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Impact of Partner Financing on Community Access to Healthcare in the Bili Health Zone in the Democratic Republic of Congo

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Abstract

Introduction: Partner financing plays a crucial role in improving community access to healthcare in the Bili Health Zone, in the Bas-Uélé Province of the Democratic Republic of Congo. The study focused on the impact of partner financing on community access to healthcare from 2021 to 2024, with the objectives of identifying sources of financing for health services; assessing the impact of partner financing on community access to healthcare; and determining the evolution of partner financing on community access to health services.

Methods: We used an inductive method based on documentary analysis concerning the overall financing of health services, sources of financing for health services, and the general trend of partner financing from 2021 to 2024.

Results: External financing, that is to say the partners in the Bili Health Zone, represents 87.6%; the share of internal financing, that is to say the communities, is 12.4%. The partners have funded accessibility to care at 54.22% of the total financing. This produces a positive impact of partner financing on community access to healthcare. The general trend of partner financing for community access to healthcare is on the rise.

Conclusion: Partner financing in the Bili Health Zone in the Bas-Uélé Province improves community access to healthcare through the construction and rehabilitation of health infrastructure, support for services, capacity building, and ensuring continuity and quality of care, particularly for vulnerable populations in complex contexts.

Keywords: Impact; Financing; Partners; Accessibility; Community

1. Introduction

Primary health care is the most equitable, cost-effective, and inclusive way to improve health and well-being, as it helps maintain healthy populations, prevent disease, and detect disease outbreaks at an early stage. Partner financing improves access to care by reducing costs for populations, strengthening national and community health systems, and promoting equity-focused reforms. However, sustaining these impacts requires the seamless integration of partner financing into robust and sustainable national policies [1]. Today, the cost of patient care continues to rise due to new technologies and the development of treatment protocols. Therefore, it is important to improve the financial performance of hospitals and to define new approaches to reimbursement and hospital financing [2]. Partner financing plays a crucial role in improving community access to health care, particularly in low-income and developing countries. Several studies had already looked into this in Africa, including in the Democratic Republic of Congo.

Lugaba LD [3] observed that household financing (61.1%), poor management of financial resources (77.8%), and insufficient financing for comprehensive support (22.2%) are the problems related to the management of these

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financing sources; the rate of curative consultations (58.3%), antenatal care, and childbirth (33.3%). Compared to performance-based financing (PBF) indicators: in the Makiso/Kisangani Health Zone, compared to 25.0% in the Kabondo Health Zone. Ngolo K. [4] found in a 2019 study in the Kisanga Health Zone in Katanga Province that 87.4% of participants had financial access to curative care. Among the factors influencing access to curative care, it was noted that the price of curative care was lower (32.99%), and the payment method was direct (74.09%).

Hospital financing models have a significant influence on the effectiveness, quality, and efficiency of patient care. Traditionally, hospitals have been funded primarily through global or line-item budget subsidies. However, several countries have opted to replace global hospital budgeting with activity-based financing. This latter model has become an international trend for high-income countries. Its objective is to introduce greater effectiveness and efficiency into medical care by establishing a close link between the services provided and the reimbursements received [5, 6].

To ensure adequate financial access to healthcare services for populations, the WHO believes that individuals should not pay directly for care, and that the amount they pay should not constitute a catastrophic expense, meaning an expense that exceeds 40% of the person paying for care [7]. In Africa, healthcare financing in Côte d'Ivoire comes primarily from three sources: the State, private entities (particularly households), and external partners. Financing for public healthcare facilities in Algeria is divided into three sources: the first comes from the State through the overall budget, the second from social security through hospital fees, and the third from households through a flat-rate contribution for access to care [8]. The Democratic Republic of Congo has a health financing policy that combines three sources with a degree of specialization: the state budget, which covers the bulk of the system's operations; external resources (technical and financial partners), primarily used to finance investments and medicines; and community financing (user payments) [9]. In the Bili Health Zone in Bas-Uélé Province, the communities' financial accessibility to healthcare significantly hinders the use of services. Payment methods, financial access, equity, and solidarity are not yet systematically addressed in the literature [10].

