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**DEMOCRATIC REPUBLIC OF THE CONGO**

**MINISTRY OF HEALTH**

**SECRETARIAT-GENERAL**



**HEALTH-SYSTEM STRENGTHENING  
STRATEGY**

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## *Preface*

The development of the Democratic Republic of the Congo relies essentially on the good health of its population, which provides a vital driving force for action in the political, economic and social spheres. The population's state of health is largely determined by the effectiveness of the country's health system, which needs to be capable of preventing diseases, restoring health and contributing to the development of conditions needed to secure an ideal: a state of complete well-being for every one of the country's citizens.

Responsibility for guaranteeing the state of health lies primarily with the Government; it must achieve this, where the health sector is concerned, by making available facilities that provide quality care and which meet the fundamental needs of the population.

In order to ensure effective operation, it was decided to organize health facilities into a harmoniously structured system, known as the zone-based service, in which all actors, whether public or private, national or international are familiar with their own and each other's role.

While such a system was in place in the country some thirty years ago, nowadays it is but a distant historical memory.

The current health system is disorganized and seems to be on its last legs. The National Health Policy and the Master Plan for Health Development are but historic documents, which exist on paper but are not put into practice in the field.

The central agencies, which are supposed to play a normative and regulatory role, do so only imperfectly and undertake measures outside their sphere of competence. Under these conditions, those numerous foreign partners that are willing and ready to assist us devote no small part of their resources to funding actions which, although praiseworthy, are inconsistent with the development of a sustainable health service. Too many resources are devoted to attaining short-term goals. The population's health situation continues to worsen because people have very limited access to essential quality health care and there is a shortage of medium and long-term funding.

Were we to continue along this path, we would push the country further into the abyss of under-development. The time is more than ripe for change.

This **Health System Strengthening Strategy**, which has just been drawn up by the Ministry of Health, is designed to provide a frame of reference for action to develop synergy for improving the population's state of health. It will be a tool for integrating any action carried out by the Ministry of Health's partners.

It will contribute towards the achievement of national priorities and of the country's global and sub-regional goals and in particular poverty control and the attainment of the Millennium Development Goals.

The strategy is also part of the broader framework of public-sector reform and is designed to provide the latter with the inputs it requires in order properly to shape the different levels of the health service.

Finally, it reaffirms Primary Health Care as the foundation of health policy and the health zone as the operational unit for the health service in the Democratic Republic of the Congo.

Emile BONGELI YEIKELO YA ATO

Minister of Health

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Publication of the document on the Health System Strengthening Strategy (HSSS) provides me with an opportunity to express my thanks to all those who have contributed, either directly or indirectly, to its preparation. My thoughts go, in particular to those Congolese officials who have taken stock of the responsibility they bear towards history and have agreed to support the Department for Studies and Planning in its task of assisting with the development of the Ministry of Health's policies and plans.

The Health System Strengthening Strategy set forth in this document is the outcome of team work based on deep reflection and field visits over a period of approximately one year (2005).

I am certain that the team, which goes under the name of the Support Group for the Health System Strengthening Strategy (HSSS), and whose members are Jean Pierre LOKONGA, Jacques WANGATA, Didier MOLISHO, Jean BOSCO KAHINDO, Albert KALONJI, Emile BONGO, Michel MULOHWE MWANA KASONGO, Florent EKWANZALA, Pierre LOKADI, Remo MELONI, SIMBI AHADI, Raphaël NUNGA, Bertin EPUMBA and Hyppolite KALAMBAY, has not only drawn deeply on its own experience to conceptualize the health-system model we wish to introduce through these strategies, but has also and above all devoted much time to the task. Allow me here to express my sincere thanks to the team as a whole.

I should also like to thank Professor Wim Van LERBERGHE and Dr Marthe Sylvie ESSENGUE of the Health Policy and Strategic Planning team at WHO in Geneva, Dr Barry SAIDOU, responsible for planning at WHO/AFRO and Dr Salif SAMAKE, Director of the Department of Studies and Planning at the Ministry of Health in Mali who helped to improve the content of the document during their support missions for health-sector reform in the Democratic Republic of the Congo. I am also grateful to Dr SONGANE from the new Global Partnership for Maternal, Newborn & Child Health for his valuable advice during the Ministry of Health's annual audit.

I would be remiss if I failed to mention all those who, by their contributions during the different meetings at which the HSSS was presented and discussed (meeting of partners on 16 December 2005, annual 2005 audit, etc.), helped to improve the quality of the work.

Finally, I should like to express my warm thanks to the kingdom of Belgium whose material, financial and technical support, through Belgian Technical Cooperation, for the Department of Studies and Planning enabled it to carry out its missions to the provinces and to organize the meetings and discussions which have led to the development of this strategy.

DR Constantin MIAKA mia BILENGE

Secretary-General for Health

### ***List of abbreviations***

ADB	African Development bank
CPA	Complementary package of activities
DMO	District medical officer
DRC	Democratic Republic of the Congo
DSP	Department for Studies and Planning
EDF	European Development Fund
EPI	Expanded Programme on Immunization
FONAMES	National Medical and Health Fund
GRH	General referral hospital
HC	Health centre
HDI	Health district inspectorate
HIPC	Highly indebted poor country
HIV/AIDS	Human immunodeficiency virus/Acquired Immunodeficiency syndrome
HP	Health post
HR	Human resources
HRE	Health in a rural environment
HSSS	Health System Strengthening Strategy
HSRSP	Health Sector Rehabilitation Support Programme
HZ	Health zone
IHC	Integrated health centre
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goal
MICS 2	Multi-Indicators Cluster Survey
MoH	Ministry of Health
MPA	Minimum Package of Activities
MPH	Master's in Public Health
MPHD	Master plan for Health Development
NASTICP	National HIV/AIDS and STI Control Programme
NGO	Non-governmental organization
NHATCP	National Human African Trypanosomiasis Control Programme

NHP	National health policy
NOCP	National Onchocerciasis Control Programme
NRHP	National Reproductive Health Programme
NTCP	National Tuberculosis Control Programme
PHI	Provincial health inspectorate
PMO	Provincial medical officer
PRSP	Poverty Reduction Strategy Paper
RHC	Referral health centre
SWAP	Sector-wide Approach
TA	Technical assistance
TMI	Technical medical institute
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USD	United States dollar
WHO	World Health Organization
WHO-AFRO	WHO Africa Region
ZMT	Zone management team

## ***Foreword***<sup>1</sup>

Since its adoption of the primary health care strategy and its endorsement, in 1980, of the African Charter for Health Development, the Democratic Republic of the Congo has constantly determined its health policy by the basic principles of organization and operation of public health services.

While official documents continue to refer to primary health care as the strategy for implementing health policy, it is increasingly obvious from current trends that the problem currently facing the health system of DRC is, inter alia, the lack of a common vision of the structure needed to address the overall health problems of the population.

This lack of vision prevents the different actors (those in the field, senior and middle managers at the Ministry of Health and donors) from establishing the link between primary health care and the health zone, which is defined as the operational unit whose development remains the prerequisite for implementing health policy. This fundamental link, which existed until around 1985, has disappeared over time to the extent that nowadays, the health zone has become a rather worn concept.

The health zone, which once was an integrated two-level health system, formed by a network of health centres and a general referral hospital, has now become a hotchpotch of actions and actors whose prime concern is to offer a high profile to donors rather than to meet the expectations of the target populations. In this way, the Minimum Package of Activities (MPA) has been sliced up into selected packages of activities, and the general referral hospital, which is considered as a "non-zone" facility, finds itself competing with the health centres. In addition, under the pretext of taking care closer to the population, a range of intermediate facilities have developed (community intermediaries, health posts and referral health centres) not all of which are necessary and many of which are harmful (health care of dubious quality, and competition with any attempt to rationalize the two levels).

The change in the political regime that took place in May 1997 raised hopes for the country's reconstruction. The preparation of the Master Plan for Health Development 1999 – 2008 (MPHD), needs to be seen in this context. In this respect, the audit of the health sector noted: "in order to set right the health situation that has prevailed in the country for several years, it is necessary to implement a health-development plan as an integral part of the national social and economic development plan and of the poverty elimination plan" (Health-sector audit, 1998).

The organization, in 1999, of the States-general for Health marked the starting point of a new agenda for the health sphere, with the adoption of four documents: - draft framework-law on public health; - draft organizational framework for the Ministry of Health; - draft health-sector policy statement and master plan for health development.

However, it was not long before the reform of the health sector in DRC and the different fora held after the States-General for Health (national SANRU 3 symposium: let's rebuild primary

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<sup>1</sup> In this document, the terms revitalization or development of health zones are used to refer to the same concept.

health care, round table on health, annual audits by the Ministry of Health, etc.) were seen as mere academic exercises, as pandering to a fashionable trend, « health sector reform».

The need for a new commitment persuaded the Ministry of Health to set up a working group to consider the health system, organized around the Department for Studies and Planning. The group, composed of managers from DSP, from the Department of Primary Health care, from the internal diaspora (Congolese managers working for partners or on their own account and who had gathered experience of health-system organization), received technical support from WHO at Geneva and from AFRO in drawing up the Health System Reinforcement strategy.

