

Training of Medical Doctors in the DRC

Consequences of uncontrolled creation of medical schools in the province of Katanga

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Overview of the presentation

- Introduction
- Aims
- Context
- Reasons for creating new medical schools
- Consequences on the quality of medical training
- Consequences on the organisation and delivery of care
- In brief: back to the framework
- Conclusion
- Way forward

1. Introduction

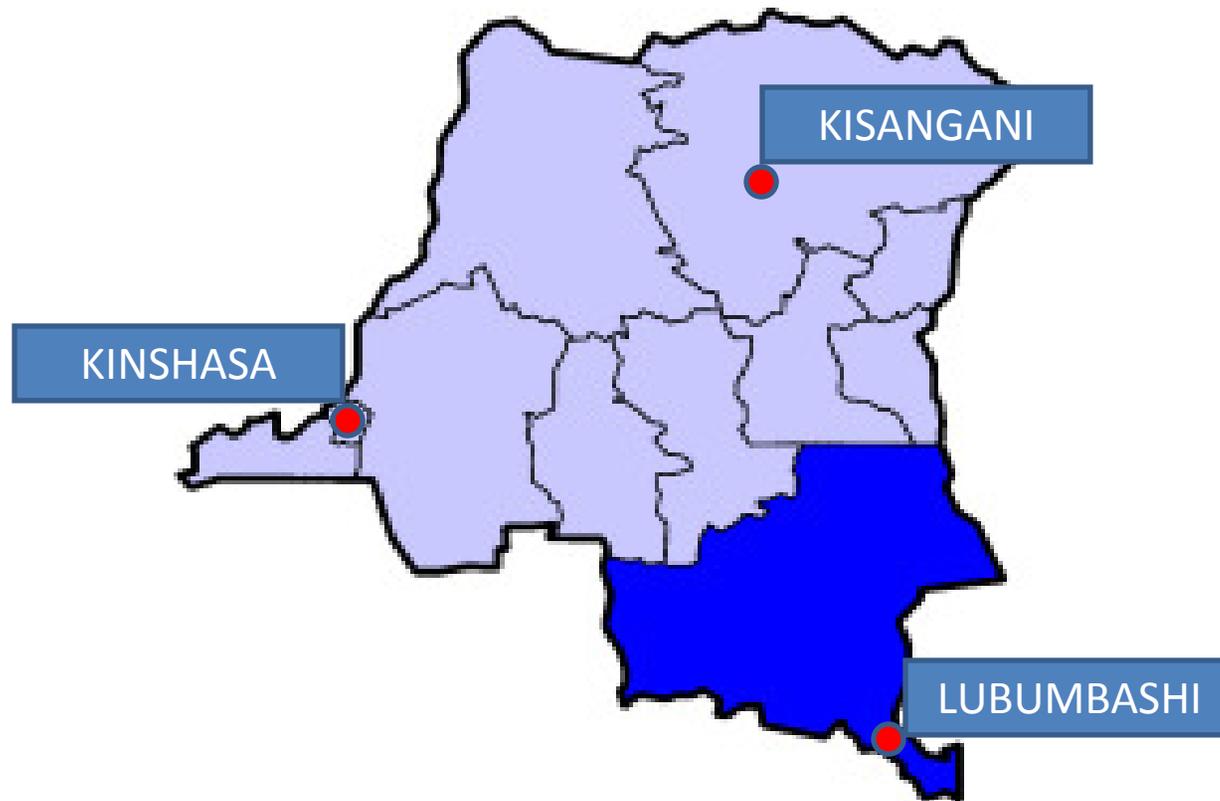
- Our analysis is focused on medical schools and their output: medical doctors
- But the uncontrolled creation of training institutions in the health sector also affects nursing training schools and leads to a plethora of nursing staff

2. Aims

- Describe and explain the reasons of the uncontrolled creation and productivity of medical schools in DRC
- To discuss its effects, beneficial and harmful, on the functioning of the Katanga Province health system

3. Context:

Fig 1. Map of DRC: From 1960-1990: 3 faculties of medicine



4. Reasons for creating new medical schools

- Liberalisation of public/private universities in DRC aimed at bringing training institutions closer to users
 - Parallel to the liberalisation of political parties in 1990 (Mashako, 1999)
- Lack of strong leadership (regulation, coordination, financing) of the Ministry of Higher Education (MoHE) led to:
 - Uncontrolled creation of medical schools:
 - due mostly to political pressures: politicians acting in collusion with professors created medical schools in their native provinces without any preparation and financing
 - as a financial “coping strategy” : yearly tuition fees varying between 250 - 500USD per student
 - Lack of central planning putting in relation needs (MoH) and production (Ministry of High Education) of health workers

