



# Budget Alignment of Partners in the Democratic Republic of Congo and Its Impact on the Performance of Health Services

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**How to cite this paper:** Mbase Bonganga, B., Mwembo Tambwe A Koy, A., Mundongo Tshamba, H., Senemona Nakwa, I. and Ilunga Kandolo, S. (2023) Budget Alignment of Partners in the Democratic Republic of Congo and Its Impact on the Performance of Health Services. *Open Access Library Journal*, 10: e10410.

<https://doi.org/10.4236/oalib.1110410>

**Received:** June 21, 2023

**Accepted:** July 24, 2023

**Published:** July 27, 2023

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## Abstract

**Introduction:** Households are the main source and a key player in health financing in the DRC in a proportion of 41% of current health expenditure. Alongside households, the other sources are foreign aid and the State Budget. The general objective of our study was to evaluate the performance of the local health system of Budjala. **Methods:** This is a cross-sectional study for analytical purposes on the budget alignment of partners in the DRC and its impact on the performance of health services conducted at the Budjala General Reference Hospital from 2013 to 2017 (a 5-year period). Our study population consisted of staff and users of the Reference General Hospital. **Results:** Our study shows that: the entire state budget was devoted to the payment of the bonus and salary of the staff; the external aid budget was allocated to the financing of human resources through bonuses and training, investment, pharmaceuticals and running costs; the household budget was allocated to finance staff bonuses, investment, pharmaceuticals and running costs. External aid funding accounted for 60.56% of the funding allocated to the Budjala Reference General Hospital from 2013 to 2017. About the performance indicators of the Budjala General Reference Hospital: regarding the supply and use of services, we found a bed occupancy rate below 60%, an average length of stay of 6.8 days, a delivery rate of 91%, a low referral rate, a mortality greater than 48 hours of 3.4%, a postoperative infection rate of 2.4%. In relation to user satisfaction: the satisfaction rate was 92.4% and the dissatisfaction rate 7.6%. Among the causes of dissatisfaction, we note the un-

availability of medicines (OR: 10.1; 95% CI: 2.4 - 43.5) and a lack of medical equipment (OR: 8.6; 95% CI: 3.7 - 19.9). **Conclusion:** External aid represented 60.56% of the funding allocated to the Budjala Reference General Hospital from 2013 to 2017, bed occupancy below 60%, mortality over 48 hours of 3.4%, postoperative infection rate of 2.4%.

## Subject Areas

Public Health

## Keywords

Health Financing, Performance of Health Services, General Reference Hospital, Democratic Republic of Congo

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## 1. Introduction

Alignment is a fundamental process consisting in redrawing the organizational structures, the processes of the information system and the production system so that they are in perfect harmony with the policy developed [1].

In the health sector, the alignment of donor actions with national procedures is one of the five fundamental principles on which the Paris Declaration is based [1].

The main function of the health system is to ensure access to quality care for the entire population and requires the pooling of resources for a better distribution of these resources and the sharing of risks. Spending on health care rose from 3% of global GDP in 1948 to 7.9% in 1997 [2].

But not all countries are experiencing the same progress. There are certain inequities in the distribution of resources devoted to health systems. Low- and middle-income countries account for only 18% of global income and 11% of global health expenditure, yet 84% of the world's population lives in these countries and this population bears 93% of the global health burden. morbidity [2].

Public health leaders have long recognized that effective and equitable health systems are essential to efforts to end poverty and foster development. Universal health coverage aims to ensure that everyone gets the health services they need without facing financial hardship due to paying for those services. This requires a resilient, efficient, responsive and well-managed health system; a health service financing system; access to essential medicines and technologies; and sufficient human resources, consisting of well-trained and motivated health workers [3].

Despite notable improvements over the past two decades, the state of health of the population south of the Sahara remains well below the average for middle-income countries as well as those with middle income (certain countries in Asia, Africa North, Latin America, etc.). In addition to insufficient funding, one of the reasons for the delay in terms of health in sub-Saharan Africa lies in the dysfunction and low performance of health systems [4].