This Health System Strengthening Strategy document, which is the fruit of a consensus among health system actors (meeting of partners, 16 December 2005, annual audit by the Ministry of Health, February 2006) is divided into two parts. The first, more generic part, attempts to identify the essential elements of the problems faced by the health system with a view to making a commitment to providing a response, and the second, more concrete, sets forth the essence of that response, the Health System Strengthening Strategy (HSSS).

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## **I. STATEMENT OF THE PROBLEM**

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## 1.1. Historical development of the health system

The historical development of the health system of DRC, like that of other African States, is marked by its institutional character and by the role played by the authorities.

When it acceded to national sovereignty, DRC inherited a health system that relied essentially on hospitals and clinics, backed up by mobile teams for controlling major endemics. The manifold political crises that beset the country immediately after independence, and which were accompanied by the gradual collapse of the economy, did not spare the health sector. As a result, the country's numerous hospitals and clinics were rapidly stripped of their equipment and the drug-supply chain broke down several times between the central level and points of use. Remote areas were most affected.

The need to reorganize the health system in order to address the situation was clearly underscored in the Manifesto on Health and Well-being, which was published in 1968. In order to put this orientation into practice, in 1973 the National Council for Health and Well-being was set up. The Council, which had an intersectoral vocation, was to be responsible for designing, directing and monitoring national health policy.

Alongside the major political developments, the 1970s were marked by experiments with community medicine, carried out respectively in Bwamanda (Equateur province), Kisantu (Bas-Congo province), Kasongo (Maniema province) and Vanga (Bandundu province). These experiments were decisive and were to leave their stamp on health policy in DRC. It was these experiments that gave rise to the first decentralized facilities which the population helped to run: the health zones.

Although several reflections, nourished moreover by experience from the field, took place, not until 1984 was there a specific document devoted to health policy. In 1984 DRC completed the definition of its health policy and strategy, thus giving concrete expression to its accession to the Charter for Health Development in Africa.

This process, which began in 1975, at the instigation of the then Minister of Public Health, with the organization of the first national conference on community medicine under the impetus of two faith-based networks involved in providing health care (catholic and protestant), would have to await the 1982 – 86 Health Action Plan and at the same time the Economic Reconstruction Plan 1983 – 86 before the political authorities turned their minds to primary health care, and the Health Zone (HZ) was instituted as the operational unit for planning and implementing the new primary-health-care based policy.

1985 saw the completion of the division of the country into health zones; it was also the last year of action inspired by a health -system vision. It was also the year in which FONAMES (the National Medical and Health Fund) was reorganized, resulting in a change in its mission from controlling epidemic and endemic diseases to coordinating, on behalf of the Ministry of Health,

assistance provided for health zones by partners. Unfortunately, FONAMES was never to perform this function, and assistance from partners to health zones continued to lack coordination.

The period 1987 – 1991 saw a waning in partners' enthusiasm for the extension of coverage via operational health zones. There were a number of reasons for this: - the training project for health zone managers (UNDP-WHO), which was implemented by FONAMES, emphasized the role of the health zone medical officer as the representative of the Ministry of Health rather than as a member of the health zone team; decisions taken unilaterally to transfer health zone medical officers who posed problems (guilty of poor management) to properly-run health zones with complete disregard for the merit principle; - unilateral decisions by the Ministry of Health to transfer health zone medical officers with training in public health (MPH) from properly run health zones to administrative functions at the middle and national levels;

The period from 1993 to date has been marked by humanitarian assistance and missed opportunities. At the national level, the period saw the change of political regime in May 1997, which offered an opportunity to reconsider all aspects of national life. There were several meetings of importance to health: - the States General on health in December 1999; - the SANRU symposium in February 2003, organized around the theme of "let's rebuild primary health care in DRC" through the community approach, better management, dynamic leadership and integration of programmes, partners and other sectors of society, and the convening, in May 2004, of the Round Table on health.

However, the question that arises is why is the health system's performance is worse than it was before 1985, even though funding for the health sector, while still inadequate, has never been as generous as today?

## **1.2. Characteristics of the health system**

The emergency situation which has been the consequence of the social and political upheavals besetting the country since 1990 resulted in humanitarian interventions whose approach to health problems was essentially ad hoc. As the economic and social situation returned to normal, these interventions were supposed gradually to give way to action for development. Unfortunately, they have become entrenched, concealing their true nature: a tool disorganizing the health system in DRC.

This ad hoc approach to health problems, which assigns priority to control measures targeting certain diseases considered most fatal, reached its peak with the adoption in September 2000, at the United Nations Millennium Summit, of the Millennium Development Goals (MDG), whose aim was to speed up poverty reduction. At the international level, this was reflected in the creation of a range of ad hoc programmes and funds to address specific health problems.

Clearly, within DRC, it is common sense that the present organization of the central Ministry into 13 Directorates-General and 52 specialized programmes makes it very difficult for the Secretary-General for Health to ensure the coordination among sectors for which he is responsible, and leads inevitably to overlapping in the tasks and responsibilities of the directorates and specialized

programmes. This state of affairs inevitably has consequences on the supply of health care at the operational level.

In addition, the individual and institutional survival strategies in place for several decades, and which have over time become inherent features of the institutional set up (in particular in the Ministries of Health and Education) have led to an uncontrolled multiplication of both training and health care facilities. In 2005, there were some sixty faculties and other university-level establishments offering training in health. Since 1998, the number of TMI (Technical Medical Institutes) has increased by about 15% each year. At present, there are 362 TMI offering training in nursing and other auxiliary professions. Of this total, 241 have been officially approved, and 121 are waiting for approval. These figures include only those facilities registered with the Ministry of Health in Kinshasa. The actual figure is certainly higher.

Behind this trend at the central level, a trend towards a multiplication of office emerged at the intermediate level; the rationale behind it was the desire to replicate the tasks performed by the central departments and to establish coordination offices and focal points for specialized programmes. In this way, the two echelons at the intermediate level - the provincial and district medical officers - determined their priorities on the basis of those of the central level.

At the operational level, besides the introduction of a new division of health zones, integration of facilities within the zones posed problems (hospitals followed their own path and competed with health centres). Most programmes subsidized by donors extended their activities to the peripheral level. Rather than being implemented in an integrated fashion by an all-round team, the MPA became an ad hoc tool implemented by specialized staff.

The distinctive feature of the health system became its disintegration, which was reflected in the breakdown of links between its components, uncontrolled practice of medicine, production of health services of dubious quality and their dehumanization.

### **1.3. Problems and their possible causes**

The problems pinpointed during various field visits in 2005 fall into 6 categories :

#### **1. Factors attributable to emergency situations.**

The emergency situations which have prevailed in recent years, with the consequent desire to deal with everything at once, have provided a pretext for intervening in disparate fashion without a consistent approach. One of the consequences of this has been the multiplication of infrastructures without any effort to rationalize health coverage. In line with the rationale of providing health care locally, referral health centres (RHC), in which surgical operations are carried out, were set up in health zones along with health posts (HP). Apart from the harmful impact of RHC and HP on the quality of care, another consequence of these trends, through their inefficiency, was their impact on the long-term sustainability of the system not only in economic, but also technical terms.

## **2. Absence of a proper frame of reference to define the services of a zone.**

Apparently, the role of the hospital as an organizing element of the health zone and a support structure for the development of primary-level services seems to have been "overlooked". Splitting responsibility between the hospital management and the health zone (chief hospital medical officer and chief zone medical officer) is another factor that disorganizes the system.

The idea that the polyvalent team from the HC operates by delegation from the zone management team (ZMT) seems to be gradually giving way to the introduction, at the health-centre level, of disease-control activities that are subdivided in accordance with well-funded priority programmes (NTCP, EPI, NASTICP, NRHP, NHATCP, NOCP,...). As a consequence, the notion of integration, of a global approach and of continuity characteristic of PHC fade away and supervision loses its substance as a tool to provide continuing training that serves to improve the overall skills of staff responsible for services and in contact with the population.

At the level of the health zone management team, there is little **team work**. This is essentially because the facilities in the health zone (HC and GRH) are not (or only barely) perceived as integrated facilities which, although having specific functions, are complementary and need to coordinate their activities.

While there is an unquestioned consensus over the need to develop health zones in line with the recommendations of the normative framework for the health sector (NHP and MPHD), it is equally true that the actors in the health sector have not yet reached an agreement over how to proceed or on what strategy (principal interventions) is to be implemented in order to develop the health zones. This lack of a common vision has been denounced at several meetings organized within the health sector; the May 2004 health sector Round Table, the 2004 annual audit, etc. The strategy for the reinforcement of the health sector set forth in this document, and which relies essentially on developing the zones, is designed to fill this gap.

## **3. The funding system and its undesirable effects**

The health sector in DRC is essentially funded from three sources: the State budget, external (bilateral and multilateral) contributions and recovery of the cost of care and services from users (up to 70% of operating costs).

