II ступінь – виражена висипка, головний біль, тромбоцитопенія, гіпоальбумінемія.

III ступінь – тяжкий стан, блювання, біль у животі, набряк суглобів, висока температура [4].

Діагностика: клінічні прояви, підвищення рівня фактора Віллебранда, гіперфібриногенемія, високий рівень імунних комплексів [4].

Лікування:

– госпіталізація, суворий ліжковий режим;
– виключення харчових алергенів;
– гепарин під контролем згортання крові;
– гепаріноїди (сулодексид, ломапаран);
– при неефективності – стероїдні гормони (преднізолон);
– санація хронічних вогнищ інфекції;
– заборона вакцинації на 2 роки [4].

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HEALTHCARE SYSTEM IN THE DEMOCRATIC REPUBLIC OF CONGO AND MITIGATION OF STATE FRAGILITY

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This paper addresses a critical and often underexamined dimension of state fragility in the Democratic Republic of Congo (DRC) – the structural weakness of its healthcare system. Persistent issues in managing public health challenges,

particularly recurrent outbreaks of zoonotic viral diseases such as Ebola and Lassa fever, and vector-borne parasitic diseases such as malaria, threaten security and erodes institutional legitimacy, deepening vulnerabilities within the state apparatus. By examining healthcare at the nexus of development, governance, and security, this paper underscores the necessity of health system reform as a strategic priority. It advances a policy framework centered on a comprehensive approach that integrates short-term interventions with long-term improvements, essential for addressing immediate risks and for laying the groundwork for sustainable development and mitigating structural drivers of state fragility in the DRC.

The DRC stands at a critical juncture in its pursuit of sustainable development, constrained by a fragile state apparatus and underperforming healthcare system. These issues are interconnected drivers of state instability, since there is a direct correlation between the healthcare system and state fragility. Political volatility, conflicts and administrative dysfunction impair aid delivery, exacerbate health disparities and limit state's capacity to manage crises, while failures in healthcare undermine the legitimacy of state institutions. This reciprocal dynamic reinforces a cycle of weak governance and poor health outcomes mutually deepening structural fragility.

The DRC consistently ranks among the most fragile states globally, with minor recent improvements. As of 2024, the fragility index was 106.7 out of 120 [2], and according to fragile state index, the DRC was ranked 5th country out of 179 countries [2]. The persistent weakness of DRC's healthcare contributes to the country's structural fragility. The healthcare system faces a confluence of structural and contextual challenges, such as chronic underfunding, lack of resources, historical challenges and persistent regional instability collectively, hindering its capacity to effectively respond to health crises. These deficits compromise institutional capacity, weaken public trust, and exacerbate human insecurity. The DRC's location in the Congo Basin, one of the world's most biodiverse zones, increases susceptibility to zoonotic spillovers due to environmental degradation and deforestation. Climate change and habitat encroachment push animal populations closer to humans, structurally embedding the risk of novel viral emergence.

The second largest outbreak of Ebola virus globally, and the most severe in DRC's history, occurred in 2018 with reported number of cases being 3,470. Reported number of fatal cases was 2,287, indicating fatality rate of approximately 66%. Declared over in June 2020 by the World Health Organization (WHO) [3], this outbreak is often referred as Kivu Ebola epidemic, demonstrated how military conflicts and regional insecurity obstruct containment, overwhelm infrastructure and intensify state fragility. The WHO described the combination of military conflict and civilian distress as a potential "perfect storm" that can rapidly worsen the outbreak [4, 5]. During Kivu Ebola epidemic,

the U.N. Security Council had to call for an immediate end to hostilities to combat the outbreak, stressing the urgency of getting medical teams to the affected areas because the disease can spread, impacting regional stability [7]. According to the WHO, health workers were attacked, some aid organizations withdrew due to violence [6]. Likely militias viewed them either as political threats or collaborators with foreign entities. The destruction of facilities and looting of supplies interrupted treatment and containment, and deepened public mistrust, especially in communities that have been historically neglected or abused.

The DRC's healthcare system suffers from underinvestment, infrastructural deficits, and lack of resources, limiting its ability to manage health crises. These weaknesses are magnified during epidemics, where institutional fragility becomes especially dangerous. The state's fragility reflects in inability to deliver basic health services for the population, and in its constrained capacity to coordinate and absorb international assistance. Despite bilateral, multilateral and organizational support mechanisms, the reception of such aid is often hindered.