According to the 2014 National Health Accounts (CNS) of the DRC, among the priority problems of financing the health sector, we note: the low allocation of public resources to the health sector, the insufficiency of mechanisms for sharing risks, the fragmentation of official development assistance and the inefficiency and poor application of financial management procedures [5].

Regarding the sources of financing, households are the main source and a key player in health financing in the DRC in a proportion of 41% of current health expenditure. Alongside households, the other sources are external aid and the state budget [5].

Indeed, the State allocated 4.2% of its budget to health, *i.e.*, 0.7% of GDP in 2013. The share of health in the State budget is minimal, well below the Abuja commitments (15%). The budget of the Ministry of Public Health (MSP) represented 4% of the State budget on average between 2007 and 2013 on a rather downward trend. During this period, the execution rate never exceeded 60%. The share of external aid increased from 33% to 37% between 2008 and 2013 with a peak of more than 47% in 2010. This level of health financing in the DRC testifies to a strong dependence on external aid [3].

The BUDJALA Rural Health Zone in general and the General Reference Hospital (HGR) have benefited from the support of partners for several years. Since 2014, the Technical and Financial Partners (technical and financial partners) in this case MEMISA-Belgium have increased their support by aligning themselves behind the Health System Strengthening Strategy (SRSS) declined in the National Health Development Plan (PNDS) 2011-2015 through its various strategic axes, in particular: the development of the Health Zone, the strengthening of governance and leadership in the health sector, the development of human resources for health, the reform of the pharmaceutical sector, health financing reform and intra- and inter-sector collaboration. To achieve this, the technical and financial partners have set themselves the objective of improving the quality of health care and allowing access to as many people as possible by strengthening the actors of the health system at the peripheral level with particular attention to populations.

## 2. Methods

We conducted a cross-sectional study for analytical purposes from 2013 to 2017 at the Budjala General Reference Hospital, which has a capacity of 86 assembled beds.

It is the first resort structure of the health zone bearing the same name with 13 health areas for a total population of 14,499 inhabitants (in 2018).

The study population consists of staff and users of the Budjala General Reference Hospital.

For the first group, we considered all the service providers and actors involved in the financial management of the Budjala General Reference Hospital, in particular the members of the Health Zone Management Team and those of the General Hospital Steering Committee.

Then we did a simple random sampling that included all sick adults and care-

givers of sick children interviewed during the data collection period.

The sample size is calculated by the formula:  $n \geq \frac{Z^2 p(1-p)}{d^2}$

$Z = 1.96$ ;

$p = 0.664$  which is the bed occupancy rate of the Budjala General Reference Hospital in 2017;

$q = 1 - 0.664 = 0.336$ ;

$d = 0.05$ .

This gave a value of  $n = 343$ .

The variables studied are the following:

a) Sources of financing: state financing, financing from foreign aid and financing from households.

b) Types of allocation

- Human Resources for Health (human resources)
- Bonuses and salaries: these are State bonuses and salaries, foreign aid bonuses and local bonuses.
- Staff training: this involves ongoing training and internships from which staff have benefited.
- Investment: this involves the construction and rehabilitation of infrastructure, equipment and/or medical materials as well as non-medical equipment and/or rolling stock.
- Pharmaceutical products and specific inputs: these are drugs and specific inputs purchased from the Regional Distribution Center (CDR-CAMENE) in the form of lines of credit or in cash and those provided by vertical programs.
- Operating costs: this is any funding allocated to the purchase of office supplies, fuel and hospital hygiene consumables.

Two data collection techniques were used for this study: documentary review during the study period and structured interview with key informants based on a questionnaire.

Administrative and sanitary. We obtained informed consent from respondents and maintained the anonymity of all those who provided the data.

