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Quantitative Evaluation of Health Service Utilization in the Kenge Health Zone, Kwango Province, Democratic Republic of the Congo

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ABSTRACT

Introduction

The Democratic Republic of the Congo (DRC) continues to face protracted socio-economic instability that adversely impacts population well-being and impedes access to essential medical care. Equitable access to healthcare services remains a critical challenge in rural settings such as the Kenge Health Zone, resulting in consistently low service utilization. Improving service availability and economic accessibility is crucial to ensuring effective healthcare delivery.

Purpose

This study evaluated the quantitative utilization of healthcare services within the Kenge Health Zone across the 2024–2025 evaluation periods.

Methods

A retrospective, quantitative, descriptive empirical design was conducted across 20 health areas randomly selected from the 29 total health areas comprising the Kenge Health Zone. Secondary performance data collected via the quantitative assessment framework developed by the Health System Development Project (*Programme de Développement des Services de Santé* [PDSS]) were extracted in collaboration with evaluators from the Performance-Based Financing Public Utility Establishment (*Établissement d'Utilité Publique - Financement Basé sur les Résultats* [EUP-FBP]). Service utilization rates were calculated against PDSS targets and evaluated using standard validation thresholds (≥ 80% indicating effective utilization).

Results

Overall healthcare service utilization remained low across both years, recording overall coverage rates of 30.8% in 2024 and 36.5% in 2025. Although specific indicators exceeded operational targets—such as contraceptive renewal (198.2% in 2024) and cesarean deliveries (119.4% in 2024; 154.0% in 2025)—most basic preventive and curative primary health services operated well below optimal thresholds.

Conclusion

Healthcare services in the Kenge Health Zone are severely underutilized by the local population. Heavy reliance on direct, out-of-pocket household expenditure serves as the main barrier to access. Given that subsistence agriculture forms the economic foundation of the zone, health policymakers should consider flexible mechanisms, including in-kind payments and fixed sliding-scale fee structures, to reduce financial barriers and enhance service utilization.

INTRODUCTION

Despite global advancements in public health, fundamental structural inequalities persist in healthcare access and delivery across developing nations (World Health Organization [WHO], 2008). Sub-Saharan African populations continue to experience severe health system deficits, where mothers frequently lack skilled attendance during delivery, children miss life-saving vaccinations, and households suffer catastrophic health expenditures due to out-of-pocket payment mechanisms (WHO, 2008).

Economic theory and empirical evidence demonstrate that demand for formal health services is highly price-elastic among low-income populations; marginal fee increases trigger significant reductions in utilization (Koch et al., 2012; McPake et al., 2011). Accelerating progress toward Universal Health Coverage (UHC) requires establishing equitable, predictable, and effective financing mechanisms (Ridde et al., 2014). Structural access barriers disproportionately affect socio-economically vulnerable groups (Sottas et al., 2020), as documented across diverse settings facing institutional exclusion and cost barriers (Kamgain, 2015). Across sub-Saharan Africa, direct out-of-pocket household expenditures account for up to 80% of total health spending, heightening systemic vulnerability and health inequities (Boukoulou, 2017).

In the Democratic Republic of the Congo (DRC), persistent socio-economic constraints severely limit national capacity to strengthen public health delivery. Primary healthcare services—specifically maternal and child health and family planning—remain underfunded. According to the Ministry of Public Health, Hygiene and Prevention (MSPHP, 2022), public health financing is low in absolute and relative terms, with total health expenditure representing approximately 4% of gross domestic product (GDP) in 2021. The national health sector relies heavily on external assistance (38% of current health expenditure in 2021) and direct household out-of-pocket payments (40% in 2021) (MSPHP, 2016, 2022). This structural imbalance yields a delivery system that is neither geographically accessible nor socio-economically equitable.

Similar pattern of low healthcare service utilization is documented in rural health zones across the country. In the Pweto Health Zone (Haut-Katanga Province), for example, curative consultation rates consistently fell short of the WHO target benchmark of 0.5 new cases per capita per year, with household head unemployment or self-employment strongly linked to severe service underutilization (Cilundika Mulenga et al., 2015).