In developing countries in general, and in the Bili Health Zone in particular, community access to healthcare, especially basic and quality care, poses enormous problems and/or difficulties and requires major attention from both national and provincial governments, as well as bilateral and multilateral partners, to ensure effective access to healthcare. However, the government's role in guaranteeing access to healthcare through direct or indirect financing is not significant.

Therefore, this study aims to analyze the impact of partner financing on community access to healthcare in the Bili Health Zone. Overall, the study's primary objective is to contribute to improving community access to healthcare in the Bili Health Zone. Specifically, it seeks to identify the sources of financing for health services in the Bili Health Zone. to identify the impact of partner financing on community access to healthcare and to determine the evolution of partner financing on community access to health services from 2021 to 2024.

2. Methods

2.1. Study Setting

This study was conducted in the Bili Health Zone in Bas-Uélé Province, Bondo Territory in The Democratic Republic of Congo. It is located 250 km north of Buta, the capital of Bas-Uélé Province. It covers an area of 13,407 km^2 and includes 12 health areas, 12 storage sites, 27 SSCs (Supplementary Health Centers), 3 CDTs (Community Development Teams), and 5 supervisory axes. The Bili Health Zone map is as follows:

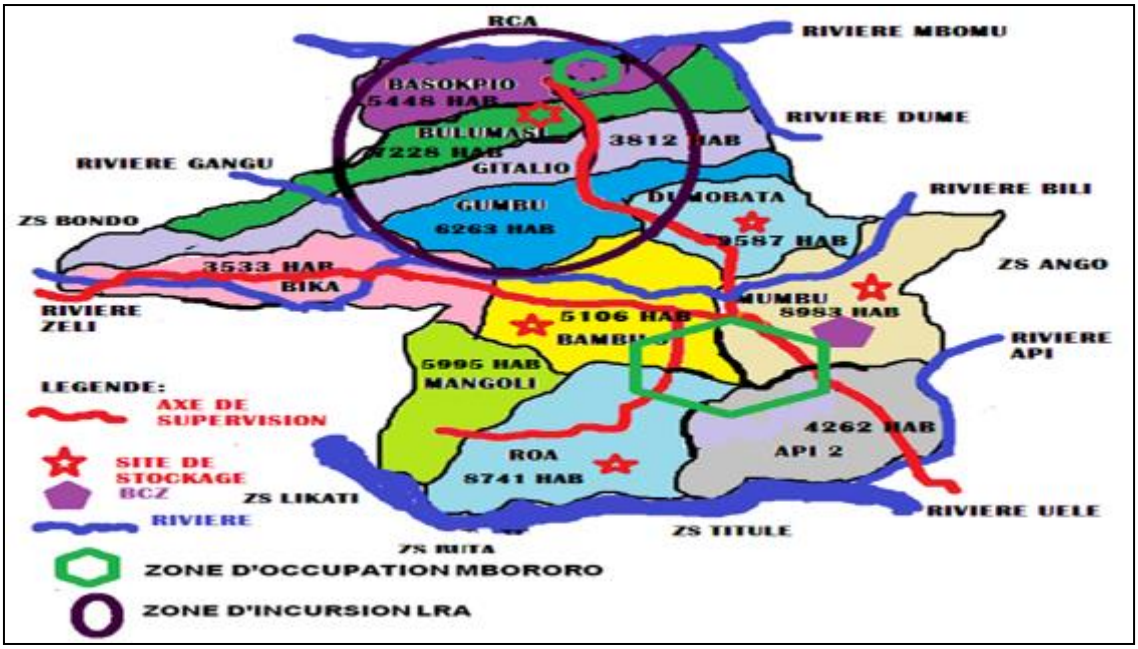

Figure 1 Map of the Bili Health Zone

The Bili Health Zone is bordered to the north by the Mbomu River, which separates it from the Central African Republic; to the south by the Uélé River, which separates it from the three other health zones (Likati, Buta, and Titule); to the east and northeast by the Api (Uélé) and Dume Rivers, which separate it from the Ango Health Zone; and to the west by the Bondo Health Zone via the Zeli River. Access is primarily by road, which is in very poor condition along all three routes :

Titule – Api – Bili route with two crossings: the first on the large Uélé River (non-motorized canoes) and the second on the Api River (manually operated ferry and non-motorized canoes);

- Ango – Api – Bili route with a single crossing on the Api River;
- Bondo – Bili route.
- It is still accessible by air via an airstrip approximately 1,000 meters long.