The data was encoded on the software made under the Excel 2010 software.

Processing followed on Epi Info software version 7.2.2.6 after importing the database compiled in Excel 2010.

### 3. Results

**Table 1** shows that 60.56% of the funding for the Budjala General Reference Hospital came from the rest of the world and 11.28% from the State.

**Table 2** shows that the entire state budget and a large part of the household budget was allocated to bonuses and staff salaries, while most of the foreign aid budget was devoted to investment at 42.17%.

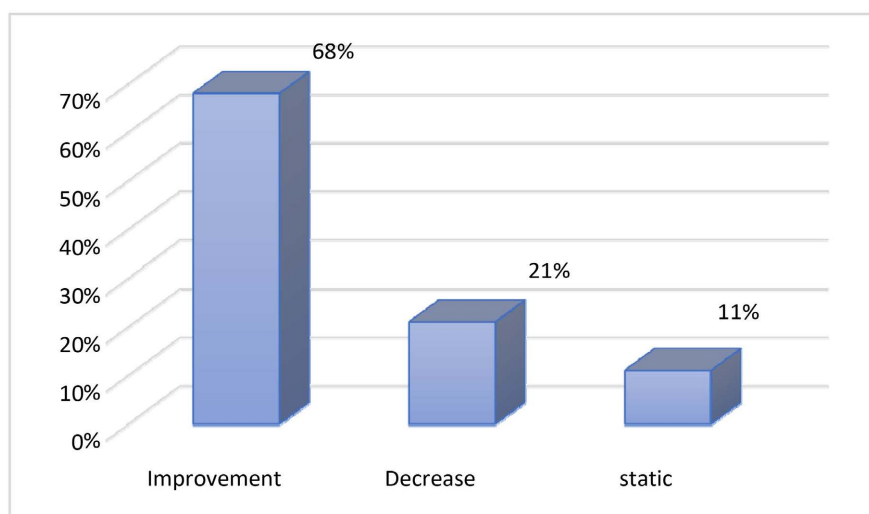
**Figure 1** shows that more than half of the staff thought that partner funding had improved the working conditions, 21% felt that the conditions had decreased and for 11% of the staff the working conditions had remained static.

**Table 1.** Breakdown of health financing sources at the Budjala General Referral Hospital from 2013-2017 (in US dollars).

Sources	2013	2014	2015	2016	2017	Total	%
State	14186.47	17447.33	23166.87	22825.26	44830.54	122456.47	11.28
Rest of the world	36426.40	158245.84	169669.69	246379.87	46517.96	657239.76	60.56
Households	37014.42	50322.78	67620.97	81570.78	69069.79	305598.74	28.16
Total	87627.28	224515.96	258957.52	349275.91	160418.30	1080794.96	100.00

**Table 2.** Distribution of funding for the Budjala General Referral Hospital by source of funding from 2013 to 2017 (in US dollars).

Sources	Headings	2013	2014	2015	2016	2017	Total	%
Government	Human resources							
	Premiums	1956.31	5217.18	10936.71	11684.92	20970.05	50765.17	41.46
	Wages	12230.16	12230.16	12230.16	11140.34	23860.49	71691.30	58.54
	<b>Total</b>	14186.47	17447.33	23166.87	22825.26	44830.54	122456.47	100.00
Rest of the world	Human Resources (Bonus)	11509.99	11367.69	51186.36	55493.32	20209.96	149767.32	22.79
	Trainings	6500	8200	47865	86800	19135	168500	25.64
	Investments	0	126311.6	61410.93	89435	0	277157.53	42.17
	Medications	18416.41	10866.55	7707.4	13151.55	7173	57314.91	8.72
	Functioning	0	1500	1500	1500	0	4500	0.68
	<b>Total</b>	36426.4	156745.84	168169.69	244879.87	46517.96	657239.76	100.00
Households	Human resources (Bonus)	24811.28	33247.88	44159.91	53720.14	29224.33	185163.54	60.59
	Investments	333.53	778.59	885.98	3030.2	10668.81	15697.11	5.14
	Medications	11386.78	15430.28	21707.36	21571.14	19945.02	90040.58	29.46
	Functioning	482.83	866.03	867.72	3249.31	9227.08	14692.97	4.81
	<b>Total</b>	37014.42	50322.78	67620.97	81570.79	69065.24	305594.2	100.00