In the Kenge Health Zone, access to primary care remains constrained despite operational efforts supporting national UHC goals. In practice, operational UHC frameworks in the DRC often prioritize care availability, structural quality, and spatial access while underestimating household purchasing power. Even when clinical care is physically available, prohibitive service fees and long transport distances effectively exclude impoverished households. Uncontrolled proliferation of unregulated private healthcare vendors further exacerbates financial exploitation, leaving low-income families without standardized protection or uniform pricing (MSPHP, 2018). High local unemployment and informal labor reliance leave Kenge residents vulnerable to health-induced impoverishment.

Research Objectives & Hypotheses

This study evaluated the quantitative level of healthcare service utilization across the Kenge Health Zone from 2024 to 2025. Specifically, the study sought to answer the following research questions:

1. To what extent are primary healthcare services utilized by the population of the Kenge Health Zone?
2. What operational and financial factors contribute to service underutilization?
3. What policy measures can optimize service utilization within rural health zones?

We hypothesized that healthcare services in the Kenge Health Zone are substantially underutilized due to high out-of-pocket care costs, limited household purchasing power, and physical accessibility barriers.

METHODS

Study Setting

The Kenge Health Zone is located within the Kenge Territory (Kwango Province, DRC). It is bounded to the north by the Kikongo Health Zone and the Wamba River;

to the south by the Kimbau Health Zone; to the east by the Inzia River (bordering the Masimanimba Health Zone, Kwilu Province); and to the west by the Boko Health Zone and the Wamba River. Transportation predominantly relies on secondary unpaved roads, which become difficult to navigate during the rainy season. National Route 1 connects Kenge to Kinshasa (280 km). The zone covers an estimated area of 5,558 km^2 with a population of approximately 320,196 inhabitants, yielding a population density of 57.6 inhabitants/km^2.

The population comprises diverse ethnic groups—including the Yaka, Pelende, Suku, Mbala, Ngongo, Songo, Tsamba, and Yansi—with Lingala and Kikongo serving as the primary spoken languages. The local economy relies on subsistence agriculture, small-scale informal trading, and seasonal manual labor, resulting in low average household incomes.

Study Design, Population, and Sampling

A retrospective, quantitative descriptive empirical study was conducted analyzing secondary service performance data covering the years 2024 and 2025. Secondary data were sourced from the Performance-Based Financing Public Utility Establishment (*Établissement d'Utilité Publique - Financement Basé sur les Résultats* [EUP-FBP]), which verifies and purchases healthcare performance indicators on behalf of the Health System Development Project (*Programme de Développement des Services de Santé* [PDSS]).

The target universe comprised 29 administrative health areas within the Kenge Health Zone. Using simple random sampling stratified by demographic weight, 20 health areas were selected: Bangombe, Bangongo, Barrière, CBCO, Fasamba, Gabia, Holy Spirit, Kapay, Kasombo, Kimafu, Kobo, Kolokoso, Lono, Makiala, Makiosi, Misele, Mukila, Mukumbi, Musaka, Musangu Tsay, and Saint Peter.

Inclusion Criteria: Health areas belonging to the Kenge Health Zone that were randomly selected and possessed complete EUP-FBP/PDSS evaluation records for both 2024 and 2025.

Exclusion Criteria: Health areas outside the Kenge Health Zone, or selected areas with incomplete or missing quarterly evaluation archives for the target years.

Data Collection and Assessment Tool

Data were extracted using the standard PDSS Quantitative Health Center Assessment Grid. Data collection was performed in collaboration with official EUP-FBP verifiers. The standardized assessment grid evaluates performance across 15 core service indicators:

1. Outpatient Consultations (new cases)
2. Indigent Outpatient Consultations (capped at 5% target)
3. Severe Cases Referred to Hospital (with documented counter-referral)
4. Minor Surgery Procedures
5. Fully Vaccinated Children (ECV)
6. Postnatal Consultations (CPON)
7. First Antenatal Care Visit (CPN1)
8. Fourth Antenatal Care Visit (CPN4)
9. Assisted Deliveries
10. Cesarean Sections
11. New Postpartum Contraceptive Acceptors
12. Renewal of Modern Contraceptive Methods
13. Child Growth Monitoring (0–23 months; CPS 0–23)
14. Child Growth Monitoring (24–59 months; CPS 24–59)
15. Home Visits (VAD)

