The State's obligations to provide public health institutions with sufficient medical equipment and to ensure continuing training of medical personnel in the Democratic Republic of the Congo: a case study of the health centre Lukula

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Abstract

The present analysis addresses two aspects of health care in the Democratic Republic of the Congo, namely medical equipment and continuing training of medical personnel within the framework of public health institutions. It focuses on the Centre de Santé (CS), which is the first health structure that brings patients in contact with the formal health system, especially in rural areas, where the majority of the population live. Indeed, despite its key role in the delivery of health care, the needs of the CS have not been prioritised by the government. The CS does not have enough medical equipment for their use. The CS isstaffed with few qualified medical professionals who are unable to upgrade their professional skills through a working system of continuous training. This constitutes a serious threat to patients' rights to health and life. Accordingly, the analysis argues that the State's obligations to equip the CS and to ensure the continuing education of its medical staff form part of its human rights obligations toward the right to health as protected under its domestic law and ratified human rights treaties.

INTRODUCTION

Epidemics and endemic diseases[1] are a part of life[2] for about 90,711,900 Congolese.[3] To cope with this burden of disease the government of the Democratic Republic of the Congo (DRC) mainly relies on public health institutions including the Centre de Santé (CS), the

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1 Epidemics include inter alia, cholera, measles, yellow fever, Ebola virus disease, monkeypox, typhoid fever, and diarrhea whereas, endemic diseases comprise of malaria, HIV, Malaria, tuberculosis, and neglected tropical diseases. See Ministère de la Santé de la RDC, Plan national de développement sanitaire 2016–2020 : vers la couverture sanitaire universelle, Kinshasa, 2016 (hereinafter PNDS 2016–2020), at 27–30.

2 *Kalisia Malemo et al*., The state of emergency care in Democratic Republic of Congo, African Journal of Emergency Medicine, Vol. 5, 2015, at 154.

3 For this estimated statistic about the population of the DRC in 2018, see the sixth periodic report submitted by the Democratic Republic of the Congo to the Committee on Economic, Social and Cultural Rights under articles 16 and 17 of the Covenant, 2019, Para. 12.

mission of which is of paramount importance in the delivery of health care from different perspectives. Firstly, the CS is the first[4] place of contact between patients and formal health services, especially in remote areas where 69, 4 % of the population live.[5] As such, it deals with all cases of emergency, whether surgical or obstetric and sudden injuries. Secondly, its proximity to the population makes it relatively accessible.[6] Finally, in those parts of the country without any General Hospital of Reference[7](GHR), the CS remains the only available and existing public health institution that caters to all the health needs of people including health issues that come under the jurisdiction of GHR.

Despite the role of the CS in the provision of health care, it is medically underequipped[8] and staffed with less skilled medical professionals.[9]Besides, due to the lack of a working system of continuing training, its medical staffs are unable to maintain and improve their medical knowledge and skills.[10] In the context of DRC where people are facing financial[11] and geographical constraints in accessing formal healthcare, the situation of the CS can negatively impact the quality of health care, threatening therefore both patients' rights to health and life. The bottom-line of this analysis is that in addition to being inherent in any activity related to the provision of healthcare by a private or public health provider, the State's obligations to equip the CS and to ensure the continuing education of its medical staff form part of its human rights obligations toward the right to health as protected under its domestic law[12] and ratified treaties.[13]

Part A explains the legal basis for the State's obligations to equip the CS and ensure the continuing education of its medical personnel; part B discusses the place of the CS within the national health system and part C contains the concluding observations.

4 Ministère de la Santé de la République Démocratique du Congo, Recueil des normes de la zone de santé, Kinshasa, 2006 (hereinafter 2006 Health Zone standards), at 16.

5 Ministère de la santé publique de la République Démocratique du Congo, Plan national de développement sanitaire PNDS 2011–2015, Kinshasa, 2010 (hereinafter PNDS 2011–2015), at 14.

6 People have to work more than 5 kilometers to reach a formal health institution, while these institutions are merely lacking in some parts of the country. PNDS 2016–2020, at 35.

7 Ibid, at 32.

8 The situation of medical equipment is deplorable at all levels of the health care system of the DRC. PNDS 2011–2015, at 59.