**Figure 1.** Staff opinion on the impact of partner funding.

It follows from **Table 3** that the population of the Budjala Health Zone had increased from 127,729 inhabitants in 2013 to 145,145 inhabitants in 2017, the number of doctors had gradually increased, the number of nurses had gradually increased until 2015 and then fell. in 2016 to increase again in 2017, the number of midwives went from 1 to 2 in 2014 then remained static until 2017 and the number of laboratory workers went from 0 to 1 from 2015 to 2016.

In view of **Table 4**, it is observed that the number of beds fitted had remained static at 65 from 2013 to 2015 then had increased to 86 in 2016 to remain the same in 2017, the number of services organized had experienced a gradual annual increase, the bed occupancy rate, the number of escaped patients, the referral rate and the counter-referral rate had fluctuated with a peak respectively at 68% in 2016, 164 in 2015, 31% in 2017 and 92% in 2017; the numbers of patients received and of loyal patients had risen to a crescendo.

**Table 5** shows that the mortality rate greater than 48 hours had experienced a regression in 2016 to remain static until 2017 and the maternal mortality rate had fallen significantly in 2015 to increase in 2016 when there was the peak and then regress in 2017.

**Table 6** shows that the average length of stay had evolved between 6 and 8 days, the postoperative infection rate had gone from 5% in 2013 to 2% in 2014 then to 3% in 2015 to fall to 1% in 2016 until in 2017 and the number of days of drug stock-outs had seen an ups and downs with a peak in 2017.

In view of **Figure 2**, many users (61.5%) suggested increasing medication.

In total, 4 factors are associated with the quality of care, namely: availability of drugs, medical equipment, waiting time for consultation and reception (**Table 7**).

The unavailability of drugs increases the chance of having poor quality of care by about 12 times.

The odds of having poor quality of care were about 3 times higher among users who said the medical equipment was insufficient than those who said it was sufficient.

**Table 3.** Indicators relating to the health professional at the Budjala General Reference Hospital from 2013 to 2017.

INDICATORS	2013	2014	2015	2016	2017
Health District population	127,729	132,083	136,437	140,791	145,145
Number of doctors*	2	2	3	4	5
Number of nurses**	27	28	34	31	35
Number of birth attendants***	1	2	2	2	2
Number of laboratory technicians****	0	0	0	1	1

\*Number of doctors assigned to curative services; \*\*Number of nurses assigned to curative services; \*\*\*Number of midwives assigned to the maternity ward; \*\*\*\*Number of laboratory technicians assigned to curative services.

**Table 4.** Indicators relating to the volume of activities at the Budjala General Reference Hospital from 2013 to 2017.

INDICATORS	2013	2014	2015	2016	2017
Number of beds assembled	65	65	65	86	86
Number of services organized	14	17	20	21	22
Bed occupancy rate	33,3%	51,8%	50%	68%	66.4%
Assisted delivery rate	100%	100%	85%	78%	92%
Number of patients received	1255	1675	1788	2249	2483
Number of loyal patients	1004	1423	1609	2003	2232
Number of escaped patients	119	110	164	156	135
Reference rate	22%	29%	27%	27,61%	31%
Counter-reference rate	87%	81%	85%	88,80%	92%

**Table 5.** Indicators relating to mortality at the Budjala General Reference Hospital from 2013 to 2017.

INDICATORS	2013	2014	2015	2016	2017
Mortality rate at 48 hours	4%	5%	4%	2%	2%
Maternal mortality rate	935/ 100,000 NV	756/ 100,000 NV	394/ 100,000 NV	1205/ 100,000 NV	846/ 100,000 NV

**Table 6.** Evolution of the average length of stay, the rate of postoperative infections and the number of days out of stock of tracer drugs at the Budjala General Reference Hospital from 2013 to 2017.