The State health budget and its rate of implementation are both weak. For example, in 2001 less than 1% of the State budget was devoted to health, and the rate of implementation was 50%. Since then the budget has certainly grown, although it still falls far short of the sector's needs.

With the gradual withdrawal of the State from health-sector funding, there has been a growth in financial flows through which patients' contributions are channelled back to finance the upper administrative levels. This practice has developed even more since the 1990s, when health centres and hospitals were required to pay from 5 to 10% of their revenue to the central health zone offices (CHZO), which had to do the same to the provincial office, which in turn paid the central level. These payments were used to run activities, but also to pay staff at the different

levels. Over time, this informal taxation system became entrenched and was one of the driving forces of the system, ensuring the financial survival of individuals and institutions.

This «survival» system is also fed by a range of channels which include, in particular, all sorts of operating permits or permits to open for private actors, fines and taxes, etc. An unregulated private sector has developed. In the absence of any mechanism to ensure quality of care, anarchic development of the private sector is a threat to the health of populations and a source of inflation in health-care costs and thus of deeper poverty (as households are the major contributors).

It is true that external funding for health has increased since 2001, although it is mainly intended for vertical programmes (Global Fund to Fight Malaria, HIV/AIDS and Tuberculosis, Multi Country AIDS Programme...etc.). The fact that funds intended for vertical programmes were almost the only ones available in the health sector following the redefinition of national health policy undoubtedly contributed to the marginalization of the primary-health-care strategy and of the health zone as an operational unit.

The health sector's heavy dependence on external funding went hand in hand with malfunctions that were apparent in the MoH structure at both the central and intermediate levels: multiplication of the number of specialized departments and programmes.

Besides creating matching structures at the intermediate level, programmes also vacuum off considerable resources from the intermediate level to frequent meetings at Kinshasa. Rather than concerning itself with providing support for the development of the HZ, the intermediate structure has its eyes turned upwards, to where it may find immediate benefits.

Against a background of poverty, a certain "political class" sees humanitarian interventions as the only means of providing resources (vehicles, motorcycles, generating units, etc.) for "its community", this is one of the reasons why the number of health zones shot up from 306 to 515 in 2003.

#### **4. Poorly understood community participation**

Once it had been recognized that services operated poorly, there was an intense development of "community intermediaries" whose qualifications and technical skills are too poor for them to represent an alternative to qualified health workers. While there were sound reasons for resorting to « community intermediaries » in the 1970s, the situation has changed completely and the context within which the health sector operates is one of a surfeit of nursing staff and a surge in the number of medical training establishments.

One of the central ideas of community participation is that the population should be able to say what it thinks about what is being offered to it: this is far from the case. Nevertheless, the population contributes approximately 70% of the funding for recurrent expenditure of some health zones.

## **5. The Problem of human resources**

Although they are only partial, the data currently available show that human resources for health pose a serious problem in DRC. While in 1998 there were approximately 2000 physicians and 27 000 nurses in the country, their present number is hard to estimate. As has already been mentioned, there are almost 60 higher-education establishments providing training for physicians and nurses in the country. Almost 1500 physicians graduate each year from the universities of Kinshasa and Lubumbashi alone. There is every indication that their number has increased considerably since the beginning of this century. The Technical Medical Institutes (TMI), of which there are approximately 362 in the country, train some 7000 nurses each year. The number of nurses too, is rapidly growing.

The pernicious effects of this excessive number of personnel are already being felt in the field. For several years, the number of health facilities in the HZ has been increasing. There are more and more health areas in which there are more than 10 health facilities. Most of these have been set up by surplus health personnel who have failed to find work in a formal structure. For reasons of individual or institutional survival described earlier, these facilities offering health care of somewhat dubious quality are kept running because they contribute to the running of the higher levels of the system.

The modest salaries currently earned in government service are another factor that seriously jeopardizes the implementation of our primary-health-care based health policy and the attainment of other national or international priorities (MDG). Apart from encouraging the survival strategy described above, the unattractive salaries mean that staff turnover is high, as people are constantly in search of a better salary.

Poor staff motivation has resulted, through the rationale of supporting ad hoc interventions, to the adoption of performance bonuses and other forms of per diem payment, whose harmful effects on staff and services rapidly became apparent. Such a system inevitably leads to fee-for-service payment, which is in complete contradiction with a global approach to health and contrary to the principle of solidarity adopted by the national health policy.

The far from equitable distribution of human resources between rural and urban areas is another problem which the management of human resources for health has to address in DRC.

## **6. Absence of leadership for the sector from the Ministry**

The consequences of the almost constant decline in the share of the State budget devoted to health include (i) loss, by the Ministry of Health, of a considerable degree of its autonomy to decide, orient and direct national health policy and the sub-sectoral policies, (ii) inadequate coordination among donors operating in the sector because of a shortage of national managers capable of ensuring coordination on the basis of clearly defined policies and strategies (a considerable number of national managers have gone over to partners and a similar number have gone abroad), (iii) lack of control by the Ministry over the sector's funding, which leaves health-sector officials in a position where they have no idea at the beginning of each budget year of the funding that will be available to implement national health policy, or of its source, rendering vain

any attempt at long-term planning, (iv) the health system's conceptual model, whose basic operational unit is the health zone, is seriously disturbed by other models through which donors channel their funding.

To conclude, the pressure of circumstances, the most noteworthy of which are poor governance, armed conflicts and the weakness of the Ministry's leadership of the sector because of a constant decline in national resources devoted to health, has led to the development of health services of somewhat dubious quality, whose main features are summarized below :

- 1 **breakdown in links between or fragmentation of services in the health zone** on account of the allocation to the sector of insufficient national resources and the consequent loss of the Ministry's regulatory role along with its role in coordinating donors. This breakdown of links is reflected on the one hand by the marginalization of the general referral hospitals, which finds themselves competing with health centres (funded by the sector's partners) thus upsetting the referral and counter-referral mechanisms, and on the other by the fact that the health centres are tuned to meeting the needs of vertical programmes and partners rather than those of the ZMT, which are gradually disappearing.
- 2 **Uncoordinated, barely efficacious and inefficient vertical interventions** designed to address emergencies or humanitarian needs **instead of integrated, continuous and comprehensive services**. These vertical programmes receive subsidies from the international community (Global Fund, World Bank, etc.), which for several years represented almost  $\frac{3}{4}$  of overall health funding.
- 3 **The emergence of private for-profit services lacking any coordination and of dubious quality** and which make it even more difficult to organize the provision of quality health care. This is partly attributable to the supply of medical staff (physicians and nurses) which increasingly exceeds demand and for whom private practice is the only option left, as well as to the development of individual and institutional survival strategies resulting in the uncontrolled opening of a plethora of health posts, clinics, so-called referral health centres performing surgery and Technical Medical Institutes.

As a rule, the use of health services reflects their performance. As is to be expected, the poor quality of the health services available has had a very negative impact on their use.

According to the World Bank report *Health and Poverty in DRC* (World Bank, 2005) the average rate of use of health services is 0,15 (0.07 – 0.42) consultations per inhabitant per year, signifying less than one consultation per person every six years. This rate was measured on the basis of approximately 54% of the total population of DRC.

Two thirds of patients in DRC do not rely on the formal health-care system for treatment, either because no services are available, because those available are of poor quality or because they cannot afford them. According to a study carried out by the Public Health School at the University of Kinshasa in 2003, 30% of family members who fell ill went to a public or denominational health centre, 40% treated themselves, 21 % went without treatment and 9%

consulted a traditional healer. This means that some 70% of patients are without access to modern health services.

#### **1.4. The role of donors in the evolution of the health service**

Analysis of the climate in which external partners intervene shows that not all of them have as their agenda the sustainable development of the health system in DRC.

The introduction, at the intermediate level, of structures representing the Ministry of Health's partner institutions poses several problems for an already fragile health system. These include: (i) growing conflicts with structures to which they are supposed to provide support, (ii) further accentuation of the vertical nature of the system through intervention by these support structures, even inside health centres and communities, (iii) considerable inefficiency in use of the resources made available to structures at this level and (iv) a gradual shift in the role these partners are supposed to play from that of providing support to that of provider.

The risk of finishing off a health system which is already in its death throes is even greater when lack of proper leadership and of a shared vision of the health system required are compounded by the struggle of some Ministry of Health Managers to ensure their own survival, and for which they form alliances with these very partners.

There has been a multiplication of central structures out of the belief that this will offer access to external funding; (since 2002 the number of departments within the Ministry has risen from 7 to 13 and the number of programmes from 17 to 52). Apart from its inherent inefficiency and the difficulty of managing facilities in a coherent manner, this leads to frequent overlapping, tension and conflict.

At the instigation of some financial partners, a new socioprofessional category has come into being, the community intermediary (CI), whose role is described as follows: "community intermediaries shall be responsible for treating diarrhoea, pneumonia, malaria, for promoting and gaining acceptance for family planning, for promoting the 12 key behaviours in the community IMCI package, and for identifying and referring obstetrical complications to the health centre or directly to the first-level referral hospital". In addition to this category of "general" intermediaries, there are also programme-specific intermediaries.