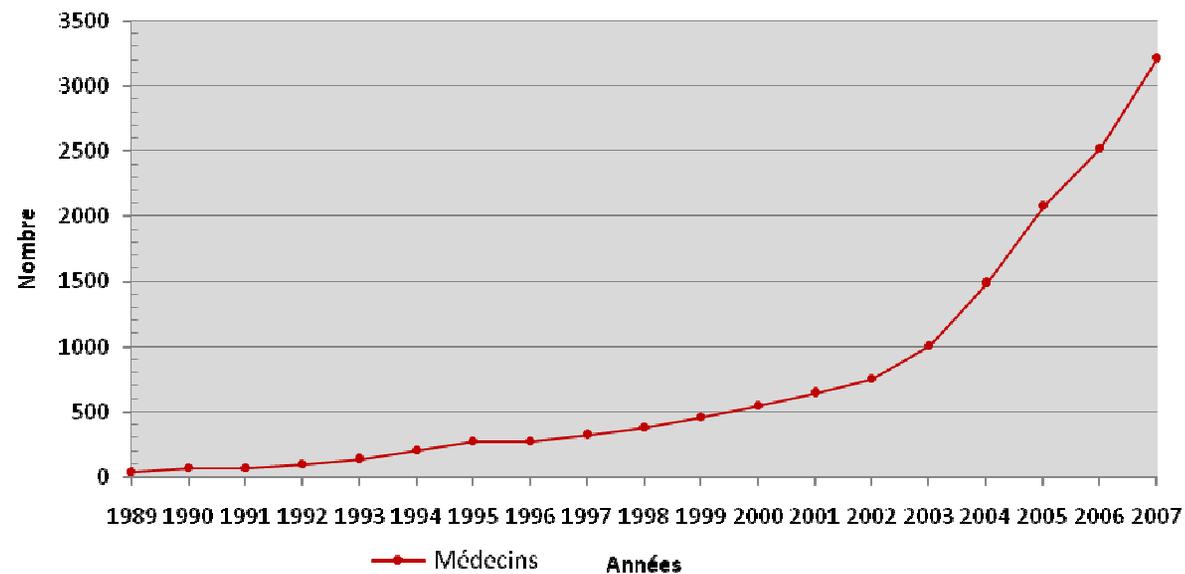
5. Consequences of the uncontrolled creation and productivity of medical schools: Poor quality of training (1)

- Increased autonomy of universities combined with a lack of central financing led to increased admission of students to boost resources (for ex. extensions of UNILU in the whole province and abroad): +/- 6000 students at the Faculty of medicine of Lubumbashi (2008-2009)
 - Training infrastructure totally inadequate
 - Lack of any form of interactive teaching
- Only four hospitals receive trainees in their last year aiming at acquiring needed clinical skills :
 - Only 1000 hospital beds used to train more than 700 students (2009)
 - Batches of trainees can sometimes reach 80 people obliging to organise alternate ward rounds

Under these conditions one can doubt of the real acquisition of the needed knowledge and skills to become a good practitioner

5. Consequences of uncontrolled creation and productivity of medical schools: Poor quality of training (2)

Fig 3. Exponential evolution of graduates from the Faculty of Medicine of the UNILU :
Cumulative curve of trained MDs