2.2. Study Population and Sample

The study population consists of all bilateral and multilateral financing received by the Bili Health Zone during the study period. Given that our survey universe is finite, the sample comprises partner financing provided to the Bili Health Zone from 2021 to 2024.

2.3. Study Type

We opted for an inductive method, which starts with specific facts—namely, partner financing—and moves toward overall facts (total financing). This method involves analyzing the facts before synthesizing them. It requires a thorough and respectful examination of the text before engaging in commentary, reflection, and discussion on its understanding, ultimately leading to a commitment to implementing what has been understood. We also used a comparative method, which allowed us to compare external financing with the overall financing received by the Bili Health Zone. All these methods are supported by techniques designed to achieve the study's objectives.

2.4. Data Collection Techniques

We also used document analysis, supplemented by field interviews with the managers of this health facility, to collect data using a pre-established data collection form. This allowed us to consult several accounting documents, including cash receipts, the cash book, partner fact sheets, and the monthly, semi-annual, and annual financial reports. The aim was to examine the numerical data on overall financing, on the one hand, and the external financing received by the Bili Health Zone, on the other.

2.5. Data Processing Technique

We used the general trend method in the application of ordinary least squares; then we used computer tools. For this purpose, we applied the ordinary least squares criteria below using the general trend method, which will allow us to present the equations of the regression lines for these economic indicators. Indeed, the general trend method in a time series is a technique for identifying the underlying trend (or evolution) of a series of observed data over time, by eliminating seasonal, cyclical, or random variations.

The general trend method is a statistical method that allows us to represent the overall evolution of a phenomenon over time through a curve or a line, called a "trend curve," often $Y = ax + b$, based on average or adjusted values. Ordinary least squares (OLS) is the technical name for mathematical regression in statistics, and more specifically for linear regression. This involves fitting a point cloud according to a linear relationship, taking the form of the matrix relationship, where Ɛ is an error term.

According to Thibault, M. [11], the least squares method consists of minimizing the sum of the squared deviations, weighted deviations in the multidimensional case, between each point of the regression cloud and its projection, parallel to the y-axis, onto the regression line. This model can take various forms. It can involve conservation laws that the measured quantities must obey. The least squares method then makes it possible to minimize the impact of experimental errors by "adding information" to the measurement process.

In the most common case, the theoretical model is a family of functions *f(x)* of one or more dummy variables x, indexed by one or more unknown parameters. The least squares method allows us to select, from among these functions, the one that best reproduces the experimental data. This is referred to as least squares fitting. If the parameters Θ have a physical meaning, the fitting procedure also provides an indirect estimate of the value of these parameters. Thus, we analyzed the following equation: Y = ax + b, with:

- Y = endogenous (dependent) variable, i.e., partner financing;
- X = exogenous (independent) variable, i.e., the time factor;
- a and b = parameters to be estimated;
- t = special time variable.

However, to estimate the parameters, we used the following formulas:

$$\mathbf{a} = \frac{\sum xY}{\sum x^2}$$

$$\mathbf{b} = \bar{y} - \mathbf{a}\bar{x}$$

$$\bar{Y} = \frac{\sum Y}{N}$$

$$\bar{t} = \frac{\sum t}{N}$$

2.6. Difficulties Encountered

We encountered significant difficulties in data collection. Some financial reports lacked essential information, certain sections were missing, etc. The data we were able to gather did not allow us to conduct a more in-depth analysis. For example, it was difficult to obtain detailed budget information for all four years (from 2021 to 2024), whereas initially, the plan was to analyze the data over ten years to obtain consistent figures. Nevertheless, the limited data collected still allowed us to undertake the work for a period of four years.