The need for data on the outcomes of the different programmes implemented and/or financed by external partners has made it necessary to reorganize the Ministry of Health's health information system, which has been rearranged into 12 independent parts. If the population really is the central concern of the health system, we have to admit that data collection for the higher levels has taken precedence over evaluation of health services and rational organization of data on patients. From performing a management-support function for health services, data collection has become an undeclared 'specific programme', whose operation, relatively speaking, costs more than funding for health services.

There are clear contradiction in the policies and methods of funding of some external partners. Many of them practice double, parallel standards: on the one hand "system - funding" in the form of support for health zones, and on the other "programme - implementation funding".

## **1.5. The Millennium Development Goals and the health system in DRC**

At one time, the health system in DRC was one of the most efficient in Africa, so much so that it inspired reflection about health reform at the international level. The period during which it fell apart (from 1990 to date) was also the period during which most of the country's social and demographic indicators became negative, as can be seen from the health-sector audit (Ministry of Health, 1998) and from MICS2 (Ministry of Planning, 2001). This shows that the negative results of the MDG indicators for health in DRC is a consequence, inter alia, of the weakening of the national response to the principal health problems because of the break-up of the system.

This break-up was largely due to the environment in which the system operated (bad governance, armed conflict, marginalization of human resources for health, who are managed by the government service in DRC, etc.).

As specific example, we may cite the following MDG indicators:

### **1. Overall, infant and maternal mortality**

Retrospective mortality surveys have shown that the mortality rate among populations affected by armed conflicts is extremely high, and an estimated 3.8 million deaths can be attributed to war since 1997. Between 1990 and 2001, Infant and child mortality rose respectively from 192 to 220 deaths per 1000 live births. The current rate corresponds to some 450 000 to 500 000 annual deaths among this age group (estimate based on a population of 58.3 million).

In the war zones, the infant and child mortality rate is extremely high. In the eastern part of the country it has been estimated that it was as high as 408 deaths per 1000 live births in 2002. The maternal mortality rate, which was 850 deaths per 100 000 live births in 1985, rose to 1289 per 100 000 live births in 2001; in other words 36 000 women die each year in childbirth, one of the highest rates in the world.

### **2. Prevalence of HIV/AIDS**

Prevalence of HIV/AIDS in DRC is estimated to be 4.5%; this testifies to the fact that HIV/AIDS infection has spread from the risk groups into the general population. Prevalence is very high among risk groups. Among prostitutes in Kinshasa, it is estimated to be 30%. Selective studies have shown a clear increase in seroprevalence, especially in the eastern part of the country, where it is as high as 24.8% among pregnant women (Save the Children, UK 2001). This level of prevalence corresponds to some 1.2 million HIV-infected adults, and there are an estimated 100 000 deaths each year from HIV/AIDS. In 2004, UNAIDS estimated that the number of AIDS orphans was 700 000. In 2004, only 5000 patients were receiving antiretroviral treatment in the country as a whole.

### **3. Malaria-control indicators**

No data on malaria are available from the pre-1985 period for comparison with current data. However, there is every indication that the breakdown of the health system has had a harmful impact on efforts to control this endemic disease. Despite the establishment of the National Malaria Control Programme (NMCP) and the definition of a policy, there is a gap between the principles set forth in the malaria control policy and what practitioners actually do. Until recently, it was not unusual for partners in some parts of the country to continue supplying health centres with chloroquine even though that molecule had already been replaced by sulfadoxine-pyrimethamine as the first-line treatment.

Ninety-seven per cent of the population of DRC are exposed to endemic malaria and the remaining three per cent are exposed to epidemic malaria in the high mountainous area in the east of the country. Prevalence of fever among under-fives is 42%. This corresponds to between 6 and 10 episodes annually per child. The total annual number of malaria episodes in the country ranges from 60 to 100 million, depending on the estimate. Since the beginning of 2005, amodiaquine-artesunate combination has been introduced as the first-line treatment for malaria in DRC. However, quinine is still being prescribed to treat episodes of fever/malaria in several of the county's medical facilities.

Malaria is the principal cause of death among children aged under five. An estimated 150 000 to 250 000 children under five years of age die from malaria each year. In 2001, coverage by insecticide-impregnated bednets was less than 1%.

#### **4. Tuberculosis-control indicators**

According to WHO, in 2003 annual incidence of smear-positive pulmonary tuberculosis in DRC was 160 cases per 100.000 population. The country is one of the 22 countries most affected by tuberculosis in the world. It ranks fifth in Africa and eleventh in the world (Global Tuberculosis Control, WHO/HTM/TB/2005.349). Since 1987, the number of smear-positive cases of pulmonary tuberculosis reported by the programme has been steadily increasing; it has risen from 15 000 new cases in 1987 to 62.519 in 2004. This increase is partly attributable to HIV infection, the average prevalence of which is 4.5% (NASTICP, 2003). Prevalence of HIV infection among tuberculosis patients is estimated to be 30%. In DRC, an estimated 36 000 deaths are due to tuberculosis each year, 28% of which are attributable to HIV (Corbett et al. 2003).

The Tuberculosis Control Programme (NTCP) has always been one of the best organized programmes in the country (integrated within the HZ structures and with a highly satisfactory performance). However, for some years now, the Programme's performance has stagnated because of the breakdown of the health system. In order to circumvent difficulties deriving from the system, NTCP like many other better-funded programmes, has been pursuing strategies one of the results of which has been the adoption of a vertical approach (appointment of supervisory "TB" nurses, payment of bonuses to nurses who detect TB cases, etc.), all of which clearly accentuates the break-up of the system.

## **5. Geographical coverage and treatment of onchocerciasis**

Some 23 600 000 people are exposed to onchocerciasis in the Democratic Republic of the Congo and more than half of them (14 000 000) are infected. Geographical coverage attains 67.34%, while treatment coverage is 50.12%. These estimates show that the proportion of infected persons who are receiving treatment is probably not more than 30%. One of the reasons for this is certainly the poor level of health coverage in the country.

## **6. Indicators for trypanosomiasis**

Approximately half the 300 000 to 500 000 cases of trypanosomiasis in Africa are in the Democratic Republic of the Congo (150 000 to 250 000 cases), putting the country in first position among countries affected. Approximately 12 000 000 people live in endemic areas and each year from 10 000 to 15 000 new cases are discovered even though the programme's geographical coverage, which depends on health coverage, is less than 20%. Improved health coverage will make it possible in turn to improve the programme's coverage and thus to intensify the control effort against this disease, which is a serious contributing factor to poverty in DRC.

Without treatment, people infected with trypanosomiasis ultimately die from the disease. Those whose treatment is delayed generally suffer sequelae which make them dependent on their community for the rest of their lives.

According to WHO, human African trypanosomiasis ranks 7<sup>th</sup> in sub-Saharan Africa among diseases in terms of disability adjusted life years. Besides the suffering inflicted on humans, the disease also affects livestock, thus aggravating the economic losses for which it is responsible. For example, in DRC, persistence of infections in the vicinity of homes compels people to slaughter pigs, sheep and goats and to cut down coffee trees and palm trees which are responsible for the persistence of tsetse flies. Trypanosomiasis is thus one of the main diseases responsible for poverty in DRC.

## **7. Nutritional status of children**

Approximately 10% of newborns are underweight. Acute malnutrition increased among under-fives, from 12% in 2001 to 16% in 2004. There was little change in chronic malnutrition during this period.

The proportion of mothers breast-feeding is generally high, 95% according to MICS 2. However, the proportion of children who are exclusively breast fed during the first six months of life is low: only 29% of two-year olds have been exclusively breast fed until the age of four months and only 24% up to the age of six months. According to the same estimates, 4.2 million children aged under five years suffer from malnutrition in the Democratic Republic of the Congo.

Health coverage in the country has very probably declined on account of the division into new administrative units, which has impaired the operation of several health zones. The Tuberculosis

Control Programme and the Expanded programme on Immunization, which count among the best organized in the country, are losing impetus because of the current weakness of the health system. The proportion of children who have received all their vaccinations, which was about 29% in 1998, declined in 2001 (23%). This is essentially attributable to the poor performance of the health system, as routine vaccination can only be carried out effectively and regularly in health facilities that achieve a certain level of performance.

It is increasingly clear that it will be hard to secure sustainable results, in terms of reducing morbidity and mortality, through selective interventions which are not part of a global framework for reinforcing the health system. Globally improving the response to the principal health problems facing our populations is now a necessity.

It is against this background that WHO, in fulfilment of its advisory role to Governments, has been sounding the alarm bell since 2000, and insisting on the need to reinforce the health system so as to ensure the success of ad hoc disease control and maternal and child health measures. "There will be only limited advances towards the United Nations Millennium Development Goals and other national health priorities without the development of health care systems (World Health Report, 2003). The same holds for maternal and child health programmes, which "will be effective only if a continuum of care is established within strengthened health systems" (World Health Report, 2005).

In this way, strengthening the health system of the Democratic Republic of the Congo is the cornerstone of the sectoral poverty control strategy as its purpose is to create favourable conditions for effective and efficient progress towards achieving the Millennium Development Goals (MDG).