Data Reliability, Validation, and Performance Thresholds

To ensure data integrity, primary facility figures underwent a two-tier verification process: initial audit by primary EUP verifiers, followed by independent cross-verification by provincial health inspectors prior to performance bonus allocations. Validated performance percentages were calculated as:

Utilization Rate (%) = Validated Volume of Delivered Services / PDSS Expected Target Volume x 100

Service utilization rates were evaluated against standardized PDSS thresholds:

a) ≥ 80%: Effective utilization

b) 70% - 79%: Good utilization

c) 60% - 69%: Fair utilization

d) 50% - 59%: Low utilization

e) < 50%: Severe underutilization / non-utilization

Ethical Considerations

Ethical approval was granted by the Ethics Committee of the Doctoral School at the Higher Institute of Medical Techniques of Kinshasa (Approval No. 0002/CBE/ISTM/KIN/RDC/PMBBL/2024, dated February 16, 2024, pursuant to institutional decision No. 055/ESU/ISTM/DG/2022). Institutional permission was obtained from the EUP-FBP executive leadership to access regional performance archives. All extracted operational data were anonymized and processed securely.

RESULTS

Quantitative Assessment for 2024

Table 1 summarizes health service utilization across the 20 sampled health areas for 2024. Overall, health services recorded low general utilization, reaching an aggregate performance level of 30.8% of validated targets (49,360 validated services against a expected total target of 160,208).

Table 1:
Quantitative Assessment of Healthcare Service Utilization in the Kenge Health Zone (2024)

Performance Indicator	Target	Reported Data	Reported (%)	Validated Data	Validated (%)	Utilization Performance Category
Outpatient Consultations (New Cases)	70,610	20,252	28.7	19,877	28.2	Severe underutilization
Indigent Consultations (le 5%)	3,716	11	0.3	1	0.0	Severe underutilization
Hospital Referrals (Counter-referred)	1,487	569	38.3	558	37.5	Severe underutilization
Minor Surgery	3,345	1,607	48.0	1,470	44.0	Severe underutilization
Fully Vaccinated Children (ECV)	2,594	1,647	63.5	1,307	50.4	Low utilization
Postnatal Consultations (CPON)	4,757	1,963	41.3	2,461	51.7	Low utilization
First Antenatal Visit (CPN1)	2,676	2,404	89.8	2,199	82.2	Effective utilization
Fourth Antenatal Visit (CPN4)	2,676	1,266	47.3	1,190	44.5	Severe underutilization
Assisted Deliveries	2,676	1,636	61.1	1,610	60.2	Fair utilization
Cesarean Sections	67	88	131.3	80	119.4	Exceeded target
New Postpartum Contraceptive Acceptors	11,488	644	5.6	659	5.7	Severe underutilization
Modern Contraceptive Renewal	250	508	203.4	495	198.2	Exceeded target
Growth Monitoring (0–23 Months)	24,082	6,537	27.1	6,387	26.5	Severe underutilization
Growth Monitoring (24–59 Months)	8,548	7,108	83.2	4,588	53.7	Low utilization
Home Visits (VAD)	21,236	7,622	35.9	6,478	30.5	Severe underutilization
Total / Overall Average	**160,208**	**55,862**	**34.9**	**49,360**	**30.8**	**Low overall utilization**

Note - **Data source:** EUP-FBP validated database (2024).

In 2024, two specific indicators exceeded expected targets: renewal of modern contraceptive methods (198.2%) and cesarean section procedures (119.4%). Effective utilization (≥ 80%) was recorded for first antenatal consultations (CPN1: 82.2%). Assisted deliveries achieved fair utilization (60.2%), whereas child growth monitoring for ages 24–59 months (53.7%), postnatal visits (51.7%), and child vaccinations (50.4%) demonstrated low utilization. All other services suffered severe underutilization below 50%.

Quantitative Assessment for 2025

Table 2 outlines health service utilization rates across the target health areas for 2025. The aggregate validated utilization rate showed a slight increase to 36.5% (59,513 validated services against a total target of 162,682).

