public health, and effective drug delivery has come increasing calls to include these workers among salaried employees of health systems. RECOs in the DRC serve in a voluntary capacity. They receive a discounted rate on their health bills and a modest stipend from the World Health Organization when they assist with various public health campaigns. Partners in Health, among other groups, has argued that salaries for community health workers benefit resource-poor populations and improve therapy outcomes. The 2023 Monrovia Call to Action recognized a growing international consensus on this issue, noting that "investing in a professional community health workforce can produce a 10 to 1 return on every dollar invested through healthier populations, increased productivity, and job creation, in particular for

[75] On the Rwandan model, see Drobac, Basilico, Messac, Walton, and Famer, "Building an Effective Rural Health Delivery Model in Haiti and Rwanda," 175–176. For more background on universal health care in the DRC, see Moussa Issa, "The Pathway to Achieving Universal Health Coverage in the Democratic Republic of Congo: Obstacles and Prospects," *Cureus* 15, no. 7 (2023), doi.org/10.7759/cureus.41935.
[76] For background on the mining sector in the DRC, see Rigobert Minani, SJ, "The Mining Industry, Conflict, and the Church's Commitment in the Democratic Republic of the Congo," in *Catholic Peacebuilding and Mining: Integral Peace, Development, and Ecology*, ed. Caesar A. Montevecchio and Gerard F. Powers (Routledge, 2022), 45–53.
[77] World Bank Group, *Reassessing Tax Incentives: Falling Short of Promised Growth and Equity*, July 2025, documents1.worldbank.org/curated/en/099072525115545348/pdf/P507143-4d5b3298-cf68-43b1-b5c1-5cc5861aab24.pdf, viii.
[78] World Bank Group, *Reassessing Tax Incentives*, 20.

women."[79] Given that seventy percent of community health workers worldwide are women, there is a strong case to be made for explicitly tying this to the WPS agenda and incorporating it into future national action plans. As the Monrovia Call concludes, "To be fully effective, CHWs need to be skilled, supervised, paid a living wage, and supplied by a well-functioning primary health care system coordinated at scale and integrated into broader public systems via data and financing."[80] Such action should be accompanied by efforts to increase women's participation in the health sector more generally, including the training of female physicians and professionals in other areas in which they remain underrepresented.

Finally, as the disruptive impact of chronic insecurity upon health delivery in the Nyankunde health zone shows, progress in health system reconstruction is not limited to factors within the health sector. Put simply, without basic security, none of the above activities can advance very far. This underscores a point that is central to the WPS agenda, namely, that each of the four pillars are interrelated. While women's health needs are typically discussed under the pillar of recovery, addressing these needs presupposes a resolve to tackle the sources of insecurity under the pillars of prevention and protection—and incorporating women's participation across all three. The sources of insecurity in Ituri are many: unresolved land disputes, the failed integration of militias into the Congolese army (FARDC), the lack of professionalized security forces, political and military elites that benefit from the continuation of armed conflict, and few alternatives for youth who turn to militia life as their only livelihood option.[81] The Congo NAP lays out clear goals for the inclusion of women in the security sector, including the police and FARDC.[82] It includes additional recommendations for increasing women's representation and leadership across many other sectors.[83] Ensuring the implementation of these dimensions of the action plan, and relating them more directly to health delivery through intergovernmental and civil society coordination, including FBHOs, is crucial to establishing the conditions

[79] 3rd International Community Health Workers Symposium, "The Monrovia Call to Action" (2023), chwsymposiumliberia2023.org/2023/03/27/the-monrovia-call-to-action-launched-by-the-liberia-ministry-of-health-at-2023-chw-symposium.
[80] 3rd International Community Health Workers Symposium, "The Monrovia Call to Action."
[81] See Jason K. Stearns, *The War that Doesn't Say Its Name: The Unending Conflict in the Congo* (Princeton University Press, 2023), and Josaphat Musamba and Erik Gobbers, *Armed Groups, Territorial Control, Land Disputes, and Gold Exploitation in Djugu, Ituri, Democratic Republic of Congo* (IPIS, 2023).
[82] Ministry of Gender, Family, and Children, *National Action Plan*, 21.
[83] Ministry of Gender, Family, and Children, *National Action Plan*, 19–20.

necessary not only for reconstructing health systems, but also sustaining them in the future.

The holistic character of the WPS agenda reflects the integral nature of peace itself. Here again, faith-based actors have something to contribute. Guided by a vision of peace as *shalom*, as a comprehensive sense of well-being, Catholic peacebuilders routinely draw attention to the inter-connected nature of peace: that peace is more than the cessation of war, more than transitional justice, new constitutions, and elections.[84] It is the restoration of right relationship, the reweaving of a torn social fabric that is political, economic, cultural, and ecological in dimension. Catholic health workers in the Nyankunde health zone demonstrate the importance of health system reconstruction to meeting the needs of women and restoring this fuller vision of peace. That their work depends upon correlative reforms in security, mining, and other areas confirms that peace has many pillars, and that women's full, equally valued participation is central to each one. M

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[84] See Robert J. Schreiter, R. Scott Appleby, and Gerard F. Powers, eds., *Peacebuilding: Catholic Theology, Ethics, and Praxis* (Orbis Books, 2010); Daniel Philpott, *Just and Unjust Peace: An Ethic of Political Reconciliation* (Oxford University Press, 2012); Lisa Cahill, *Blessed are the Peacemakers: Pacifism, Just War, and Peacebuilding* (Fortress Press, 2019), 325–364; and Montevecchio and Powers, eds., *Catholic Peacebuilding and Mining*. For more on the notion of integral peace, see Gerard F. Powers, "Toward an Integral Catholic Peacebuilding," *Journal of Social Encounters* 1, no. 1 (2017): 1–13, doi.org/10.69755/2995-2212.1000, and Tobias Winright, "Peace on Earth, Peace with Earth: *Laudato si'* and Integral Peacebuilding," in *All Creation is Connected: Voices in Response to Pope Francis's Encyclical on Ecology*, ed. Daniel R. DiLeo (Anselm Academic, 2018), 195–211.