3. Results

3.1. Overall Financing of Health Services

Table 1 Presentation of Partner Financial Support

Partners	Years								Total	
	2021		2022		2023		2024			
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Caritas Development	20,171.0	11.37	28,171.0	8,30	12,118.0	4.31	24,236.0	8.71	84,696.0	7.87
Cordaid	5,052.0	2.847	8,052.0	2,37	925.0	0.32	1,110.0	0.39	15,139.0	1.41
WHO	5,214.0	2.938	15,709.0	4,63	39,866.0	14.19	34,964.0	12.57	95,753.0	8.9
Unicef	37,527.0	21.15	32,803.0	9,67	13,451.0	4.78	12,705.0	4.56	96,486.0	8.97
Global Fund (Gavi)	8,031.5	4.526	13,201.0	3,89	5,106.0	1.81	4,208.0	1.51	30,546.5	2.84
SPN (MTN)	4,352.0	2.452	14,900.0	4,39	4,751.0	1.69	4,208.0	1.51	28,211.0	2.62
Give well	0.0	0.0	0,00	0.0	0,00	0.0	5,481.0	1.97	5,481.0	0.51
Malteser	19,700.0	11.1	64,000.0	18,87	78,629.0	27.99	64,417.0	23.16	226,746.0	21.1
Central Government	57,960.0	32.66	115,290.0	33,99	91,300.0	32.5	94,240.0	33.89	358,790.0	33.4
Communauties	19,453.0	10.96	47,066.0	13,88	34,811.0	12.39	32,546.0	11.7	133,876.0	12.4
Total	177, 460.5	100	339, 192.0	100	280,957.0	100	278,115.0	100	1,075,725.0	100

Based on this table, it appears that the total amount of partner financing for community access to health services in the Bili Health Zone is USD 1,075,725.00, with a peak in 2022 estimated at USD 339,192.00. Furthermore, of all partners, the central government of the DR Congo contributed USD 358,790.00 (33.4%), followed by Malteser with USD 226,746.00 (21.1%), and the communities with USD 133,876.00 (12.4%). In comparison to the central government's financing, partners collectively contributed 54.22% of the total financing.

3.2. Sources of Financing for Health Services

Table 2 Overview of Financing Sources for Health Services in the Bili Health Zone

Financing Sources	Years								Total	
	2021		2022		2023		2024			
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Internal financing	19,453.0	11	47,066.0	13.9	34,811.0	12.4	32,546.0	11.7	133,876.0	12.4
External financing	158,007.5	89	292,126.0	86.1	246,146.0	87.6	245,569.0	88.3	941,849.0	87.6
Total	177,460.5	100	339,192.0	100	280,957.0	100	278,115.0	100	1,075,725.5	100

The data in this table indicate that external financing, i.e., partners in the Bili Health Zone, represented 87.6% of financing during the period from 2021 to 2024, while internal financing, i.e., from the communities themselves, accounted for 12.4%.

Graph 1 presents the proportion of external financing for the Bili Health Zone:

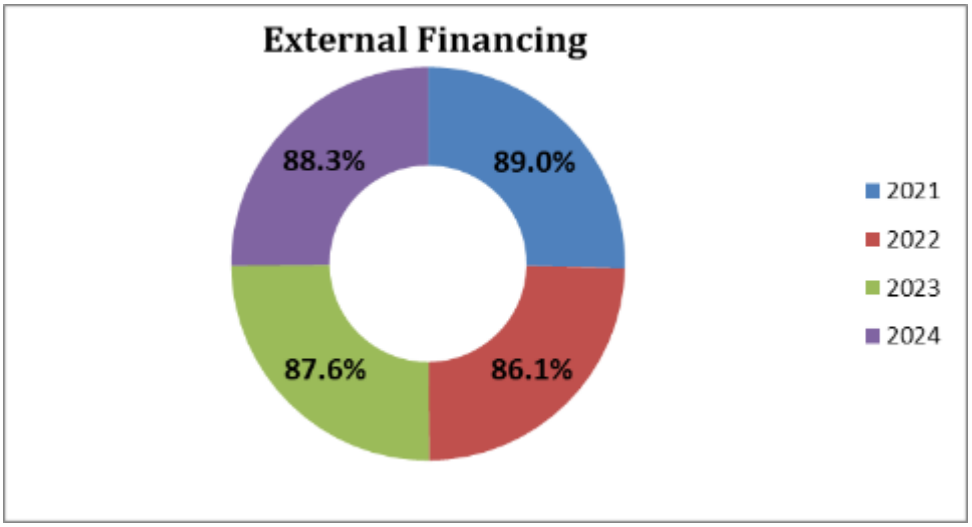

Figure 2 Proportion of external financing for the Bili Health Zone from 2021 to 2024

In graph 2, we present the proportion of internal financing for the Bili Health Zone.