Table 2:
Quantitative Assessment of Healthcare Service Utilization in the Kenge Health Zone (2025)

Performance Indicator	Target	Reported Data	Reported (%)	Validated Data	Validated (%)	Utilization Performance Category
Outpatient Consultations (New Cases)	76,047	20,625	27.1	19,725	25.9	Severe underutilization
Indigent Consultations (le 5%)	4,002	1,880	47.0	1,625	40.6	Severe underutilization
Hospital Referrals (Counter-referred)	3,602	500	13.9	287	8.0	Severe underutilization
Minor Surgery	4,002	2,371	59.2	2,026	50.6	Low utilization

Fully Vaccinated Children (ECV)	2,794	1,786	63.9	1,224	43.8	Severe underutilization
Postnatal Consultations (CPON)	2,882	2,554	88.6	2,142	74.3	Good utilization
First Antenatal Visit (CPN1)	2,882	2,329	80.8	1,782	61.8	Fair utilization
Fourth Antenatal Visit (CPN4)	2,562	1,876	73.2	1,563	61.0	Fair utilization
Assisted Deliveries	2,562	2,580	100.7	2,470	96.4	Effective utilization
Cesarean Sections	53	97	183.0	82	154.7	Exceeded target
New Postpartum Contraceptive Acceptors	1,601	898	56.1	627	39.2	Severe underutilization
Modern Contraceptive Renewal	5,043	1,239	24.6	983	19.5	Severe underutilization
Growth Monitoring (0–23 Months)	25,295	15,271	60.4	9,416	37.2	Severe underutilization
Growth Monitoring (24–59 Months)	9,046	7,374	81.5	2,693	29.8	Severe underutilization
Home Visits (VAD)	22,871	15,210	66.5	12,868	56.3	Low utilization
Total / Overall Average	**162,682**	**76,590**	**47.1**	**59,513**	**36.5**	**Low overall utilization**

Note - **Data source:** EUP-FBP validated database (2025).

In 2025, cesarean section volume (154.7%) continued to exceed calculated population projections. Assisted deliveries (96.4%) achieved effective utilization. Postnatal care (CPON) moved into the good utilization category (74.3%), while CPN1 (61.8%) and CPN4 (61.0%) demonstrated fair utilization. Home visits (56.3%) and minor surgery (50.6%) showed low utilization, with all remaining indicators demonstrating persistent, severe underutilization below 50%.

Comparative Utilization Trends (2024 vs. 2025)

Table 3 compares validated service performance indicators across both evaluation years.

Table 3:
Comparative Analysis of Validated Healthcare Service Utilization (2024–2025)

Indicator	2024 Target	2024 Validated	2024 (%)	2025 Target	2025 Validated	2025 (%)	Absolute Δ (%)
Outpatient Consultations	70,610	19,877	28.2	76,047	19,725	25.9	-2.3
Indigent Consultations	3,716	1	0.0	4,002	1,625	40.6	+40.6
Hospital Referrals	1,487	558	37.5	3,602	287	8.0	-29.5
Minor Surgery	3,345	1,470	44.0	4,002	2,026	50.6	+6.6
Fully Vaccinated Children	2,594	1,307	50.4	2,794	1,224	43.8	-6.6
Postnatal Consultations	4,757	2,461	51.7	2,882	2,142	74.3	+22.6
First Antenatal Visit (CPN1)	2,676	2,199	82.2	2,882	1,782	61.8	-20.4
Fourth Antenatal Visit (CPN4)	2,676	1,190	44.5	2,562	1,563	61.0	+16.5
Assisted Deliveries	2,676	1,610	60.2	2,562	2,470	96.4	+36.2
Cesarean Sections	67	80	119.4	53	82	154.7	+35.3
New Postpartum Acceptors	11,488	659	5.7	1,601	627	39.2	+33.5
Contraceptive Renewal	250	495	198.2	5,043	983	19.5	-178.7
Growth Monitoring (0–23 m)	24,082	6,387	26.5	25,295	9,416	37.2	+10.7
Growth Monitoring (24–59 m)	8,548	4,588	53.7	9,046	2,693	29.8	-23.9
Home Visits (VAD)	21,236	6,478	30.5	22,871	12,868	56.3	+25.8
Overall Total	**160,208**	**49,360**	**30.8**	**162,682**	**59,513**	**36.5**	**+5.7**

Note - **Data source:** EUP-FBP verified reports (2024–2025).