INDICATORS	2013	2014	2015	2016	2017
Average length of stay	6 jours	7 jours	6 jours	8 jours	7 jours
Postoperative infection rate	5%	2%	3%	1%	1%
Number of break days *	17	37	14	32	63

\*Number of days out of drug stock.

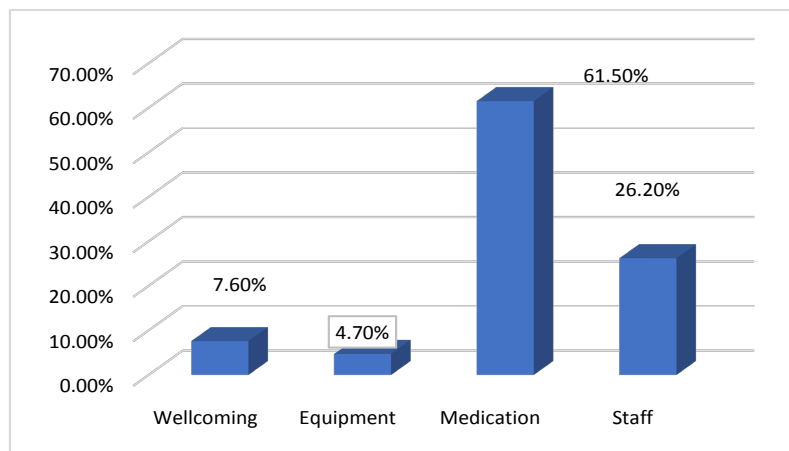
**Table 7.** Opinion of users on the quality of care.

Variables	Quality of care			OR	CI95%	p-value
	Bad n (%)	Good n (%)	Total n (%)			
<b>Availability of drugs</b>						
No	49 (25%)	147 (75%)	196 (100%)	11.9	[4.2; 33.9]	0.000
Yes	4 (2.7%)	143 (97.3%)	147 (100%)			
<b>Medical equipment</b>						
Insufficient	15 (28.85%)	37 (71.15%)	52 (100%)	2.7	[1.4; 5.4]	0.004
Sufficient	38 (13.06%)	253 (86.94%)	291 (100%)			

Continued

**Consultation  
waiting time**

More than 30 min	10 (41.7%)	14 (58.3%)	24 (100%)			
				4.6	[1.9; 11]	0.0002
Less than 30 mins	43 (13.5%)	276 (86.5%)	319 (100%)			
Welcome	23 (45.1%)	28 (54.9%)	51 (100%)			
Bad	30 (10.3%)	262 (89.3%)	292 (100%)	7.2	[3.7; 14]	0.000



**Figure 2.** User suggestions for improving the performance of the Reference General Hospital.

When a user had waited more than 30 minutes for the consultation, he was about 5 times more likely to say that the quality of care was poor compared to one who had waited less than 30 minutes.

There is 7 times more chance of speaking of poor quality of care by a user who describes the reception as poor.

After the bivariate analysis, two factors are associated with the satisfaction of services offered, namely: the availability of drugs and medical equipment. However, the quality of infrastructure and the price are associated with user satisfaction but are not statistically significant (**Table 8**).

The odds of users being dissatisfied with services offered were about 10 times higher among those who said the drugs were not available than those who said they were.

The odds of being dissatisfied with the services offered were about 9 times higher among users who said the medical equipment was insufficient than those who said it was sufficient.

## 4. Discussion

The discussion of our results revolved mainly around the financing and performance of the Budjala General Referral Hospital.