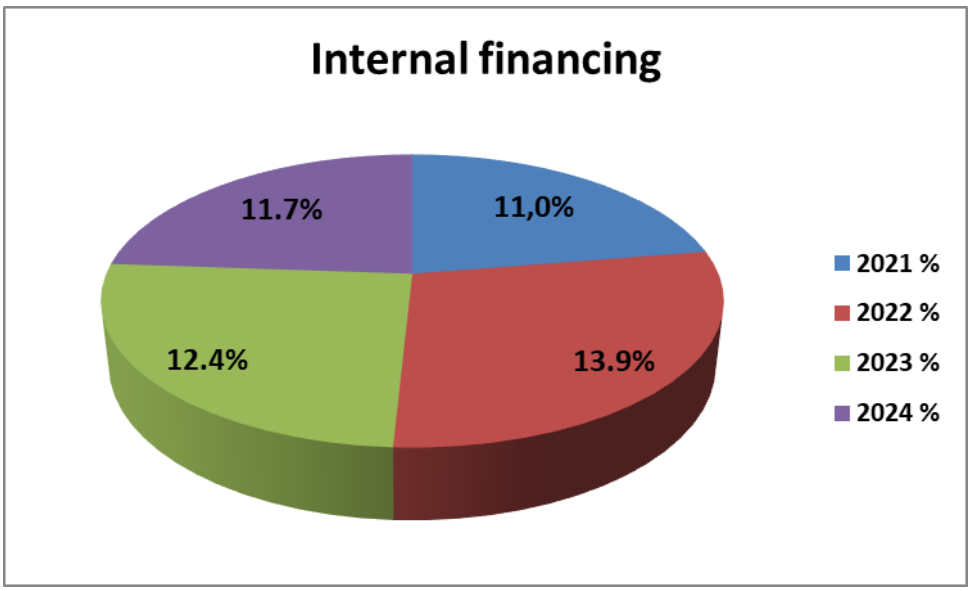

Figure 3 Proportion of Internal Financing for the Bili Health Zone from 2021 to 2024

As can be seen in Figures 2 and 3, partner financing represents the largest share of overall financing for the Bili Health Zone, averaging 87.76%, compared to 12.35% for internal financing. Comparing the two figures, we observe that external financing is significantly higher than internal financing.

3.3. Determining the Evolution of Partner Financing in the Bili Health Zone

For our study, we chose to analyze time series data using the ordinary least squares (OLS) method. To determine the overall trend in partner financing for access to healthcare over a time series, it is necessary to analyze the evolution of this financing over a given period, using the following steps:

- Draw a line graph (curve or histogram) with time on the x-axis and amounts on the y-axis.
- The visual trend (increasing, decreasing, stable, or sawtooth) provides an initial indication.

We then used the trendline fitting method: linear regression: $Y = aX + b$.

Where:

- Y = amount of partner financing (external),
- X = year (transformed into a numerical variable),
- a = slope (indicates the direction of the trend),
- b = constant (intercept).

If a > 0, the trend is increasing;

If a < 0, it is decreasing.

The results are interpreted taking into account the following assumptions:

- A positive trend indicates an increase in partner support.
- A negative trend shows a gradual withdrawal.
- A stable trend may indicate constant financing, without major changes.

X	**Y**	**x**	**y**	**xy**	**x^2**
1	158007.5	-1.5	-77454.625	116181.9375	2.25
2	292126.0	-0.5	56663.875	-28331.9375	0.25
3	246146.0	0.5	10683.875	5341.9375	0.25
4	245569.0	1.5	10106.875	15160.3125	2.25
10	941848.5	0	0	108352.25	5.00

$$\overline{X} = \frac{\sum Xi}{n} = 2.5$$

$$\overline{Y} = \frac{\sum Yi}{n} = 235462.125$$

We will estimate the values of parameters *a* and *b* using the following formulas:

$$a = \frac{\sum XY}{\sum X^2} = 21670.45$$

$$b = \overline{Y} - a\overline{X} = 235462.125 - 21670.45\ (2.5) = 181286.00$$

Knowing the values of parameters a and b, we present the function $Y = aX + b$ as follows: $Y = 21670.45(X) + 181286$. This means that partner financing increased by an average annual amount of 21670.45, with a constant value of 181286.