DISCUSSION

Overall utilization of primary healthcare services in the Kenge Health Zone remained low across the two evaluation years (30.8% in 2024 and 36.5% in 2025). These figures confirm our central hypothesis: despite ongoing health reform initiatives, formal healthcare facilities remain underutilized by local communities.

This persistent underutilization stems primarily from socio-economic barriers. Out-of-pocket health payments pose a major obstacle for households in Kenge, where informal economy employment and poverty limit financial capacity. These findings align with earlier national assessments by the MSPHP (2004, 2018), which demonstrated that fee-for-service payment models inhibit healthcare access across rural DRC. Similar health service underutilization has been documented internationally when direct user fees overburden vulnerable households (Médecins du Monde, 2008; USAID, 2023).

Our findings align with research conducted by Masudi (2018), who identified point-of-care user fees as the primary structural barrier to essential primary healthcare in rural and peri-urban DRC. Likewise, Cilundika Mulenga et al. (2015) identified informal employment, unemployment, and low household income as major

drivers of low curative care consultation in the Pweto Health Zone. Recent evidence from Lubumbashi by Manya et al. (2023) further confirms that fee-for-service billing and high treatment costs remain the chief determinants of care avoidance among household heads.

Conversely, structural governance challenges—such as supply chain disruptions, drug stockouts, and administrative delays in health worker remuneration—also impair overall service delivery, as noted in national strategic plans (MSPHP, 2020). However, in rural agrarian settings like Kenge, financial demand-side barriers remain the decisive factor causing households to delay or forego clinical care.

The marked variation observed among specific performance indicators warrants attention. Targeted indicators—such as cesarean section procedures (119.4% in 2024; 154.7% in 2025) and assisted deliveries (96.4% in 2025)—achieved high compliance, driven largely by focused donor support and emergency maternal care interventions. In contrast, routine preventive care—including outpatient consultations, routine child growth monitoring, and indigent care coverage—remains severely underfunded and underutilized.

Study Limitations

This study relied on retrospective secondary data collected via EUP-FBP audit mechanisms. Consequently, the analysis was subject to secondary administrative data limitations, including potential recording inconsistencies across facility registries and an inability to directly control primary data collection instruments. Furthermore, this study did not directly capture qualitative patient satisfaction dimensions, institutional governance dynamics, or informal care-seeking behaviors outside formal primary care centers.

CONCLUSION

This study demonstrated that primary healthcare services within the Kenge Health Zone were underutilized during 2024 (30.8%) and 2025 (36.5%). Heavy reliance on direct out-of-pocket health expenditures creates severe financial barriers for rural agricultural households, limiting overall healthcare access.

To improve service utilization and move toward Universal Health Coverage, health policymakers should consider the following recommendations:

1. **Increase Public Health Funding:** Government authorities should increase budgetary allocations to primary health care, reducing health facility reliance on direct fee-for-service household payments.
2. **Implement Flexible Payment Mechanisms:** Given that subsistence agriculture forms the basis of the local economy, local health authorities should explore regulated in-kind payment options and community risk-pooling models to lower financial barriers to care.
3. **Establish Sliding-Scale Standardized Fees:** Implementing standardized, equity-oriented fee structures adjusted for household income can help protect vulnerable populations from catastrophic health expenditures.

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Authors' Contributions:

i. **Nsungu Mbuku Emery:** Writing – original draft, Investigation, Writing – review & editing.
ii. **Otshomampita Aloki Adalbert**: Supervision, Project administration, Writing – review & editing, Validation.
iii. **Nswele Ilundu Odon:** Conceptualization, Methodology, Writing – review & editing, Validation.
iv. **Onoya Wedi Josué:** Software, Formal analysis, Data curation.
v. **Mandina Flory:** Methodology, Writing – review & editing, Validation.
vi. **Ngbolua Koto-te-Nyiwa Jean-Paul:** Formal analysis, Validation, Visualization.
vii. **Matondo Aristote:** Validation, Writing – review & editing.
viii. All authors read and approved the final version of the manuscript.

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