Cultural norms regarding death and burial practices posed challenges during Ebola outbreaks [8, 9], as dead bodies remain infectious; thus, traditional rituals and embalming practices increased transmission risk [10]. Community mistrust, rooted in colonial legacies and cultural practices complicated outbreak containment and strained resources. As Ebola outbreaks has shown, one notable obstacle is the perception of medical personnel as potential spreaders of the disease or oppressive forces. In some communities, traditional beliefs about the origins of the virus and the role of healthcare workers contributed to suspicion and fear, illustrating how sociocultural dynamics interact with state fragility, resulting in obstacles for the outbreaks' containment. Under-five mortality is high in the DRC due to pneumonia, diarrhea, and lack of safe environment [11]. Malaria remains a major public health burden in the DRC, accounting for a significant share of global malaria mortality. As of 2022, in DRC it caused over 27.3 million cases and nearly 24,880 malaria-related deaths [12], with estimated 97% of the DRC's population living in zones with stable malaria transmission, mostly affecting pregnant women and children [13]. National efforts are constrained by limited access to preventive tools, diagnostics and medications.

Logistical constrains and fragmented data systems impair healthcare interventions in the DRC. Remote regions remain physically isolated due to lack of paved roads, electricity, and communication network, delaying the transport of medical supplies, establishment of treatment centers, especially during rainfall seasons. These structural barriers undermine public health resilience. The lack of a centralized data management system impairs coordination, disease tracking and resources allocation. Inconsistent records, limited digitalization, and fragmented communication between health authorities delay outbreaks containment. Without real-time data, decision-makers are unable to scale

the outbreaks, identify priority zones, or deploy resources efficiently. Strengthening information systems by using digital tools, standardized reporting, and trained personnel, is essential for the enhancement of capacity to respond to both endemic and emerging threats.

The DRC's complex healthcare challenges both reflect and reinforce patterns of state fragility. The DRC's acute vulnerability to disease outbreaks underscores the urgency of a comprehensive and resilient health strategy. Existing policies are insufficient, as evidenced by the failures to respond effectively to public health emergencies. Policy frameworks shortcomings, unreliable funding, deteriorated or absent infrastructure, the disruptive impact of armed conflict, and the systemic fragility of emergency response mechanisms – are compounded by shortages of medical equipment and professionals, fiscal constraints, and corruption. These interlocking deficiencies constitute a structural barrier to health reform, impeding the development of a coherent and effective public health strategy capable of withstanding both routine pressures and exceptional crises.

Two distinct approaches can be identified to address the structural deficiencies of the DRC's healthcare system. The first and most comprehensive approach involves a systemic overhaul of the healthcare sector. While resource-intensive and dependent on international support, it addresses structural vulnerabilities at their root. This approach entails large-scale investment in infrastructure, facilities modernization, workforce training, and the expansion of preventive communitive care. An enhancement of the healthcare can generate positive ripple effects in other sectors, contributing to improved societal well-being, bolstering national stability, and mitigating drivers of state fragility. The capital investment to build and modernize healthcare facilities would stimulate economic activity, increase employment, and produce spillover effects in related sectors, fostering economic development. However, this approach demands increase of public expenditure and sustained external financing – raising concerns over long-term dependency. Given the DRC's economic constraints, reform implementation would require strong political will and the alignment of multiple donors. Tangible results may take years, during which transitional disruptions and institutional friction could temporarily degrade service quality, fueling public discontent and reinforcing fragility. Resistance from entrenched interests may further obstruct progress. Yet despite these challenges, systemic reform remains the most transformative and necessary path to sustainable healthcare.

The second approach – targeted improvements within the existing system – offers a more feasible option in a resource-constrained environment. It acknowledges limited but real progress of the DRC and seeks to address specific gaps without pursuing full-scale reform. By directing resources towards high-impact areas, it can deliver improvements in underserved regions, reducing

institutional overload. However, the disadvantages of this approach are notable. It fails to address structural deficiencies and reinforces inequalities, especially if driven by political or donor interests. Focusing on symptoms over root causes, it risks entrenching a cycle of patchwork solutions and lost opportunities for transformative change. Without a coherent national strategy, such fragmented improvements lack the scalability and integration needed to produce lasting effects. This approach may address immediate concerns, but the long-term efficacy and adaptability of the healthcare system may be compromised.

Healthcare plays a vital role in post-conflict reconstruction and peacebuilding. In conflict-affected regions of the DRC, it serves not only humanitarian needs but also functions as strategic instrument for restoring legitimacy and social cohesion. Integrated with broader peacebuilding framework, healthcare reform enables a shift from reactive crisis management to proactive state-development. As both a barometer and vehicle of state capacity, equitable access to healthcare mitigates grievances, reduces community tensions, and restores a sense of normalcy. Through policy reform, infrastructure investments, and collaborative engagement, the DRC can build a resilient healthcare system capable of mitigating state fragility.

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