We now want to estimate the variable X in the model $Y = 21670.45(X) + 181286$ to represent the overall trend in partner financing for access to healthcare for communities in the Bili Health Zone:

- For X = 1, then Y = 21670.45(1) + 181286 = 202956.45
- For X = 2, then Y = 21670.45(2) + 181286 = 224626.90
- For X = 3, then Y = 21670.45(3) + 181,286 = 246297.35
- For X = 4, then Y = 21670.45(4) + 181,286 = 267967.80

Knowing the estimated values of the variable X, the general trend in partner financing for community access to healthcare in the Bili Health Zone is shown in the graph below:

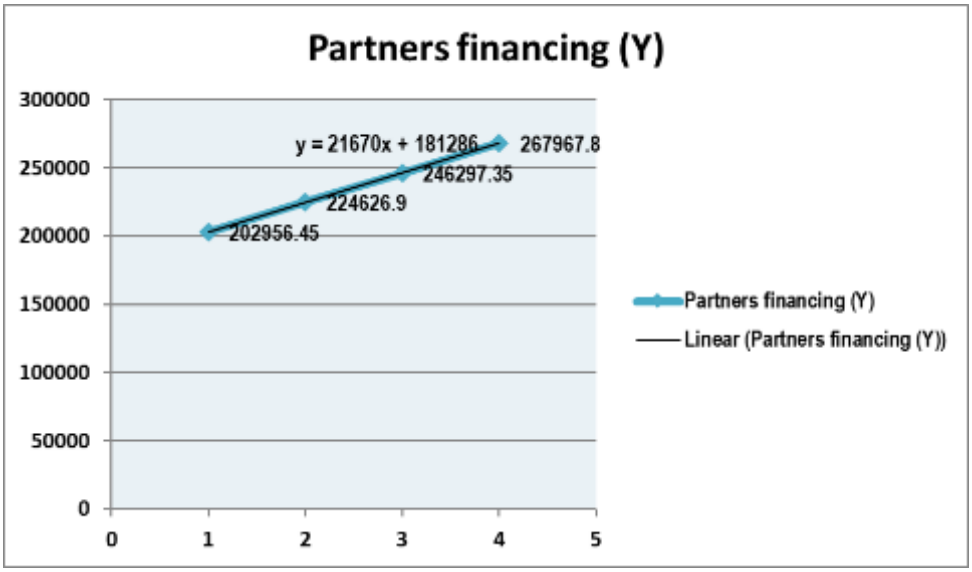

Figure 4 General trend in The Bili Health Zone partner financing from 2021 to 2024

Analysis of this graph clearly shows that the overall trend in partner financing for community access to healthcare in the Bili Health Zone is upward during the study period.

4. Discussion

4.1. Overall Financing for Health Services

Analysis of this data series reveals that the total amount of partner financing for community access to healthcare services in the Bili Health Zone is US$1,075,725.00. The central government contributed 33.4%, while partners provided 54.22% of the total financing. This result is slightly higher than that found by Assukulu NK in 2011, in his study on "Process of community participation in primary health care activities in the South Kivu health district in the DRC", which reports that the overall financing of health services amounts to USD 2,784,567.50, and that communities financed a significant share estimated at 58.3% of the overall financing [12].

According to Ramazani TD [13], financing from international partners is often greater than that from the central government in the Democratic Republic of Congo for several structural and cyclical reasons: low mobilization of domestic revenue, immense development needs and a structural deficit, the size and nature of partner financing, and budget management problems within the central government. In Togo, Hounkpati JD [14] reported that the Tokoin University Hospital in Lomé generates its own revenue through various hospital activities. Indeed, revenue projections are based on services such as outpatient consultations, hospitalizations, electro diagnostic and laboratory examinations, and especially morgue services—in short, self-financing, which becomes the sole source of income from patients, who are solvent clients. Revenue generated from hospitalization fees represents a significant percentage of total revenue, at 51.37%.