9 Existing norms on the national health system do not allow for the presence of physicians at the CS. PNDS 2016–2020, at 37.

10 The national health system lacks a continuing education system to effectively manage activities on-the-job training. PNDS 2011–2015, at 42.

11 About 75 % of people in rural areas have financial difficulties to access health care. PNDS 2016–2020, at 35.

12 Constitution de la République Démocratique du Congo de 2006 telle que révisée à ce jour (hereinafter DRC Constitution), art 47.

13 See, for instance, articles 12 of the International Covenant on Economic, Social and Cultural Rights, 1976 (hereinafter ICESCR) and 16 of the African Charter on Human and Peoples' Rights, 1986 (hereinafter African Charter) to which the DRC is a party.

A. Legal justification for the State's obligations to equip public health institutions and ensure the continuing training for public medical professionals

The legal justification for the State's obligations to equip public health institutions and ensure the continuing training for public medical professionals is mainly based on those legal instruments and provisions on the function of the State as health care provider discussed in part (I) and its commitment to the legal protection of the right to health as explained in part (II).

I. Obligations incumbent upon the government as healthcare provider

The Congolese government is the owner of health institutions some of which were inherited from colonial authorities.[14] According to article 24 of the Presidential Ordinance 2020, "the Ministry of Health has in its remit, the organization, creation and control of public medical services and pharmaceutical."[15]These attributions of the national Ministry of Health must be broadly interpreted to entail and encompass the State's obligations to build, equip, fund and staff public health institutions. It is within this context, for instance, that the DRC Constitution vests the power to hire and appoint medical personnel in public health institutions with both the national and provincial governments.[16] The health facilities are state funded as opposed to those in the private sector.[17] They consist of peripheral, provincial and national health institutions, and other State's structures involved in the provision of health care.[18] Their activities comprise inter alia, preventive medicine; curative, promotional and palliative care, maternal and child health; sexual and reproductive health, military medicine, and pharmacy.[19] To adequately cater to the health needs of the population, the government as healthcare provider, has to equip public health institutions with appropriate medical equipment and staff them with skilled and trained medical professionals who can regularly update their professional knowledge through a working system of continuing education as it will be explained in the following sections.

14 Upon its accession to national and international sovereignty, the DRC inherits a health system based mainly on hospitals and clinics supported by mobile teams to combat major epidemics. See Cour des Comptes, Rapport d'audit des fonds alloués au secteur de la santé 2006–2012, Kinshasa, 2013, at 8.

15 Ordonnance N° 20/017 du 27 mars 2020 fixant les attributions des Ministères (hereinafter the Presidential Ordinance 2020), article 24.

16 DRC Constitution, arts Art 203 (10), and 204 (18).

17 Loi N° 18/035 du 13 décembre 2018 fixant les principes fondamentaux relatifs à l'organisation de la Santé publique (hereinafter Public Health Act), art 12.

18 Examples include inter alia, medical service of the armed forces. PNDS 2016–2020, at 24.

19 Public Health Act, art 12.

1. Medical equipment as requirements for better health care services

Medical equipment, including diagnostic and therapeutic technologies, is useful in the improvement of the quality of health care.[20] Being the main health care provider, public health institutions are the principal consumer of medical equipment, which is necessary for the management of patients, including for clinical, paraclinical, and diagnostic examinations, treatment, or evolution.[21] Currently, more than 10,000 types of medical devices are available, some of which are commonly considered as important or necessary for specific preventive, diagnostic, treatment or rehabilitation procedures carried out in health care facilities.[22]Medical equipment or devices are essential to the successful delivery of almost every form of daily health care in every health institution.[23] Regarding the CS, the existing applicable standards require that it is equipped with at least a fridge to keep some medicines, transport equipment such as bikes, motorbikes, and ambulances, running water for medical use, a safe source of energy, laboratory and diagnostic equipment, furniture (chairs, tables, beds), office equipment and other facilities.[24] These are the minimum basic medical equipment deemed necessary and fixed according to the situation prevailing in DRC.[25] To further contribute to the quality of care, medical equipment needs maintenance guarantee and training for its use.[26] However, it is reported that the public health sector in DRC has a shortage of medical infrastructure and equipment that meets the national standards. Regarding the CS's infrastructure, for instance, only 1006 out of 8,266 existing CSs are built of sustainable materials, of which 671 are in an advanced state of disrepair.[27] 7120 CSs are built of semi-durable materials such as straw.[28] These kinds of buildings can impede the installation and use of some medical devices used for radiology and ultrasound services. The selection of needed medical equipment will be influenced by the type of health facility where such equipment is to be used.[29] As far as medical equipment is concerned, reports reveal that in

20 PNDS 2011–2015, at 103 and 203.

21 *Mangalaboyi J*, Optimisation de l'acquisition de l'équipement médical en RDC, Ann. Afr. Med., Vol.8, 2015, at 1923.