#### Grounds for hope

In spite of the very advanced state of deterioration of the health system, there are still health zones here and there in the Democratic Republic of the Congo which have held out and which still retain features of an integrated health system, along with other initiatives which may serve as a foundation for rebuilding the health system. Examples of such zones are Katana (Sud Kivu province), Kyondo, Kayna, Rutshuru, Kirotshe (Nord Kivu province) and Pawa (orientale province). These HZ still operate with satisfactory links between the general referral hospital and the health centres.

We might also mention a number of initiatives designed to strengthen the steering and managerial roles of the intermediate levels, which have made it possible slightly to improve coordination of activities carried out by partners, although they have gone no further as they were not part of a common vision shared by all the actors in the health sector.

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## **II. STRATEGY**

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## ***Introduction***

Two tasks have to be performed in order to rebuild the health system in DRC : - restoring the necessary health-system vision within a public-service approach - reviving the sense of vocation of human resources and transforming them into conscientious health professionals.

One approach would be to turn to the history of the health system of RDC (from which many lessons can be drawn) and, to complement this, to draw on syntheses of know-how produced by others in order to answer the following two questions:

1. Do we want to have operational health zones that are robust enough to integrate the activities of different disease-control programmes and specific health problems and capable of dealing with the essential health problems of the population, with their participation ? or do we prefer:
2. Ad hoc prevention programmes along with a number of other programmes designed to control specific major endemic diseases (possibly free of charge) while leaving curative activities for the private sector (which is deregulated in DRC)?

Since 2000, WHO has been emphasizing the need to reinforce health systems in order to progress towards the MDG and other national health priorities.

The Health System Strengthening Strategy set out in this document takes into consideration the systemic nature of health services and is made up of six lines of action which, while interdependent, are set out separately for reasons of form.

This strategy is to be considered as a set of actions involving the overall reorganization of the health system to enable it eventually to provide the whole population with health facilities offering basic health care (comprehensive, continuous integrated, efficacious and efficient) in place of those provided by vertical programmes and by the nascent private sector, which are uncoordinated and of dubious quality.

The main thrust of this strategy is therefore the development of health zones within a two-tier health system (general referral hospital and health centres) under the responsibility of a zone management team.

In order for this revitalization of the health zones to be efficaciously and efficiently carried out under prevailing circumstances, a number of actions, which form the other lines of action of the strategy, need to be carried out. These are prerequisites for implementing the development of the health zones.

## ***2.1. Strategic lines of action***

### **2.1.1. Revitalization of the health zones and correction of the distortions that have developed at the peripheral level**

#### **Why should we opt for revitalization of the health zones?**

The history of the health system of DRC is marked simultaneously by the use of ad-hoc programmes designed to address specific health problems and the introduction of health zones. However, in 1984, the synthesis of the different experience led DRC to define its health policy on the basis of primary health care with the health zone as the unit for planning and implementation.

Revitalization of the health zones represents an approach that ensures a constant equilibrium between the basic values (equity and solidarity in funding, respect for the population's dignity and professional ethics), best respects the guiding principles of the national health policy (NHP) and is consistent with the implementation of the master plan for health development (MPHD).

The debate currently under way over treatment of patients with TB and HIV co-infection clearly underscores the limits of the ad-hoc approach and spurs decision-makers into adopting a new approach in order to reinforce health systems. The debate would be void of substance if the concerns of the two programmes involved were not truly taken into consideration by the day-to-day activities of the health zones

The characteristics of the health zone, as an integrated health system, enable the health system to operate efficiently and at the lowest cost and make revitalization of the health zones a prerequisite for reinforcing the health system from the following angles:

1. **Sociological:** developing health zones means setting the population at the heart of the health system as the subject, and not merely the object of health interventions. The types of care which the health zones need to organize will take account of the demand expressed by the population and not just of epidemiological priorities and the priorities of donors.
2. **Strategic:** it is only possible to develop a health zone by encompassing it within a robust intermediate level, which possesses not only the organizational and operational skills required by a health system but also genuine authority. The needs which have been identified in order for health zones to operate will thus lead to a redefinition of the role of the intermediate and central levels.
3. **Methodological:** by reinforcing basic services it can be shown that it is possible to take into consideration the concerns of disease-control programmes. The minimum package of activities and the complementary package of activities as defined by the operating standards for health zones include the main interventions, which are frequently invoked to justify the vertical approach that currently characterizes the health system.

4. **Political:** the health zone is the operational unit for the national health policy. Its development is a sine qua non for implementing the basic strategy: «primary health care».
5. **Consistency** with the efforts needed to fulfil the **international commitments made by DRC in respect of health**, and in particular the Millennium Development Goals (MDG). Unquestionably, reinforcing the health system as a whole and the peripheral level in particular is a sine qua non for any progress towards the MDG for health (Health and the Millennium Development Goals, report 2005).

With a clear vision of the overriding need to rebuild the health system, the challenge is to do so within a sustained and deliberate process of fundamental change.

### **Principle of revitalizing health zones**

The basic purpose of revitalizing the health zones is to ensure their gradual development.

Given the limited means available (financial and technical), it is reasonable to assume that it is impossible simultaneously to develop all health zones. This makes it obligatory to do so gradually. The gradual approach makes it necessary to select health zones within a province, and within each zone, the health centres from which the approach is to be started.

The health zones will need to be ranked in accordance with their potential for development, after which the groundwork to bring about their revitalization will begin with the health zones with the greatest development potential. The justification for this choice is the possibility rapidly to revitalize those zones with high development potential, which may then serve as pilot health zones (which may be visited to observe how to organize primary health care, how to apply the lines of action for revitalizing health zones, etc.) and as training grounds for health staff from other zones. This type of training may offer a valuable alternative to the numerous seminars organized within the Ministry, which too frequently distracted staff from their day-to-day concerns. Another reason for this choice is the need to spread the resources available (which are already quite limited) among as many people as possible, the HZs with a high development potential being chosen among those with a population of at least 100 000 habitants.

In the health zone, the health centres with the greatest potential for development will be rationalized first of all. Once rationalized, these HC become the facilities in which a small all-round team introduces an integrated MPA (based on standardized instructions drawn up by the zone management team) for the population for whom it is responsible (which has been counted and registered) under regular and systematic supervision by a member of the management team.

In concrete terms:

1. The zone management team is responsible for the operation of **the entire zone**. Nowhere in the zone is left without supervision or entrusted to an outside authority.
2. The starting point is an existing situation, which it has to be possible to describe and whose transformation is desired (the description will concern the different health facilities present, including the hospital, and their operating status).

3. Once it has been decided to transform a first-level health facility into a reorganized health centre, the procedure will be to introduce the MPA in a single step. This implies that not all the first-level health facilities will be transformed into reorganized health centres at the same time.
4. Those HC not concerned by rationalization will nevertheless (initially) continue to plan activities, with possibly some input from the management team to help improve their performance.
5. **The coverage plan** will thus involve defining, on the basis of the inventory of first-level facilities in place (HC, clinics and health posts), those which are to become, on completion of the process, reorganized HC, taking into account, in particular, the consideration of population density. It will also determine those which might need to be set up to ensure complete coverage of the population. This corresponds to the «division into health areas », a hypothesis that needs regularly to be revised as coverage by reorganized HC increases (the need to set up new areas or to eliminate others).
6. Development of health zones on the basis of what already exists should make it possible, in the long run, **to correct the distortions that have been introduced** at this level when the previous divisions were introduced. The task of revitalizing the HZ will start from the GRH, which it will be necessary to reorganize first of all. When complete, this approach should make it possible to get an idea of the real needs for GRH in the different provinces, which should match the actual number of HZ required in the provinces.

### **Secondary lines of action for revitalizing the health zones**

It is possible to envisage the development of health zones as a continuous process developing along five lines. These five lines are gradually reinforced with different levels of intensity, which vary depending on the level of development and specific needs of each of the zones. Two other criteria, which represent prerequisites, need also to be taken into account: funding and partnership.

#### **2.1.1.1. Development of integrated leadership at the health zone level**

The overall success of the health-zone revitalization process depends on the quality of leadership. Leadership must be assured by the zone management team (ZMT). It implies that the members of the team appreciate the need to, and possibility of changing the operating mode of the health system in the health zone, on the basis of a clear and coherent concept of an alternative mode of operation, and that they possess the necessary managerial authority to take the required decisions to address the manifold problems identified. To do so, the ZMT needs a shared vision of the development of the health zone and responsibility for the overall health system in the zone.

The composition of the health zone management team must take into account the need to involve in the overall task of transforming the health system all those who carry any weight in the decision-making process. For example, the chief medical officer and the chief staff physician at the GRH might be part of the ZMT.

Development of integrated leadership will involve the performance of a number of tasks, which include the following: (i) designation of the members of the ZMT from among the staff working in the health zone, (ii) organization of joint training sessions for all the members of the ZMT, (iii) definition of both the vertical and horizontal responsibilities of each member of the team, (iv) preparation of a schedule of work for the team as a whole, including the responsibilities of each of its members both at the level of the general hospital and of the health centres, (v) introduction of a bonus/wages system to stimulate team spirit, (vi) drafting of internal rules of procedure for the ZMT, which need to be approved by the provincial medical officer, etc.