According to Aymar Dansou B. [15] in his study on the budget analysis of a public health facility in Benin: the case of the Pobè District Hospital, the hospital's revenue-generating activities are the sale of medications, medical services, and ancillary products. According to Criel B. [1], partner financing improves access to care by reducing costs for populations, strengthening national and community health systems, and promoting equity-focused reforms. However, the sustainability of these impacts requires the harmonious integration of partner financing into robust and sustainable national policies. Securing sufficient resources for health and eliminating barriers to accessing health services, especially for the most disadvantaged populations, is a strong priority for donors, who recently met in New York to strengthen the advocacy capacity of their stakeholders. The objective is to take stock of the financing and promote access to health care for populations in developing countries; to identify financing options for UHC in these countries and their potential impacts [16].

The superiority of partner financing over central government financing in the DRC is explained by a combination of factors: the state's limited capacity to mobilize domestic revenue, massive development and humanitarian needs, and

the willingness of partners to support the country in its reconstruction and development efforts in the face of these challenges. However, efforts are underway to strengthen public finances and reduce dependence on external aid.

4.2. Sources of Health Service Financing

This study found that external financing, i.e., partners in the Bili Health Zone, accounted for 87.6% of financing during the period from 2021 to 2024, while internal financing, i.e., community financing, represented 12.4%. The same observation was made by Bitilaongi L. [17], who found that external financing contributed 59.4% to the operation of the Mangobo Health Zone during the study period, while households contributed 39.8% of the total financing. In France, the French health system involves actors at the national and regional levels. Its financing is provided by both the public and private sectors. The French government allocates a total of 11% of its national wealth to health, 14% more than the European Union average. France is the OECD country where households contribute the least financially [18].

According to Kouyaté et al. [19], over the entire period from 2016 to 2020, the Bangui General Referral Hospital in the Central African Republic generated revenues of approximately US$2,037,058.55 (two million thirty-seven thousand fifty-eight dollars and fifty-five cents). 2018 saw a particularly high revenue of US$538,252.90, followed by 2019 at US$464,522.58. These revenues fluctuated. Furthermore, revenues from medical services amounted to a significant US$882,750.14, followed by drug sales at US$668,331.41. The study by Kaswera L. [20] demonstrated that the forecasts of own revenue were estimated at US$452,719.00 at the Kabondo General Referral Hospital, during the period from 2017 to 2019, of which medical services occupied first place with US$300,031.00, followed by the sale of medicines at US$149,001.00 and printed materials at US$3,687.00 and that the year 2019 came out on top with a total of US$166,176.50 and that the year 2018 forecast less own revenue at US$142,525.50.

According to Ngolo K. [4], partners play a crucial and multifaceted role in financing healthcare, particularly in low- and middle-income countries. Their involvement is essential to bridging financial gaps, strengthening health systems, and achieving ambitious public health goals. For Mushagalusa SP [21], the importance of partner financing is defined by the main roles of partners in healthcare financing: providing direct financial resources through official development assistance for health, innovative financing mechanisms, private sector investment, strengthening national health systems through alignment with national priorities, technical assistance and capacity building, and advocacy for sustainable financing. Cooperation, coordination, and the mobilization of civil society and the private sector are also key.

According to the study by Hounkpati JD [14], the Tokoin University Hospital Center in Lomé generates its own revenue through various hospital activities. Indeed, revenue projections are based on service provision, which becomes the sole source of income from patients, who are solvent clients. Revenue generated from hospitalization fees represents a significant percentage of total revenue, at 51.37%. For its part, the study by Fillol et al. [22] reports that household financing accounts for 61.1%. In our country, the share of partners in financing healthcare is high because the central government is unable to support the healthcare system, and households bear a large share of the cost of accessing healthcare, despite their negligible purchasing power. This is justified by the fact that the Democratic Republic of Congo is a poor country with a relatively unstable healthcare system.