22 For an illustrative list of core medical equipment, see the World Health Organisation, Core medical equipment, Geneva, 2011.

23 World Health Organisation, Medical devices: managing the mismatch: an outcome of the priority medical devices project, Geneva, 2010, at 9.

24 2006 Health Zone standards, at 21.

25 The selection of appropriate medical equipment always depends on local, regional or national requirements including the burden of disease experienced in the specific catchment area. See the World Health Organisation, Core medical equipment, note 23. See also the Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 2000 (hereinafter General Comment 14), para 12.

26 *Mangalaboyi*, note 22, at 1923.

27 PNDS 2016–2020, at 36.

28 Idem.

29 World Health Organisation, Core medical equipment, note 23.

addition to being dilapidated and incomplete, existing medical equipment is inadequate.[30] Finally, the maintenance of medical equipment is neglected at all levels and in all areas because of the lack of applicable rules and standards, as well as the lack of a maintenance culture.[31]

2. Skilled and trained medical personnel as an essential component of health care

Health care services in public health institutions must be provided by skilled and trained medical personnel. It is the State's duty to ensure that these medical skills and training are acquired through initial education which is described in part (a) and continuing training in part (b) as discussed below.

a) Initial education for the medical profession

The initial vocational training prepares students in medical science to acquire the skills they will need in their professional life and it usually results in the successful obtention of a certificate or diploma.[32] In DRC, the exercise of and the admission to the medical profession are subject to the provisions of relevant legislations[33]which have been operational since colonial period. For instance, under the 1952 Decree on the Practice of Medicine adopted during the colonial time but still in vigour albeit partially, nobody can be entitled to exercise the profession of doctors, dentists, nurses and nursing assistants, health workers, birth attendants, and pharmacists[34]without holding the corresponding school or university's degree. The same requirement is reiterated in post-colonial adopted legislations. As an illustration, no one can be admitted to the national board of pharmacists without a pharmacist degree from a Congolese university or a diploma held to be equivalent issued abroad.[35] Furthermore, to be included in the order of nurses, one must possess the nursing diploma or any other title deemed equivalent by the ministry with health science education in its remit.[36] Finally, to be appointed as doctors in public health hospitals, applicants must have a

30 PNDS 2011–2015, at 59.

31 Idem.

32 *Abbatt F.R. et Mejia A*., La formation continue des personnels de santé : manuel pour ateliers, OMS, Genève, 1990, at 10.

33 DRC Constitution, art 202, 36 (h).

34 Décret du 19 mars 1952 relatif à l'exercice de l'art de guérir, see Title I-VII.

35 Ordonnance-loi 91–018 du 30 mars 1991 portant création d'un Ordre des pharmaciens en République du Zaïre, art 40.

36 Loi N° 16/015 du 15 juillet 2016 portant création, organisation et fonctionnement de l'ordre des infirmiers en République Démocratique du Congo, JO, N° spécial, 57ème année (hereinafter Nurse Act), art 6.

doctor's degree in medicine, surgery, and delivery or an equivalent degree.[37] Depending on the subject study, initial medical education lasts between three to five years associated with some period of internships. It must be recalled that all medical studies are fully self-funded.[38]

b) Continuing education

Continuing education of medical professionals refers to all experiences that follow the initial training and help caregivers acquiring new skills and maintaining the needed skills to deliver health care.[39] It covers the period starting from the beginning of any medical profession until retirement.[40] The objectives of continuous education for medical professionals consist of inter alia, helping health professionals to preserve the quality of their work, adapting their professional behaviour to changes in health care policy and the health status of the population, and learning to overcome the weaknesses of their initial training.[41] The objective of filling in some deficiencies of initial training is relevant in the context of DRC, where most medical personnel have received poor quality of medical education at the initial stages.[42] This poor quality of medical education is attributed to inter alia, the lack of appropriate laboratories and professional practice rooms within the training institutions they went and the under-qualification of their teachers.[43] As a result, only a few students in medical science have the opportunity to spend the required years in clinical rotations.[44] The existing legislation provides explicit general and specific State's obligations towards continuing education as described below.