### **2.1.1.2 Rationalization of the operating mode of health facilities**

The mode of operation of health facilities in the health zone and interaction between them need to be improved.

Rationalization of the mode of operation of health facilities prepares the ground for action designed to improve the quality of care provided by the different health facilities in the zone. It makes it possible to improve both administrative (personnel, finances, logistics, etc.) and technical (introduction of flow charts, better management of non-salary inputs, determination of referral and counter-referral criteria, rates charged, etc.) management. Rationalization will make it possible to integrate the hospital within the zone's health system, etc. and harmoniously to ensure provision of the minimum package of activities in the health centres and of the complementary package in the hospitals.

Hospitals, which are the largest, most complex and costly facilities, are those whose activities need to be rationalized as a matter of priority. This process will enable them effectively to operate as referral structures while preventing access by users of primary care, and enable them to prepare to satisfy the demand that will develop as a result of the rationalization of the health centres.

Health centres need a permanent team to enable them to provide primary care to users in need of it. The service needs to be organized so that patients receive all the care required by their state of health at the same place and from the same staff.

### **2.1.1.3 Improving the health coverage of the health zone**

This line of action involves ensuring that the population are provided with coverage by proper quality health services. Such coverage represents an acceptable compromise between *quality of care* (which presupposes that health workers do not lose their skills because they serve too small a population, which would be the case if the number of health facilities were too large), and *accessibility* of services, not only in geographical terms but also from the psychological and cultural angles (which means that the distance patients have to travel to health facilities is shorter).

Rigorous planning will make it possible to strike a balance between the need to decentralize in order to improve access for the population, and the need to focus resources in order to provide the critical mass of equipment and staff necessary to provide high-quality health services.

Coverage may be improved either by setting up new health facilities (health centres, etc.), or by rationalizing the activities of those that exist (both public and private). It should make it possible to reverse the trend to use hospitals to provide primary care and to under-use them for cases requiring referral.

#### **2.1.1.4. Improving the quality of care**

Better quality care comes from an interaction between several factors which include: (i) clear instructions on the procedures and techniques to be adopted by health staff, and in particular on whether to treat or refer TB cases, severe and complicated malaria, haemorrhage in pregnancy, antibiotic prescription etc. (ii) regular provision of non-wage inputs, and in particular of essential drugs, proper equipment and regular maintenance of health facilities (rehabilitation and upkeep), (iii) periodic supervisory training to maintain the skills of staff, (iv) integration of curative and preventive care, (v) development of an information system to make it possible to evaluate the performance of hospital services and health centres (hospital information system, etc.) and (vi) other more subjective factors, such as user-friendliness, etc.

The required information system should be used in order better to organize care for patients and to improve local management of facilities rather than to meet the needs of vertical programmes and of donors, as is the case at present. It should also enable health personnel better to understand their responsibilities towards a particular population, while the population served should have a stronger sense of belonging to a supportive community.

#### **2.1.1.5. Community participation**

Community participation is an important thrust of the primary health-care strategy. It allows the community to become an actor, and thus a partner, in the production of the care from which it benefits. The importance of the community as a major factor in improving both health-centre management and the quality of care provided there has to be appreciated.

Community participation may take several forms, from active participation by patients in their treatment (which is needed to ensure its efficacy) to more significant and higher-profile action, such as participation with health professionals in decision-making, provision of resources in proportion to their means, etc.; this may range from fee-for-service to building health centres.

Actions in which the population is responsible for taking decisions, for implementing them and calling in health professionals when it feels their presence is needed to solve a specific problem are also conceivable. In this way, the population will continuously interact with the staff of the health centre, its level of participation in decisions and action increasing while that of staff diminishes, and vice versa.

The population will need to be organized to enable it better to participate in health measures (management committee, health committee, health-area development committee, etc.)

## **2.1.2. Reorganization of the central and intermediate levels**

### **2.1.2.1 Central level.**

Reform of the central level will be carried out over the long term, as part of overall public service reform. The required approach, some of whose elements are already in place, is clearly described in the documentation on the public service sector.

One fundamental issue in this respect is defining how the Ministry of Health is to provide the Congolese population with quality health care that meets the needs of each of them. It is above all on this aspect that the proposed strategy, whose starting point is reform at the peripheral level, will be able to help the central level to define its normative role on the basis of actual experience in the field. Combination of both approaches will produce a Ministry capable of properly discharging the tasks with which it is normally entrusted. The form taken by the central level should be that which enables it best to achieve the sector's objectives.

### **2.1.2.2 Intermediate level.**

There are at present two echelons at the intermediate level : the provincial health inspectorates and the district health inspectorates. The latter were set up essentially because of the size of some provinces.

The creation of new provinces under the New Constitution has done away with the argument that invokes the size of provinces and the creation of a second intermediate level is no longer justified. For the purposes of the strategic framework presented here, only one intermediate level will be considered for reform; its prime function to develop the plan for provincial coverage and thus to support the development of the provincial health zones.

What is needed at the provincial level is a small management team (PMT), whose all-round members share responsibility for the development of the zones (with one group of zones per member). This team will be helped by a logistic department in managing the inputs needed to conduct activities in the province. The PMT is the alternative to a multitude of intermediate-level structures (offices, focal points, etc.). The profile for the members of the team might well match that of some of the present district physicians. The way in which the teams operate will provide food for thought on reform at this level (intermediate-level organization chart) and in particular on the required structure and role of this level, as its role will be to support the development of the health zones.

In present circumstances, in order to set up such teams it will be necessary to strengthen the intermediate level by providing technical assistance of a « public health » type, with experience of strengthening health systems. The purpose of this assistance will be to help draw up and implement provincial development plans, to integrate vertical programmes and to improve the skills of health staff at this level, especially as regards the provision of provincial 'basket funding'.

## **Action to be carried out in the short term at the central and intermediate levels**

The Ministry of Health is directly responsible for adopting a number of urgent interim measures to prevent the distorted and ballooning institutional set up characteristic of the recent period from becoming set in stone and forming an obstacle to any major reform effort.

The following measures must be considered:

1. Consolidating programmes under the authority of seven departments, whose establishment satisfies every administrative and legislative requirement. To bring about this consolidation, there will have to be a moratorium on the creation of new programmes; the departments will have to regulate supervisory activities in order gradually to prevent the central inspectorates from taking over the work of the intermediate levels;
2. Ordering a moratorium on the establishment of new department or programme coordination offices at the provincial level, so as not to freeze a situation which is due shortly to change;
3. Ordering a moratorium on approvals for TMI; organizing an audit and certification process for existing TMI;
4. Subordinating the establishment of health facilities to the plans for coverage in the health zones, with an immediate moratorium on the establishment of "health posts", of "referral health centres", the transformation of health centres into "referral hospitals", and on the installation of new zone central offices.

By implementing these measures it will be possible to provide support for the reform at the peripheral level, pending measures that might include institutional reorganization of the Ministry of Health, which will need to be considered within the medium term as part of comprehensive reform of the public service in line with the objectives the sector has to attain.

In functional terms, plans will also be made on the one hand to organize the provincial hospitals (PH) to enable them to ensure the care continuum for users whose health problems will require technical resources not available in the GRH in the health zones, and on the other, as part of inter-sectoral collaboration, to rationalize the activities of the county's three university teaching hospitals (Kinshasa, Lubumbashi and Kisangani) to provide treatment for cases referred to them by the PH.

### **2.1.3. Rationalization of health funding**

#### **2.1.3.1. Decentralization of the venue for negotiation of funding**

Development of the capacity of the decentralized level to negotiate funding is to be considered as a process which, in the long run, should result in the decentralization from the central to the provincial level of the venue for negotiating funding, so as to set up provincial 'basket funding'.

Decentralization of the venue for negotiating funding would thus make it possible to correct current trends, which are marked by excessive « withholding » of funds by the central level and a multiplication of coordination bodies at that level.

As the Constitution guarantees a unitary State, it is possible to imagine that when funding agreements are negotiated between the Congolese State and donors, it would be possible rapidly (immediately) to decide which provinces are to receive the funds. They should then be in position to use those funds to finance their plans for the development of health zones. For example, the 9<sup>th</sup> EDF health programme, fits this concept.

### **2.1.3.2. Shift from programme-oriented external funding to funding for integrated provincial plans**

Provision has to be made for a changeover in the way negotiations for external funding are conducted, from programme-oriented funding to funding for integrated provincial plans, in the form of provincial 'basket funding'.

This will make it possible to correct the contradictions in the policies and modes of funding of external partners. Many external partners operate a dual parallel system: on the one hand, "system funding" in the form of support for health zones, and on the other "programme-implementation funding". The later is takes the form of support for programmes, which are negotiated at the central level, although activities may occasionally trickle down to the community level.

At the operational level, this programme-funding comes into conflict with the comprehensive rationale of health zone revitalization, a conflict which is exacerbated by the lack of coordination and an ad hoc approach to wages bonuses for staff, as well as by the development of parallel "pump" systems to draw off funds.