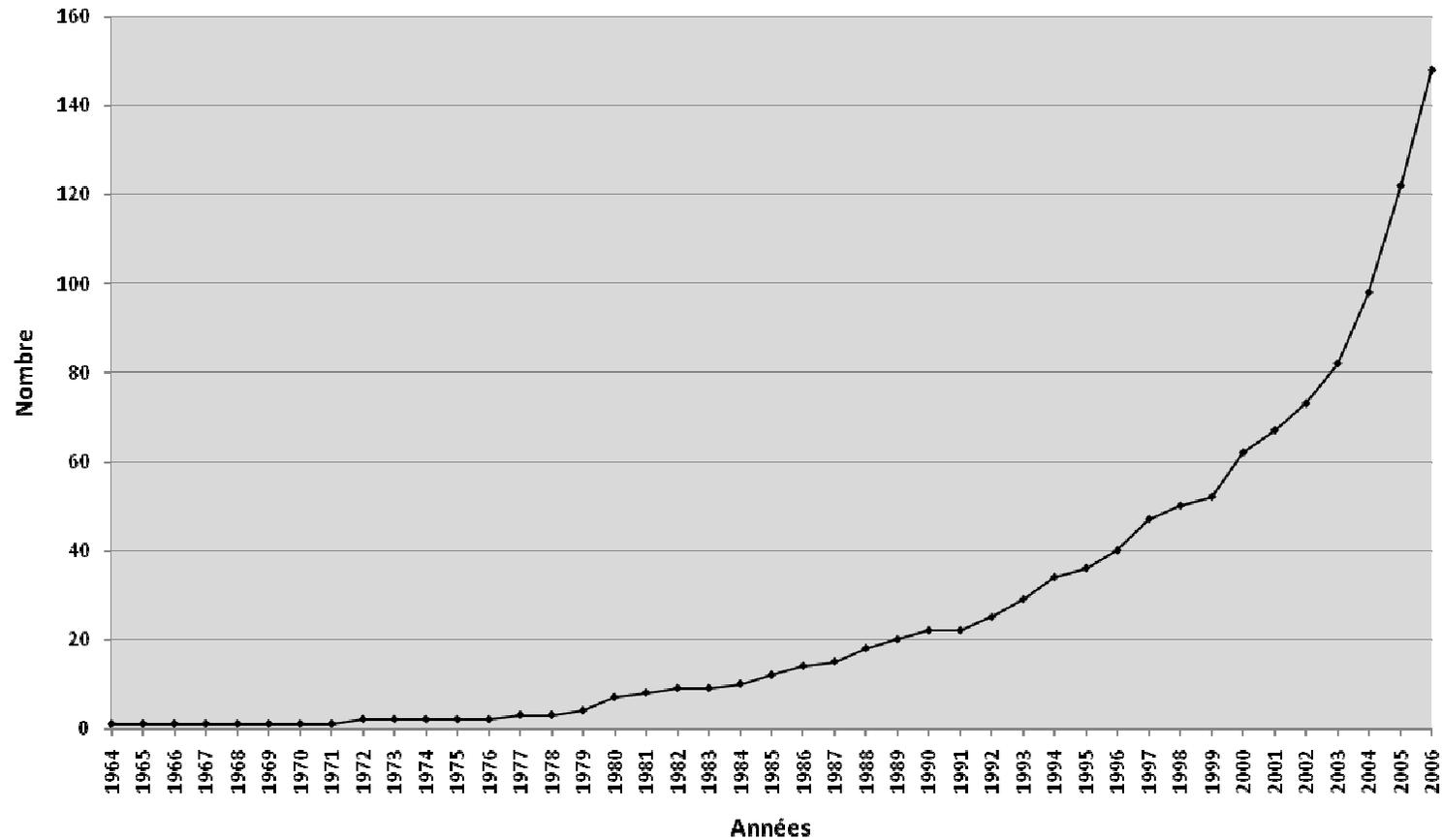
6. Consequences on health services and on health care delivery (1)

- The # of MD posted in MoH hospitals is increasing regularly but is not linked to an increase of workload. The low # of cases treated per MD does not allow them to maintain their clinical skills.
- MD's not hired by MoH reorient themselves to private practice: increasing # of 'intermediary' structures and of 1st line health services staffed with MDs
- This plethora of MDs needs to be paid on the revenue generated in the facilities. This has a detrimental effect on financial accessibility
 - Since 2005, the price of a normal delivery at a first line health service increased 10 times in Congolese Francs (CF) and 4 times in USD
 - At hospital level, the price in USD of a C-section tripled in the same period

Consequences on health services and on health care delivery (2)

Health Facility Ownership	First line services	Intermediate services	Hospitals
- Government	15 (6,8%)	4 (17,4%)	6 (66,7%)
- Missionary	31 (14,1%)	2 (8,7%)	1 (11,1%)
- Other (enterprises, local NGOs)	10 (4,4%)	1 (4,3%)	2 (22,2%)
- Private for profit			
Medical Doctors	39 (17,8%)	13 (56,5%)	-
<i>Other Health professionals</i>	95 (43,4%)	-	-
<i>Other non-health professionals</i>	30 (13,7%)	3 (13,0%)	-
<i>Sub-total</i>	164 (74,9%)	16 (69,6%)	-
Total	219 (100%)	23 (100%)	9 (100%)

Consequences on health services and on health care delivery (3)