i. Explicit State's general obligations towards continuing training

According to article 52 of the Public Health Act, "a national system of continuing education is established to build the capacity of health human resources." It derives from this provision that the system of continuing education should serve the whole country because of its national character. This provision however, does not expressly determine the institution of the state responsible for the establishment of the said national system of continuing education. The Presidential Ordinance of 2020 vests the national Ministry of Health with the specific power to develop a training program for health professionals in collaboration with the

37 Décret N° 06/130 du 11 Octobre 2006 portant statut spécifique des médecins des services publics de l'Etat. JO, N° spécial, 47ème année (hereinafter Decree on Public Physicians), art 5.

38 *Kalisia et al*., note 3, at 155.

39 *Abbatt et Mejia*, note 33, at 9.

40 Idem.

41 Ibid. at 9–10.

42 PNDS 2016–2020, at 41.

43 Idem.

44 *Kalisia et al*., note 3, at 155.

Ministry of Higher Education.[45] However, the above training program has never been developed. The provision under discussion suggests that capacity building constitutes the primary aim of continuing education whose purpose is to allow its beneficiaries to update their professional knowledge. Capacity building can relate to various aspects of the medical profession, such as treatment, prevention, and control of diseases as well as the use of some medical equipment or technology. Finally, the word "health human resources" must be broadly understood to include all medical personnel performing within public health institutions such as nurses, physicians, pharmacists, radiologists, laboratory technicians and others. Article 52 under discussion does not provide a further indication of how the above national system of continuing education should work. For instance, it does not expressly provide for mandatory continuing education and neither does it indicate the person or institution which should bear the cost of continuing education. The act does not provide for any special fund to cater for the training.

ii. Explicit specific State's obligations towards continuing training for nurses and doctors

The Nurse Act and the Decree on Public Physicians deal respectively with the issue of continuing training for nurses and physicians. According to article 47 of the Nurse Act, "every nurse has the right to keep his professional knowledge up to date. The State and the national order of nurses shall organize the capacity building training". Under this provision, the update of one's professional knowledge is a right to be enjoyed by all nurses. The full enjoyment of this right can only be achieved when the continuing training is organized by the State in collaboration with the order of nurses. However, the article at hand does not specify the modalities of its application. In part, Article 47 of the Decree on Public Physicians reads as follows, "The State provides the physician, to the extent compatible with the requirements of his duties, all facilities to ensure his continuing education through improvers' courses, appropriate internships at home or abroad, participation in conferences and congresses related to the medical profession that he performs". Compared to the previous provisions, this article is relatively revolutionary from different perspectives. Firstly, the obligation imposed upon the State to provide the physician all facilities must be interpreted to include financial, administrative, or social means necessary for an appropriate continuing education. To this end, the Decree at hand determines and regulates some of these facilities. For instance, in addition to benefiting from a temporary leave of absence[46] the physician who carries out continuing education for the interest of the country upon his/her request is entitled to a quarter of his/her remuneration as well as the all social advantages.[47] Moreover, the duration of the continuing education is included in that of professional experience

45 Presidential Ordinance 2020, art 24.

46 Decree on Public Physicians, art 54.

47 Decree on Public Physicians, art 57.

or career.[48] At the end of his/her continuing training, the physician can return to his/her work.[49] Secondly, the Act recognises different forms of continuing training such as participating in courses, internships, conferences, and congresses. Thirdly, this provision makes it explicit that the above continuing training may take place either in the country or abroad. However, the Decree under discussion has also some weaknesses. For instance, during the training period, a physician who carries out continuing training for the interest of the public hospital he/she works for, does not have the same advantages and rights than a physician who carries out a continuing training of general interest to the country.[50] Moreover, it still remains unclear whether the training to be carried out shall be fully funded by the State, the health institution concerned, or the physician.