**Table 8.** Opinion of users on the satisfaction of services offered.

Variables	Satisfaction			OR	CI95%	p-value
	No n (%)	Yes n (%)	Total n (%)			
<b>Availability of drugs</b>						
No	24 (12.2%)	172 (87.8%)	196 (100%)	10.1	[2.4; 43.5]	0.0002
Yes	2 (1.4%)	145 (99.6%)	147 (100%)			
<b>Medical equipment</b>						
Insuffisant	14 (26.9%)	38 (73.1%)	52 (100%)	8.6	[3.7; 19.9]	0.0000
Suffisant	12 (4.1%)	279 (95.9%)	291 (100%)			
<b>Infrastructure quality</b>						
Bad	2 (14.3%)	12 (85.7%)	14 (100%)	2.1	[0.4; 10.01]	0.333*
Good	24 (7.3%)	305 (92.7%)	329 (100%)			
<b>Tarification</b>						
Expensive	16 (7.8%)	190 (92.2%)	206 (100%)	1.07	[0.5; 2.4]	0.87*
Cheap	10 (7.3%)	127 (92.7%)	137 (100%)			

At the end of our research, we found that the largest funding for the Budjala General Referral Hospital came from the rest of the world (60.56%) followed by households (28.28%) and the State (11.33%) (**Table 1** and **Table 2**). This leads us to confirm the hypothesis that the financing of the health sector in the Democratic Republic of Congo and other low-income countries is highly dependent on external aid [5] [6]. However, these results are not the same as those of the report of the National Health Accounts of the Democratic Republic of Congo of 2014 where households were the main source of financing for health care and services up to 42%, followed by from the rest of the world at 40% and from the State at 18% [5]. In the WHO Cooperation Strategy with Benin 2016-2019, the main sources that contribute to health financing are: households (52%), the State (31%), local authorities (less than 1%), and technical and financial partners (16%) [3]. On the other hand, 66% of the external financing included in Mali's 2011 Operational Plan comes from technical and financial partners who have signed the compact [7]. In a study on comparative analysis of health financing in OECD countries conducted in Montreal in 2007, the authors found that public financing provides on average 75% of the countries' total health costs, individual contributions 20% and the share of private insurers is on average 6%. The share of households in health financing represents less than 25% in 83% of OECD countries. We observe that in 50% of countries, household payments are less than 15%, in 33% of cases, they are between 15% and 25% and in 17%, *i.e.* 5 countries, they are higher than 25% and reach up to 53% in Mexico [8].

In a study on Health financing and cost recovery in the Democratic Republic

of Congo: the heavy burden of households, J. Manzambi Kuwekita found that current health expenses are borne by households (40%) and by international co-operation (45%), and carried out by direct payment without cost sharing (93.7%) [9].

Regarding the types of budget allocation of these three sources of financing (**Table 1**), the financing of external aid was devoted to staff training (25.81%) followed respectively by the bonus (22.94%), medical materials and equipment (22.7%), infrastructure (18.38%), drugs in the form of donations (5.84%), drug credit lines (2.94%) and non-medical equipment (1.38%). As for the financing of households, it was devoted to the staff bonus (60.59%), drugs (29.46%), investment (5.14%) and operation (4.81%). The entire state budget was allocated to staff bonuses and salaries. It should be noted that the medicines received as donations are medicines from the Global Fund in the context of the fight against malaria and tuberculosis. The drug credit lines are fed into the account of the Regional Distribution Center (CDR/CAMENE) where the general referral hospital gets its supplies.