4.3. Evolution of Partner Financing in the Bili Health Zone

In this series, we observed that the overall trend in partner financing for community access to healthcare in the Bili Health Zone increased during the study period. Financial partners, including international institutions, collaborate with governments, NGOs, and the private sector to expand the reach of health services, notably through insurance or community-based programs tailored to informal populations. These partnerships promote better risk and resource sharing, thereby reducing catastrophic expenditures for households. External financing also supports the strengthening of technical capacities, the establishment of logistics information systems, and supervision, which are essential elements for ensuring the availability and quality of medicines, supplies, and health services in this region. Partner support also translates into better coordination among stakeholders (health authorities, local organizations, donors), improved infrastructure, and enhanced health coverage, which helps reduce inequalities in access to care in an area still marked by its geographical isolation.

In Turkey, out of a total of $79, the private sector contributes $47 and the government $29. In low-income countries, including the Democratic Republic of Congo, total annual health expenditure was $6, of which $4 was privately funded and $2 was government-funded annually in 2000, as reported by the World Bank in 2013. Turkey is a country offering health services that are highly sought after by people worldwide. Health services in Turkey are available to all residents because everyone is entitled to social security under the Constitution of the Republic of Turkey. Private and public healthcare is accessible and affordable for all [23].

According to Grolier J., et al [24], partner financing for healthcare support has evolved significantly over the decades, reflecting changes in global priorities, development models, and health challenges. The main features of this evolution are evident in the 1980s and 1990s: the era of bilateral aid and "sectoral development." The 2000s saw the explosion of Public-Private Partnerships (PPPs) and the disease-based approach. The 2010s saw a shift towards strengthening health systems and Universal Health Coverage (UHC). The 2020s and beyond: Post-COVID-19, resilience and pandemic preparedness

For the World Bank [16], the evolution of financing for health partners has moved from a primarily bilateral and fragmented approach to more structured global partnerships focused on specific diseases, and then to a more integrated vision focused on strengthening national health systems, UHC and preparedness for future health crises, with increasing involvement of the private sector and innovative financing mechanisms.

Like other West African countries, Côte d'Ivoire, Benin, and Senegal have undertaken reforms that have led to improvements in the functioning of their respective health systems. However, these reforms have had a negative impact on the affordability of healthcare for the majority of the population, who do not benefit from social insurance systems in general, and for the poorest in particular. The three countries have nevertheless decided to respond appropriately by implementing Universal Health Coverage (UHC) projects. These various projects combine, or plan to combine, public financing, social insurance mechanisms, and community-based insurance to ensure financing that meets the needs of the population [25].

Partner financing has a significant and often positive impact on access to care, especially for vulnerable populations. However, this impact is optimal when actions are: well-coordinated with local authorities, integrated into national systems, and designed to be sustainable in the long term. The impact of partner financing on access to healthcare is considerable, especially in low-income countries or fragile health systems.

In our opinion, the increase in partner financing can be explained by the central government's inability to adequately subsidize healthcare facilities in all their diversity. Generally speaking, the central government only contributes by paying risk allowances to medical, paramedical, and administrative staff. However, financial, technical, and material support remains the prerogative of partners.

5. Conclusion

Partner financing improves access to healthcare by reducing costs for the population, strengthening national and community health systems, and promoting equity-focused reforms. However, the sustainability of these impacts requires the harmonious integration of partner financing into robust and sustainable national policies. The Congolese government is unable to finance the healthcare system; therefore, it relies on partner financing to facilitate access to care for the population.

The project, funded by the German Federal Foreign Office through Malteser International, is currently underway in the Bili Health Zone. Its primary focus is the construction of essential health facilities, the provision of medicines, technical support, and other related activities. These projects significantly improve access to medical infrastructure in this often underserved and remote region, providing a crucial foundation for increasing access to quality healthcare. External financing also supports technical capacity building, the implementation of logistics information systems, and oversight, all essential elements for ensuring the availability and quality of medicines, supplies, and healthcare services in this region.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that there are no conflicts of interest in the conduct of this study.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

Authors' contributions

Data design, collection, and processing were carried out by Raphaël TABANDITE TOZAWANE; formatting and text processing by Raymond ASSANI RAMAZANI; and proofreading by Alain ALOMA SAIDI.

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