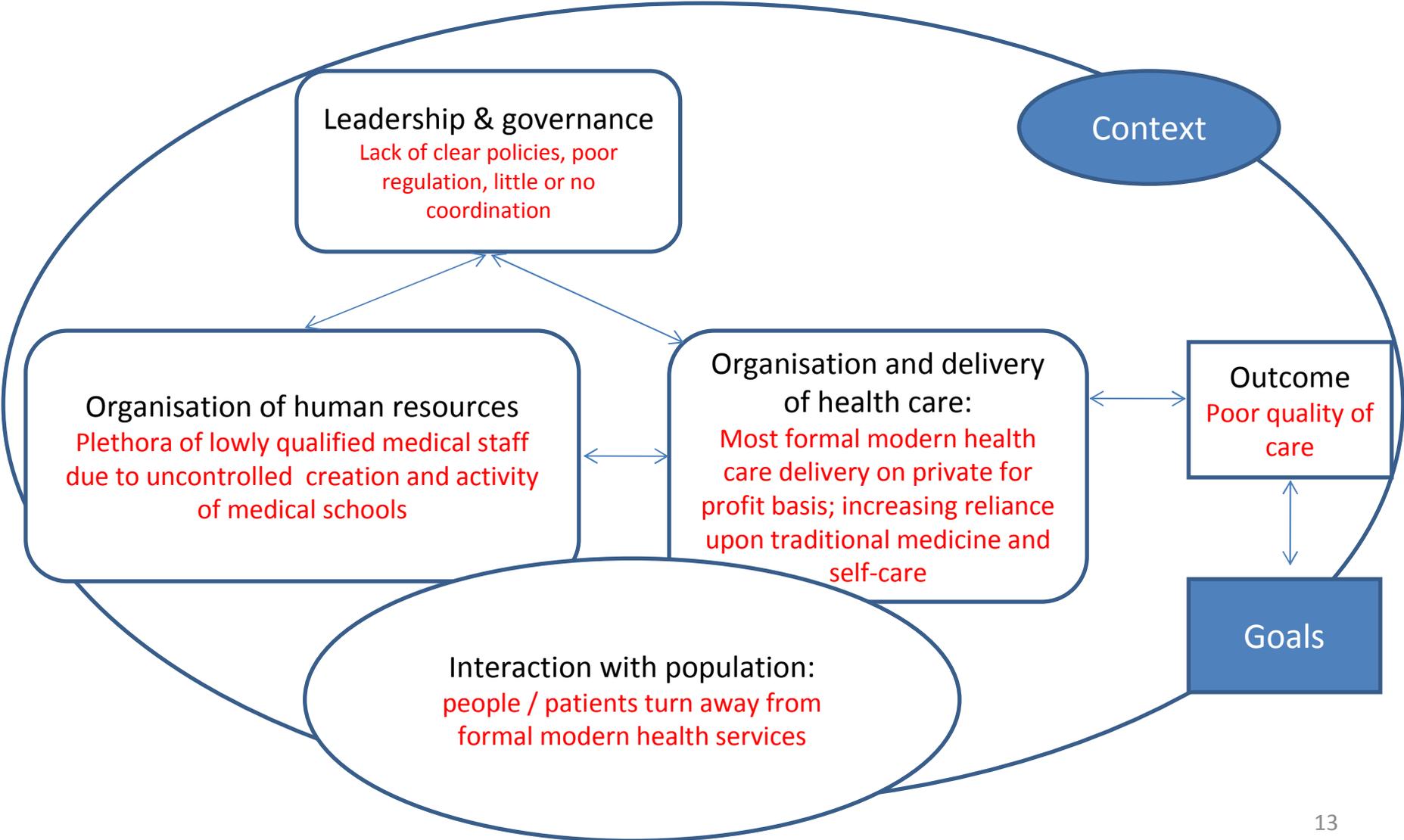


7. General consequence: deteriorating quality of care

- Health facilities in city of Lubumbashi are poorly used
 - < 1-3 curative consultations/day
 - Overall utilisation rate in city of Lubumbashi (2006) <0.4 NC/inh/year
- Medical prescriptions out of standard
 - Overprescribing of antibiotics : 1/3 of contacts receive 2 to 4 injectable antibiotics given 2-3 times a day in ambulatory treatment
 - Systematic prescription of dexamethazone injection at paediatric ward level
 - 2/3 prescriptions > 4 drugs, some not related to the diagnosis

Under such conditions, quality of care is jeopardised

8. An overview



9. Conclusion (1)

- In a situation of State failure, the uncontrolled production of MDs does **more harm** (poor / dangerous quality of care) **than good** (better coverage of health services in urban area)
- Under similar circumstances, the health system **cannot reach its goals**

10. Way forward: measures being implemented

- Quality assurance mechanism: admission tests in first and fourth years
- Rationalisation of number of schools: progressive suppression of all peripheral extensions of UNILU's medical school
- Inventory and quality control of all medical schools (private/public) throughout the country
- Feed decision-makers with research data on the phletora of health staff and its detrimental consequences for people's health

THANK YOU FOR ATTENTION