In comparison with the results of Makamba Mbonariba on the issue of health financing in the DRC in 2004, the State budget in the health sector in 2002 was distributed as follows between the categories of expenditure: 62% of allocations are allocated to salaries, 14% to operating costs, 13% to investment expenditure and 10% to ancillary budgets. This breakdown is quite different in the 2003 adjusted budget with the increase in available resources; the share of wages falls to 13% (*i.e.*, around USD 6 million); goods and equipment items represent 75% and finally 8% is allocated to buildings. Also in this same study, it was shown that most external financial resources for health gave a preponderant place to investment. Thus, the analysis of the PMURR budgets showed that 50% of the funds were allocated on average to investment, 25% to operation/performance bonuses, 11% to drugs and 12% for the administrative costs of intermediary organizations [10].

About the performance of the Budjala General Reference Hospital, referring to the activity standards of an HGR in force in the Democratic Republic of Congo, the Budjala General Reference Hospital offers a package of complementary activities that meet Standards.

As for human resources, if we consider a capacity of 100 beds, there is a shortage of health professionals at the Budjala General Reference Hospital, which should be 71 [3] instead of 43 (**Figure 1** and **Table 3**). The averages of the main health personnel/population ratios (1 doctor for 42,637 inhabitants, 1 nurse for 4401 inhabitants and 1 midwife for 75,798 inhabitants) are below the standards recommended by the WHO, namely 1.5 doctors for 10,000 inhabitants, as well as 2.4 nurses and 2.9 midwives per 5000 inhabitants.

Compared to continuous training, 52.1% of staff had benefited from on-the-job training (**Table 2**). This could be justified by the fact that the development of human resources was retained by the technical and financial partners as one of the strategies. In addition, the health workforce is the backbone of a strong and

resilient health system as illustrated in the report of the High Level Commission on Health Employment and Economic Growth of the World Health Organization of 2016 [3]. Universal health coverage and the guarantee of global health security are only possible with adequate investments in the health workforce.

Regarding motivation, the inadequacy of the bonus granted to staff remains a real reason for demotivation, as confirmed by all the staff interviewed. This only confirms the problem of low motivation of health personnel mentioned in the PNDS/DRC 2016-2020. Certainly, the fact of undergoing on-the-job training is a motivation for the staff of the Budjala General Reference Hospital since all the staff who had undergone the training were satisfied.

Compared to material and drug resources, they did not occupy a prominent place in the financing of the General Referral Hospital from 2013 to 2017, as confirmed by staff and users (**Figure 2**). Prior to 2010, the General Reference Hospital recovered 40% of the value of drugs consumed and the rest was included in other expenses. This recovery then rose to 60% and then 80% of the value of the drugs consumed from 2011 years before 2014. However, this funding allocated to the drug was still insufficient compared to the real needs.

With regard to the materials, they were provided by the technical and financial partners according to their possibilities.

Regarding the bed occupancy rate, although its average (53.9%) is below the target set by the Health Zone at 60%, this rate has made significant progress over time. We believe that the strengthening of the technical platform with the implementation of new services such as medical imaging, eye care, oral care and others has contributed a lot to this. In the same vein, the number of patients received, and loyal patients have also gradually increased for the same reason. This rate is much higher than that of Côte d'Ivoire, where there was an underutilization of health services at 18% in 2008 [11].

In relation to the assisted delivery rate, the Budjala General Reference Hospital remained efficient except in 2016 when it recorded an assisted delivery rate below the target (80%). However, the average of this rate (91%) is higher than the birth rate assisted by health personnel at the national level, which was 80% in 2014. In Mali the rate was 66% in 2009 [8].

On the side of the reference and counter-reference system, there is a problem of low reference rate (**Table 4**). This could be explained by a weak power of attraction of the General Reference Hospital until the beginning of 2014 on the one hand and by the insufficient means of evacuation of patients at the level of health centers on the other hand.

Regarding the average duration of hospitalization, it remained normal at 6.8 days on average from 2013 to 2017 (**Table 6**). This result is almost the same as that found by Alain Lopez and Pierre Louis Rémy in their report on the measurement of satisfaction of users of health establishments in 2007 [12].