II. State's obligations based on the right to health

The DRC protects the right to health through both its ratified human rights treaties and domestic laws. Regarding ratified human rights treaties, they have precedence over the domestic laws other than the Constitution according to article 215 of the DRC Constitution. They consist of all the major human rights treaties that protect the right to health,[51]including article 12 of the International Covenant on Economic, Social and Cultural Rights.[52] Indeed, in addition to the freedoms component, the right to health contains entitlements that include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[53] Its full implementation calls for the creation of conditions which would assure all medical service and medical attention in the

48 Ibid.

49 Ibid, arts 53 and 58.

50 See art 56 of the Decree on Public Physicians.

51 Illustrations include the 1979 Convention on the Elimination of All Forms of Discrimination against Women, art 12, the 1989 Convention on the Rights of the Child, art 24, the 1990 African Charter on the Rights and Welfare of the Child, art 14, the 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, art 14, and article 16 of the African Charter. For details about human rights treaties to which the DRC is party, see la Commission Nationale des Droits de l'Homme de la République Démocratique du Congo, Troisième rapport annuel d'activités de la Commission Nationale des Droits de l'Homme (janvier à décembre 2018), Kinshasa, 2019 (hereinafter CNDH Annual Report 2019), at 70.

52 The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;(b) The improvement of all aspects of environmental and industrial hygiene;(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

53 General Comment 14, para 8.

event of sickness.[54] These conditions comprise inter alia, the provision of equal and timely access to basic preventive, and curative health services; appropriate treatment of prevalent diseases, illnesses, injuries, and disabilities, preferably at the community level.[55] More importantly, trained and skilled medical professional personnel, and scientifically approved and unexpired hospital equipment that would enable enjoyment of the right to health.[56] Reference to "trained and skilled medical personnel" implies that in addition to initial medical education, medical professionals benefit from continuing education. Therefore, the State is obliged to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill, and ethical codes of conduct.[57] The same obligation applies to hospital equipment which must be appropriate.

At the domestic level, the right to health is protected under article 47 of the DRC Constitution, which calls expressly for the enactment of the law that sets out the fundamental principles and rules organizing public health and food security. Adopted 12 years after the coming into force of the DRC constitution, the Public Health Act entitles every patient to quality health care.[58] Further legislation including the HIV law,[59] and the Child Act also protects the right to health.[60] Taken together, public health institutions cannot provide quality health care services without appropriate medical equipment and skilled and trained medical personnel. This is because, appropriate medical training and health equipment are essential parts of the quality of health care.[61] Consequently, the lack of capacity building for the provider of medicines including pharmacists constitutes a threat to the right to health.[62] It is within this context that, some cases of violation of the right to health associated with the dilapidation of health infrastructure and equipment for public health institutions and poor hygienic conditions have been submitted before the National Commission for Human Rights.[63] This is an indication that Congolese people can bring the State before national[64]

54 See article 12 (2) (d) of the ICESCR and 16 (2) of the African Charter.

55 General Comment 14, para 17.

56 Idem.

57 It is the State's obligations to ensure the appropriate training of doctors and other medical personnel. Ibid. paras 35–36.

58 Public Health Act, art 17.

59 Loi N° 08/011 du 14 Juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées, art 11.

60 Loi N° 09/001 du 10 Janvier 2009 portant protection de l'enfant, art 21.

61 The lack of skilled and trained health professionals coupled with inappropriate existing basic health infrastructures and equipment in public health institutions affect the quality of healthcare. PNDS 2016–2020, at 34.

62 *Bofoe Lokangu*, La criminalité pharmaceutique en République Démocratique du Congo : une véritable menace au droit à la santé, Paris, 2019, at 51 and 59.

63 CNDH Annual Report 2019, note 52, at 60–66.

64 National protection human rights mechanisms include inter alia, courts and tribunals, the National Commission of Human Rights, and the national ministry with human rights in its remit. See ar-

and international[65] human rights mechanisms for violation of the right to health based on the under-equipment of public health institutions and the lack of appropriate medical skills of public health personnel.