### **2.1.3.3. Improving funding of the health zone**

Considerations relating to health-sector funding need to be examined as a key factor in the revitalization of health zones, because funding is a means of improving their development potential (it is impossible to revitalize a HZ without funding). The mode of financing adopted for a health zone may prove decisive in making health care affordable to communities, given the widespread poverty in DRC.

The measures that need to be adopted in respect of funding for health services include: (i) mobilization of both public- and private-sector resources for health, (ii) reversal of the current trend in order to assign more resources to peripheral areas, (iii) better use of community financing, (iv) encouragement for mutual health insurance schemes, of scales of charges that fit with the principle of comprehensive care and which take into account the need to recover costs, (v) health-care subsidies,...etc. Naturally, all of this depends on an overall improvement in the efficacy of the health zone.

#### **2.1.4. Strengthening intra- and intersectoral partnership**

It is also essential that institutions directly responsible for the quality of health care, such as training colleges for physicians and nurses, health-research establishments, facilities responsible for supplying quality drugs should be associated and thus become stakeholders in the reform process. Commitment by the State to help these institutions fulfil their key role in providing high-quality staff and inputs for health services is vital.

An effort will also be made systematically to collaborate with related sectors such as water resources, transport and communication, education, the environment and agriculture, which are essential participants in any effort to improve community health. Such collaboration/coordination is to be practised at all levels at which development plans are drawn up, such as territorial development for example.

It is possible rapidly to improve health-services coverage by including the private for-profit and non-profit sectors (faith-based organizations, NGOs) in health-related activities.

Private health facilities will be identified and an evaluation made of their needs in terms of support (staff training, logistic support with the cold chain, drug supplies etc.). Those private health facilities (whether for-profit or faith-based) which attain a satisfactory level of performance and which have a public-health ethos should receive support from the public sector in terms of training, supervision ,...etc. This will consolidate collaboration between both these sectors.

Collaboration with other sectors should also safeguard the population against the activities of health facilities that are a threat to users because of the poor quality of their services.

#### **2.1.5. Development of human resources for health (HRH)**

Development of human resources is one of the most important aspects of the strategy to reinforce the health system. This is so both because of what needs to be done in this area (better distribution of staff, improved and more diversified skills, creation of an environment that fosters a professional ethos, etc.) and of the way in which it needs to be done, which calls for the commitment of staff who, as we know, are often opposed to any idea of change. It would be simplistic to assume that health-system reform may content itself with changing structures without developing, first and foremost, an attitude capable of accepting, understanding and imagining what the reform actually demands.

Possible activities under this line of action include : (i) initial training for the management team and for the all-round health-centre teams, (ii) in-service training of health staff during supervisory training sessions. Training sessions in health zones whose level of performance is good (i.e. a pilot health zone), offer an interesting alternative to training sessions.

Undoubtedly, improving the skills of staff and putting into place a proper system of incentives are important elements of the development of human resources; however, without a human resources development policy and strategic planning for human resources in order to strike the

right balance between the need for and production of human resources, and without genuine HR management, few sustainable improvements of our health system are to be expected.

In addition to the simple administrative aspect of operational planning for HR, human resources management needs to evolve so as to adopt a more strategic approach. Measures that need to be adopted include:

1. Developing closer links with other ministries, such as the Ministry of Higher and University Education, (coordination between production of HRH and their use), the Public Service Ministry, the Ministry of the Budget, of Finance, etc. ;
2. Starting negotiations with professional bodies and associations over the declining quality of training ;
3. Redefining the HR management roles of the different levels of the health system with a view to achieving decentralization as set forth in the Constitution;
4. Acquiring reliable information on serving staff: number, assignment, qualifications, skills, sex, etc. This information is to be collected from the bottom up, i.e. from the operational to the central levels. It would be desirable for the information to be consolidated by the next rank up in the hierarchy;
5. Drawing up an emergency plan for human resources for health in order to identify those approaches that need to be developed in the next few years, in order to offer a sustainable response to the crisis affecting the country's human resources for health.

The current public service reform, which involves the introduction of cells focusing on a particular topic, is an opportunity to assert ownership over the different actions. However, this means entrusting the cell responsible for a particular topic with clear leadership and presupposes that its members possess the requisite technical expertise regarding strategic aspects of HR management.

Alongside improvement of staff skills, raising wages is another significant factor for ensuring the strategy's success. While it has to be recognized that present circumstances do not make it possible to provide, at least in the short term a significant increase in wages, which can only be done as part of the overall government wages policy, it is equally true that better application of the system of bonuses may help to improve the way the health system operates. This bonus system is based not only on better working conditions, but also covers career prospects.

#### **2.1.6. Improving research into health systems**

Such is the complexity of the situation in which the health system reinforcement strategy is to be implemented that action-oriented research is an essential line of action. This research will make it possible on the one hand to improve the quality of standard-setting activity and on the other to identify not only the bottlenecks holding back implementation of the strategy, but also alternative solutions.

## **A scientific approach to policy development**

Standards need to be set in order to redefine organizational principles, principles relating to inputs, the organization, and expected outcomes of the health zones. This task includes estimation of the costs deriving from gradual implementation of the standards and the methods used to integrate programmes (for example, determining the cost of the Minimum Package of Activities and of the Complementary Package of Activities).

Policies (for the organization of care, on human resources, on funding and on management of the pluralistic system) will be developed as soon as the zones are introduced, with a hoped-for demonstration, training and knock-on effect that will help bring about a political consensus;

A number of studies will be carried out in connection with the implementation of the strategy: the health standards applied in the health zones will be evaluated and the level of community financing and the willingness and ability of users to pay for treatment will be assessed. This research will essentially be carried out in the pilot health zones, which will need rapidly to be set up.

The Democratic Republic of the Congo is as vast as a continent, with a range of situations that make it vital to make constant adjustments on the basis of research findings.

### ***2.2. Institutional set up***

In order to bring about change, there have to be support structures which play different, albeit complementary roles at different levels of the health system. These structures may change as the process goes forward.

Given the delicate nature of the task, there is obviously a need at each level for skilled personnel. The launching of new projects in support of the health sector must be used as an opportunity to introduce support structures for the HSRS.

#### A single national steering committee for HSRS.

The steering committee for the next stage of the DSP support project may take on this function, or alternatively form the core around which the HSRS National Steering Committee (NSC) will form.

#### A single steering committee in each province.

The provincial steering committee (PSC) will comprise the PMO, the DMOs, the TA from all the projects, a representative of the provincial authorities and a representative of the political authorities from the Ministry of Health. In this way, in the long run it might be possible for there to be only one TA per province with a broad range of competence in public health so as to organize complementarity of financial and technical support, making it possible to draw up a single health development plan for the province and to set up provincial 'basket funding'.

### ***2.3. Cost of the strategy***

The cost of implementing the strategy will depend on what is done during the action-oriented research. Information on the cost at the operational level will be collected in the pilot health zones as part of the contribution from the Department for Studies and Planning which is due to begin early next year. However, a minimum annual contribution of US\$ 3 (excluding community funding) per person towards operating expenditure represents a working hypothesis for running the health zone.

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## **III. ANNEXES**

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## Annex 1 : **Planning** approach adopted in order to strengthen the health system in DRC

### **Introduction**

Several surveys (Health-sector audit in 1998 and MICS2 in 2001) have shown that health and demographic indicators in DRC have worsened. This is true of maternal mortality, which was evaluated by these surveys at 1837 and 1289 maternal deaths per 100000 live births in 1998 and 2001 respectively and of infant mortality, evaluated at 127 and 126 deaths per 1000 live births in the same years. In response to this situation, the health sector has adopted a national policy and a health development plan which determine the framework within which action to improve the population's state of health is to be conducted. Both these documents reassert the importance of primary health care as the core strategy for the health sector, and the health zone as the policy's operational unit.

Five years after the national health policy was set forth, it has to be admitted that far from improving, the health of the Congolese population is getting ever worse. This leaves the impression that the actions being carried out by the Ministry of Health miss what really matters. One example is the fact that the notion of integrated health care is giving way to a whole range of uncoordinated vertical programmes which have little impact on the population's health.

In a resource-bound situation such as that of DRC, the choice of a more suitable planning method capable of identifying those actions that are effective and which make an efficient contribution to truly improving the health of the community is a matter of necessity.

### **At the peripheral level**

Two approaches to planning find themselves face to face: on the one hand, (i) **planning based on problems of morbidity and mortality** and on the other (ii) **operational-unit based planning**.

#### **1. Planning based on problems of morbidity and mortality.**

This is probably the most widespread approach. It involves identifying the principal problems related to morbidity and mortality within a target group, setting the desired objectives and the measures to be taken to attain them, before determining the cost. This is the approach used for the Ministry of Health's 2004 plan.

It has the advantage of producing rapid improvements in indicators for coverage by activities. However, it has to be borne in mind that an improvement in indicators for coverage by activities does not necessarily reflect an improvement in the population's state of health. A fully-vaccinated child may die from anaemia if the health centre which has provided all the vaccinations is unable to diagnose anaemia and refer the child for a blood transfusion if needed.