Compared to the postoperative infection rate (**Table 6**), although its five-year average (2.4%) is higher than the objective (1%), a significant change has been noted over the years. This could be explained by the provision of sterilization

equipment (autoclave, Poupinel and pressure cookers) and the training of staff in hospital hygiene by MEMISA Belgium from 2014.

However, mortality greater than 48 hours and the maternal mortality rate remained high with a respective average of 3.4% and 827 per 100,000 live births (**Table 5**). The maternal mortality rate is higher than that of the WHO at 230 per 100,000 live births, than those of Benin and Mali located respectively at 125 per 100,000 live births in 2015 and 464 per 100,000 births in 2006 [8]. This situation could be justified by the low availability of drugs, materials and equipment confirmed by service providers and users (**Table 8**) as well as the late arrival of women at the referral general hospital.

Although this pricing is negotiated with the population, it is not fully paid by the users, especially since we observed a considerable number of escapees (**Table 4**).

Regarding satisfaction, 92.4% of users were satisfied with the services offered by the General Reference Hospital. This satisfaction had focused on medical equipment and infrastructure while dissatisfaction on the availability of drugs and the price. A study on the Perspective of users followed in outpatient clinics of first, second and third line establishments conducted in Montreal with 856 patients by Perreault *et al.* found 58.2% satisfaction, 7.2% mixed satisfaction and 34.6% dissatisfaction. Patients were generally very satisfied with the way of being providers and the therapeutic alliance established with them. However, the organization and operation of the services generated significantly lower satisfaction rates [13].

In relation to the quality of care, it is good in 84.55% of users of the Budjala General Reference Hospital and is statistically associated with the availability of drugs (OR: 11.9; 95% CI: 4.2 - 33.9), medical equipment (OR: 2.7; 95% CI: 1.4 - 5.4), waiting time for consultation (OR: 4.6; 95% CI: 1.9 - 11) and reception (OR: 7.2; 95% CI: 3.7 - 14) (**Table 7**). The prolonged waiting time could be justified by the lack of medical personnel. The result relating to the quality of care is contrary to that of the Doumbouya study on the accessibility of health services in West Africa: the case of Guinea carried out in 2008 where users had denounced nearly 50% poor quality of hospital and health center services [14].

## 5. Conclusions

At the end of our study on “Budgetary alignment of partners in the Democratic Republic of Congo and its impact on the performance of health services. Study carried out at the General Reference Hospital of Budjala from 2013 to 2017”, it seems important to us to take a break.

Our study essentially consisted of a main objective to contribute to the performance of the local health system of Budjala. In relation to the types of partner budget allocation, we have observed that the entire State budget was devoted to the payment of the bonus and salary of the staff; external aid budget was allocated to financing human resources for health through bonuses and training, investment (infrastructure, medical equipment and materials, non-medical equip-

ment/rolling stock), drugs (lines credits and drug allocations) and operation; household budget was allocated to the financing of staff bonuses, investment, pharmaceutical products (recovery of drugs) and operation. In terms of the supply and use of services, the performance of the Budjala General Referral Hospital is characterized by the averages of the following indicators:

However, the lack of rich documentation did not allow us to compare our results with those of other studies conducted before ours, especially at the provincial and national level. In addition, due to lack of time, we were unable to contact the NGO MEMISA Belgium to obtain the results of its evaluation carried out at the Budjala General Reference Hospital in 2016. It should be noted that the performance observed at the Budjala referral general hospital is not only the fruit of funding from its technical and financial partners, but also of the determination of service providers associated with support at the intermediate level, which aspect is not taken into account in this study. It is important to respect the Abuja agreements by financing the health sector up to 15% of its budget; pay bonuses and salaries to all staff; strengthen and regularize drug funding; to create mutual health insurance while taking into account the purchasing power of the population; to complete this study by integrating other elements that have not been taken into account here or by improving what we have done.

### Conflicts of Interest

The authors declare no conflicts of interest.

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