B. The place of the CS within the national health system and its role in the delivery of health care

I. The national health system

The national health system is organized at three stages: national, provincial, and peripheral levels. The central level defines the broad directions of national health policy and sets out guidelines, standards, and intervention strategies. It consists of the Minister with public health in his remit, the general secretariat, and the general inspectorate of health.[66] Regarding the national health minister, in particular, he/she is further vested with the power to among others, to organize, create, and control public medical and pharmaceutical services.[67]It must be emphasized that, the DRC Constitution extents health matters to the competence of the national government, which must be broadly understood to include the national executive and the parliament. To this end, it entrusts the national government with the exclusive competence[68] of making legislation on the profession of pharmacist, and the admission to the medical professions, organizing preventive medicine, maternal and child protection, ensuring the technical coordination of medical laboratories and the distribution of doctors. The central government has further concurrent jurisdiction with the provincial government in the hiring of the medical command staff.[69]

From its part, the intermediate or provincial level is responsible for the coordination, support, supervision, control, monitoring, and evaluation of all health activities under its jurisdiction. It ensures the implementation of national health policy, guidelines, standards, and strategies.[70] The intermediate level is managed by provincial health departments, the number of which has recently increased from 11 to 26.[71] Like with the national level, the Constitution[72] recognizes the exclusive jurisdiction of the provincial government in some competences, such as the assignment of medical personnel, the enforcement and control of

ticles 150 (1) of the DRC constitution, 6 (2) et 28 of Loi organique N° 13/011 du 21 mars 2013 portant institution, organisation et fonctionnement de la Commission Nationale des Droits de l'Homme, and 25 of the Presidential Ordinance 2020.

65 For instance, the African Commission on Human and People's Rights. See arts 55 and 56 of the African Charter.

66 Public Health Act, article 7.

67 Articles 24 of the Presidential Ordinance 2020 and 10 of the Public Health Act.

68 DRC Constitution, art 202, 36 (h).

69 DRC Constitution, art 203.

70 Public Health Act, Article 8.

71 DRC Constitution, art 2.

72 Ibid., Article 204.

national medical and pharmaceutical legislation and the organization of curative medicine services, medical laboratories, and pharmaceutical services, the organization and promotion of primary health care. The peripheral or operational level is headed by the Zone de Santé (ZS),[73] which organizes the structures responsible for providing comprehensive, ongoing, and integrated health care.[74] A ZS is a geographically limited space covering a theoretical population of 100,000 to 150,000 inhabitants. It consists of the central office of the ZS, the General Hospital of Reference (GHR), health centres of reference, CS, health posts and other public and private health facilities under its jurisdiction.[75] The ZS is further subdivided into health areas (AS) which, through the CS, provides health care for about 5,000 to 10,000 inhabitants.[76] Currently, the national health system counts 516 ZS, of which 393 only have a GHR, and 8,504 planned health AS with 8,266 CS.[77] These statistics indicate that some areas of the country have neither a GHR nor a CS.

II. The role of the CS in the provision of health care

In DRC, the formal health care starts with the local CS,[78]which is a compulsory health structure of the first contact of the population with the health system.[79] Health services provided by the CS consist of a minimum package of activities that include inter alia, preventive activities, curative care, such as treatment of chronic diseases and small surgery, and promotional activities. In the ZS with a GHR, the CS maintains an operational relationship with the HGR which delivers the complementary package of activities, through the process of reference and counter-reference. Accordingly, if reference consists of referring patients from the CS to the HGR for appropriate care, counter-reference allows the HGR to return patients to the CS.[80] Unless it is intended to ensure medical follow up to the health status of patients who have already received appropriate care at HGR, the counter-reference in this context seems unnecessary. It is worth recalling that in ZSs without HGR, the CS may be the only available health institution that provides all the medical care without any possibility for transfer. Concerning human resources, at least five positions should be filled within the CS by namely: two graduate nurses respectively in charge of consultation and health care; one technician of laboratory; one person in charge of reception with a humanity school's diploma and one person in charge of maintenance and logistics.[81] The underpin-

73 Public Health Act, article 9.
74 PNDS 2016–2020, at 21.
75 Public Health Act, art 10.
76 PNDS 2016–2020, at 23.
77 Idem.
78 *Kalisia et al.,* note 3, at 155.
79 2006 Health Zone standards, at 16.
80 2006 Health Zone standards, at 18.
81 Ibid. at 20.

ning idea for a minimum of two nurses is that one nurse should serve about 5,000 inhabitants.[82] This minimum number of medical staff assigned to a CS is small as compared to the number of the population that rely on healthcare. Regrettably, the worker in charge of logistics and maintenance of medical equipment does not need to meet any education requirement.