The drawbacks of morbidity and mortality based planning include the following: (i) the approach's partial or complete disregard for the system within which the specific actions are to be carried out - which poses the problem of their sustainability and efficiency. Under this approach, (ii) there is a tendency for the central level to stand in for the other levels of the pyramid by planning and even implementing measures at the peripheral level (training for traditional midwives, community intermediaries, etc. (iii) it fosters a vertical approach which, in turn, leads to a multitude of demands on and travel for staff at all levels, distracting them from their regular work. In the long run, (iv) such an approach contributes to the break-up of the health system, which is actually in need of reinforcement.

## **2. Operational-unit based planning.**

This approach gives precedence to improving the overall response to most, if not all the health problems of a well-defined population. It aims to enhance the performance of operational facilities so as to enable them comprehensively to address the main health problems of the population concerned.

The requisite measures under this approach include: appointment of a management team in the health zones and of all-round teams in the health centres, streamlining the operation of care facilities (hospital and health centres), improving the quality of care, promoting the development of human resources, extending the coverage of health services, training health workers through traineeships in well-run operational units, etc.

The drawback of this approach is that it can only be implemented over the long term. This however, has to be put into perspective against the sustainable nature of the actions and their outcomes.

The main benefits of this approach include: (i) its contribution to genuinely improving the health of the community through rehabilitation of the health system (ii) its unquestionably high level of efficiency, (iii) its consistency with the primary-health-care strategy (iv), training staff by means of traineeships in well-run operational units means that they are able to free the time they need to carry out scheduled activities, and (v) it lays the foundations for a comprehensive vision of management of the health of the community.

***It is this approach which seems best suited to the present situation of the health system in DRC.***

### **What are the roles of the intermediate and central levels under this approach to planning?**

#### **Intermediate level**

This level is responsible for translating the policies and strategies drawn up by the central level into plans and programmes (projects as a whole); it will need to draw up a health-development plan for the province on the basis of the health zones' coverage plans and plans of action, supplemented by the actions carried out by the intermediate level itself in order to meet the need for technical support arising from the health zones' plans. It will also be responsible for ensuring

resources are available to implement the provincial development plan. Thus defined, with the participation of all the province's health actors, the provincial plan will serve as a tool in negotiations and for integrating and coordinating all interventions in the province concerned.

### **Central level**

The role of the central level is to set standards, regulate and finance the health sector. This means determining the major orientations and strategies needed to improve the health of the community. As regards financing, the central level is responsible for drawing up a medium-term expenditure framework (MTEF) as an alternative to planning methods solely based on needs and which fail to take into account either the capacity of facilities to contribute to sectoral objectives or the resources available, which often results in gaps that are hard to fill. This level should avoid drawing up operational plans in place of the lower levels.

## *Annex 2 : Opportunities for the development of health zones*

### 1. WHO-assisted training for health-zone managers

This training process is now beginning. Trainers at the central level have now been hired and trained. They will be responsible for designing the training modules to be used. This training is an opportunity for the health-zone development strategy because it is the ideal framework for laying the foundations of a management team and developing its skills to enable it to draw up and implement coverage plans and plans of action for their health zones.

Given the potentially significant influence of this training for the future of the sector (see, under Statement of the Problem of HSRS, training organized by FONAMES), it is important to remember that its focus is HSRS and the tools needed for its implementation (compilation of standards for the health zone, planning framework, etc.).

### 2. Updating health standards

The Department for Studies and Planning and the Department for Development of Primary Health Care are in the throes of updating/harmonizing the operating standards for health zones in DRC. The document produced by this process will have to contain a set of concepts along with instructions and standards relating to the process of developing health zones. This document will make it possible to reach a minimum of consensus in order to make a start with implementing the health system reinforcement strategy. At this stage, standards are to be considered as working hypotheses to be tested in the health zones, and in particular in the pilot zones. The outcome of this action-research will make it possible to validate the standards within the different levels of the health system.

### 3. Reform of the public-service sector

An institutional audit of the Ministry was carried out by a team from WHO at Geneva in August 2005. This audit helped to improve the content of the Health Sector Reform Strategy (HSRS) document. Reform of the health sector, which is part of overall public service reform, will be driven both by the need to provide the public service with forms and structures that will best enable it to attain its objectives and by the needs in terms of management that will be identified at the peripheral level when HSRS is implemented.

This reform will have a direct or indirect impact on the process of reinforcing the health system. For example, it is conceivable that if the central Ministerial level is reorganized, it will be possible to release additional resources for the development of health zones while avoiding the need to invest in setting up new programmes and departments. This will improve coordination at this level, physicians in the provinces will be less and less distracted from their regular activities and will be able to devote sufficient time to their tasks relating to the development of health zones.

#### 4. Start up of HSRSP and of the support project for the implementation of the Master Plan for Health development (MPHD) in orientale province (PO), of the EDF IX health programme and of other bilateral cooperation support activities (Belgian and Canadian cooperation, USAID, etc.)

Several donor-funded projects are due to start up in the health sector within the coming months: the Health Sector Rehabilitation Programme financed by the World Bank, the support programme for the implementation of the Master Plan for Health Development in Orientale province, the health programme of the 9<sup>th</sup> European Development Fund, the USAID-financed AXxes project, the support project for health development in Kisnagani and the Bas Congo health development support project financed by the Kingdom of Belgium, etc. Now that the Ministry of Health has determined its strategy, these projects are to be considered as sources of funding for its implementation. To bring this about, negotiations with the different donors concerned are needed to align the different interventions planned as part of these projects with the different lines of action of the HSRS.

This will be one of the first tasks to be carried out by the different HSRS steering committees at both the national and provincial levels.

#### 5. Identification/formulation of new projects

Several projects are currently being identified/formulated within the Ministry of Health. One of these is the support project for the Department of Studies and Planning, the draft report on which has just been made available by Belgian Technical Cooperation. It is designed to enable the Secretary-General fully to perform his steering role in respect of HSRS through the Department for Studies and Planning. This project will help with monitoring of the implementation of HSRS.

Steps need to be taken to ensure that when forthcoming projects are identified and formulated, the main thrusts of the HSRS are taken into account.

#### 6. The WHO/DRC biennium

WHO has just defined its framework of cooperation with DRC for the next two years. The document sets out a number of measures which are directly or indirectly linked to the development of health zones. They include: (i) support for the revitalization of 40 health zones, (ii) support for the preparation of the human resources development policy, (iii) improving health system performance in 60 HZ, (iv) training managers from the same health zones, etc. It is appropriate to mention that development of human resources, without which it is unreasonable to expect any tangible results in the sector.

#### 7. Finalization of PRSP

The PRSP is now being finalized. Once it has been accepted by the Bretton Woods institutions, this document will become the sole framework for support for DRC from the international community over the next 25 years. The current health-sector poverty reduction strategy is

essentially based on the HSRS; this improves consistency between action carried out by the Government and action in the health sector.

The development of health zones is a long and costly process. In order to finance it, DRC will have to continue to rely on contributions from its development partners.

## 8. HIPC funds

The HIPC initiative is designed to make available funds to finance social sectors, including health. The volume of these funds will increase as time goes by. According to forecasts by the Ministry of the Budget, more than 200 million dollars will be available for health each year between 2006 and 2008. This means that the Ministry will need to prepare to make efficient use of the funds. It should be pointed out that as this budget is currently being drawn up, the above figures are not final.

## 9. The GAVI Fund for health systems strengthening

The GAVI Alliance, which finances vaccination activities in several countries, has made available funds for health system strengthening (HSS) in countries that are interested. The basic idea is to improve health-system performance to enable it to support and ensure the sustainability of vaccination activities. For countries such as DRC, whose per-capita GDP is less than US\$ 350, GAVI could finance up to US\$ 5 per par child cohort for the duration of the planning cycle. Access to these funds for DRC may help to support activities such as steering HSRS, improving the supply of health services, human resources for health (HRH), etc.

In order to draw up the proposal for submission to GAVI, a medium-term sectoral expenditure framework (MTSEF) has first of all to be prepared to make it possible to put interventions to be financed by GAVI into a broader framework showing the funding currently available in the sector.

*Annex :3 criteria for classifying HZ in accordance with their potential, for use in drawing up the first phase of the provincial development plan.*

Potential \ Zones									
Favourable sociopolitical env.									
Favourable economic env.									
OHI and DHI in the zone already in receipt of support									
Ease of access for PHI and DHI									
Presence of partners **									
Presence of partners in /2006 *									
Existence of HGR (operating status?)									
2 operational HC									
Existence of a central office in the zone									
Population = or > 100.000 h									
Existence of a particular disease									
Total									

HGR and Pop. assigned 8 points

Points assigned :

Highly favourable : 4 Favorable 0

Exists : 4 Existe.... 0

Operational : 4 Fonctionr 0

Presence of endemic : 4 Existe.... 0

Kisaka

\* Information to be provided by DSP

\*\* Important partners are those who provide overall support for the zone, or who take responsibility for running the hospital, for example

Marking makes it possible to rate zones in declining order in terms of their potential.

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