III. The case study of the CS Lukula

CS Lukula was created in 1989 and depends on the ZS of Masi-Manimba located in the province of Kwilu. In addition to serving as centre of reference for three health posts, it maintains a working relationship with the HGR of Masi-Manimba situated at about 3 kilometres away. It covers an estimated population of about 16, 000 inhabitants.

1. Medical staff and continuing training

The medical personnel of the CS Lukula consist of 36 members namely: 25 nurses, 2 midwives, 1 laboratory technician, and 8 other employees with no medical background. The highly qualified medical staffs hold an undergraduate degree (3 years) in medical science, while the less qualified have a certificate from medical humanities school from Institut Technique Médical. It must be recalled that the distribution of medical personnel between health institutions is made by both the central and provincial governments[83] and is done in an unequal manner.[84] For instance, existing norms on the distribution of medical personnel do not provide for the presence of physicians or doctors at the CS's level.[85] As a result, CSs in DRC are staffed with and run by providers ranging from non-licensed individuals with minimal training to nurses who have graduated from government -certified programmes.[86] In addition, CSs are characterized by a shortage of an important number of medical specialists, such as pharmacists, surgeons, radiologists, obstetricians, anaesthetists, and physiotherapists[87]as well as occupational health physicians.[88] As a result, nurses assigned to the CS Lukula combine their traditional tasks with some services that fall within the specialty of some of these medical staff. Without undermining the skill of the medical personnel, their capacity to contribute to the health quality of patients is unlikely to be effective. The absence of a worker in charge of maintenance for medical equipment is an indication that the

82 Idem.

83 DRC Constitution, arts 202, (36) (h) and 203 (10).

84 PNDS 2016–2020, at 36.

85 PNDS 2016–2020, at 37.

86 *Kalisia et al.,* note 3, at 155.

87 The country is deficient in these categories of health professionals. See PNDS 2016–2020, at 39.

88 The Democratic Republic of the Congo is orphan regarding occupational physicians. See *Loko Mantuono*, Couverture sociale des maladies à caractère professionnel en République Démocratique du Congo. Plaidoyer pour la réforme de la sécurité sociale, Paris, 2016, at 179.

CS Lukula does not have appropriate medical equipment that needs maintenance, or its existing medical equipment is not appropriately maintained.

For continuing training, medical staff affected by the CS Lukula do not benefit from a system of continuing education from the State. As a result, their professional knowledge is not regularly updated. Indeed, although formalized and recognized by some laws and regulations as discussed earlier, continuing education for medical professionals is not implemented due to the lack of an operational continuing education system,[89]a sub-sectoral strategy in this area, a national continuing education plan, as well as clear standards and guidelines for regulating the field.[90] Nevertheless, some medical staff such as the nurse in chief, participates in selective trainings organized by some State's partners who support vaccination, family planning, and management of malaria. Needless to recall that all expenses for training including travel expenses, accommodation, and restoration are covered by the State's partner concerned. The main criticism against this selective training according to the needs of specialized programmes is that, it threatens the implementation of health services that provide quality health care, which is global, continuous, integrated, and effective.[91]

2. Medical equipment

The CS Lukula is housed by a building made of semi- durable materials. In addition to some beds and material for small surgery, its main medical equipment consists of a microscope for laboratory services. This can be partly attributed to the health workforce available[92]to the CS, which does not include medical specialists capable of handling modern medical equipment such as X-ray machines, medical lasers, or blood gas analysers. Admittedly a microscope can be used for routine examinations, but not for specialized examinations.[93] This can impede an appropriate diagnosis and result in inadequate treatment. The collaboration between the diagnostic laboratory and clinicians is an essential element for quality care[94]in that an appropriate treatment depends on the accuracy of the laboratory results. For such collaboration to be successful, laboratories must have a technical platform that allows them to play the three main roles, namely diagnosis, biological assessment, and epidemiological surveillance.[95] However, unlike in developed countries where the confirmation of diagnosis requires further examinations, in underdeveloped countries such as

89 PNDS 2016–2020, at 41.

90 PNDS 2011–2015, at 142–143.

91 Cour de Compte, note 15, at 4.

92 World Health Organisation, Core medical equipment, note 23.

93 *Linsuke et al*., Laboratoires médicaux et qualité des soins : la partie la plus négligée au niveau des hôpitaux ruraux de la République Démocratique du Congo, Pan African Medical Journal, 2020, at 4.

94 Ibid., at 2.

95 Idem.

DRC, diagnosis is often presumptive and clinicians are often forced to treat all differential diagnoses with non-compliant prescriptions and poor patient management as the results.[96]

In the case of the CS Lukula, such collaboration between laboratory and clinicians is doomed to fail because of lack of special laboratory equipment necessary for further or specialized examinations and the limited number of qualified laboratory technicians. The current state of the laboratory equipment of the CS Lukula confirms the assertion that, laboratories are among the neglected sectors of the Congolese health system,[97]to the extent that they cannot detect the major epidemics in time.[98] Thus, the Congolese government has still a long way to go towards the acquisition of new diagnostic and therapeutic technologies.[99] On the other hand, the CS Lukula lacks some basic equipment such as fridges needed to keep some medicines and transport equipment including ambulances. It means that medicines and other health utensils received from the ZS are transported to the CS on foot, despite the eventual risk of bad weather. Further, there can never be a prompt and secure transfer of patients and people in risk to the HGR in case of emergency or when the CS is unable to deal with the medical issue brought to it.

C. Concluding observations and recommendations

In recognizing the CS as a first-level care facility,[100]the Congolese government entrusts it with a crucial mission in the delivery of health care, especially in rural areas. Paradoxically, the CS is one of the public health institutions which is poorly equipped and run by less skilled health personnel. Due to the lack of an appropriate system of continuing education, its medical staffs cannot update their professional knowledge and skills therefore putting an end to the ongoing nature[101] of medical education. This is the situation of the CS Lukula whose medical staff does not include any physician, pharmacist, surgeon, or radiologist having the microscope as the main medical equipment. In sum, the lack of an appropriate continuing education system and medical equipment for the CS does not allow the facility to cater to people's health needs through the delivery of health care services of good quality. To fill in these shortfalls, the following actions must be taken:

- The government should prioritize the needs of the CS, including the CS of Lukula through the assignment of the most qualified medical professionals such as physicians, pharmacists, and surgeons and the allocation of appropriate and basic diagnostic, therapeutic, laboratory and transport equipment. This recommendation takes into consideration not only the emergencies that the CS deals with, but also geographical difficulties to

96 Idem.
97 Ibid. at 5.
98 PNDS 2016–2020, at 27.
99 PNDS 2011–2015, at 60.
100 2006 Health zone standards, at 16.
101 *Abbatt et Mejia*, note 33, at 10.

access a GHR especially in rural areas. Otherwise, the CS would be akin to a reception room whose function shall consist of merely transferring all patients to the GHR if any. The risk beyond this is that the GHR may also see its functions limited to issuance of records such as death certificates of transferred patients from the CS.

- The government should make continuing training compulsory by implementing the existing legislation and regulation on the subject through the establishment of a working continuing training system. Medical science and health issues are continuously evolving therefore it is more than a necessity to allow medical personnel to update their knowledge, experiences and skills to this evolving science.
- People should resort to the existing national human rights protection mechanisms (the courts of law, the National Commission on Human Rights, and the national ministry with human rights in its remit) to prompt the Congolese government to comply with its human rights obligations towards the right to health. The obligations can be fulfilled by the government by adequately equipping all CSs including the CS Lukula and ensuring a continuing training of its medical staffs.
- Finally, members of the National Assembly or the Senate need to make use of parliamentary means of control over the national government, such as oral or written questions, interpellation, and hearing in the commissions upon the national ministers of health and higher education regarding the establishment of a national system of continuing training and upon the national health minister regarding the equipment of public health institutions, including the CS of Lukula.[102] If the use of these parliamentary means of control proves to be ineffective, the national assembly can use its exclusive power relating to the adoption of the motion of no-confidence.[103]

102 DRC Constitution, art 138.

103 When a motion of no confidence against a member of the government is passed, he/she is deemed to have resigned. See art 147 of the DRC Constitution.