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Community Health Delivery System in Ituri Province the Democratic Republic of Congo

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Abstract

WHO reports in 2010 that the Democratic Republic of Congo (DRC) private health sectors stepped to filling up health system delivery by lack of state health care provision?

In DRC's state-building many NGOs and government partners interacted in multiple arenas with multiple stakeholders' health policies are presented is a need to conclude that a lot of improvement more efforts and resources are required (WHO, 2010).

NGOs and governmental states share the common interest of providing health services, but their institutional interests vary. Though independent, health actors interact in a variety of ways to solve public health problems in the DRC. Through longstanding patterns of interactions regarding processes, state and non-state partners have developed a de facto networked health sector governance that accounts for the survival of the fragile health DRC context.

Keywords: *Community, Health, Delivery System.*

Introduction

A health care system or as healthcare system, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations. There is a wide variety of health systems around the world, with as many histories and organizational structures as there are nations. Implicitly, nations design and develop health systems in accordance with their needs and resources, common elements in virtually all health systems are primary healthcare and public health measures. **White F (2015)**.

In some countries, health system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions, charities, religious organizations, or other coordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary *(***Health care system". Retrieved 6 August 2011.** Social institutional structures, health systems are likely to reflect the history, culture and economics of the states in which they evolve. These peculiarities bedevil and complicate international comparisons and preclude any universal standard of performance. In DRC, similarly in Ituri province, the health system is deconcentrated at a different level through the management offices: provincial level (Division Provincial de la Santé) and at field level (the Bureau Central de Zone de Santé) representing the Ministry of Health (MoH) and decentralized at the operational level through the Heath Zone's operational autonomy. The Democratic Republic of Congo Government develops partnerships in terms of interaction fields in multidimensional and of the nature and content of interventions. Interactions among state and non-state actors in the health system reflect the architectural design of this system **(RDC/MINISANTE, 2012)**.

The government actors operate in various areas of the health sector, with either traditional non- state partners (faith-based organizations and community-based organizations) or development NGOs **(RDC/MINISANTE, 2012)**. Integrative actors such as faith-based/community-based organizations and traditional bilateral and multilateral cooperation partners build up the policy community. Partners or donors brought their plan according to their respective interests, and therefore there is always a priority setting problem between the governmental state and donors'.

Results health policy decision making restrictedness and vertical interventions, which contrast severely with the integrated approach.

Likewise, mainly humanitarian international NGOs and private for-profit organization pursue their respective agendas based on a short-term emergency logic or a for-profit approach.

In Ituri, due to the clash of inter-ethnic conflicts since Dec, the health delivery system is destroyed with the consequence of the rural exode of the population in big Towns Bunia, Mahagi, Aru, Ariwara, etc.

Djugu territory has faced decades of violent conflict, political and economic instability resulted in widespread poverty and little infrastructure over the previous years. Furthermore, the number of IDPs in Bunia Town is still increasing due to ongoing military operations against rebel groups in Djugu and due to reprisal attacks against the population by assailants of CODECO of dominance Lendu.

Djugu territory excluded as being the epicenters of the violence, the civil war has led people to leave their homes and settle in big Bunia Town, Headquarter of Ituri Province estimated about 900.000 habitats and are searching for protections near Monusco Contingent bases.

Displacement and surveys indicate that the number of deaths is increasing in armed conflicts and internally as reported in 5 territories (Djugu. Aru. Mahagi, Mambasa, and Irumu) as armed groups perpetrated attacks on the local population and the protection of civilians is a real need.

UNHCR UNICEF DRC Humanitarian Situation Report in February 2018, more than 18,410 households in the response of the Ituri crisis were searching for health assistance as several houses were set ablaze, health centers, and harvest destroyed, consequences of historical tensions between the parties in conflict. (https://monusco.unmissions.org/).

The burden on the health system in Ituri province is the COVID -19 pandemic and Ebola disease Outbreak in the last couple of months, the initial epicenters of the Ebola Outbreak were Mangina, Mandima in Ituri, and Beni in North Kivu with a high rate of criminalities. Ebola ripostes teams tackled several attacks from armed groups that have hindered the health system in the area health policies made for containing the disease.

Considering, we were motivated to research the health delivery system in Ituri Province during the critical period of COVID-19 and the Djugu community inter-ethnic conflict.

Purpose of the study:

The purpose of this study is to examine how the health system is delivered in DRC in general and particularly in Bunia IDPs Camp and in Ituri province during the critical period of atrocities ad COVID_ 19 pandemics.

Objective

The objective of this study is to help provincial health authorities in planning health policies during the period of disaster.

COVID -19 pandemic and catastrophes.

Research questions

The health sector policies engage the government of Ituri province through interactive processes of system governance and health service provision management.

This engagement is the fundamental question of this study:

- What 's the level of provincial authorities' engagement and how they determine the health system in Ituri Province during the out
- Did they associate health actors with other actors such as INGO or private institutions when making decisions on health system delivery?
- Did the policies of managing the health sector exist to contribute to state-building and the health acceptability in Ituri Province?

Hypothesis

Provincial authorities did not contribute to state-building health acceptance in Bunia Town and their level of engagement is low in health policy managing.

Significance of the study

The significance of this study is for a professional perspective to provide information for further studies as well as to health stakeholders for decision making on health policies.

Assumptions and limitations

The assumptions and limitations are no access to administrative records on policy management by the researcher, refusal, or no willingness for an interview, internet connections, and time constraints reported amongst several limitations.

Scope of the Study

To present the boundary or limits on the research in terms of the content of the study based on qualitative and quantitative data collection in the Bunia Health zone as operational levels. Policymaking interactions concern the management of the health sector throughout the province interaction in Bunia Health Zone, where a high level of international engagement in health care delivery due to the presence of Djugu internally displaced people (IDPs) and COVID19 pandemic restrictions.

Materials and Methods

The methodology for the study used was the qualitative and quantitative study data collected over two iterative phases from multiple participant groups using semi-structured, in-depth interviews between July 2020 and October 2020.

In phase 1, we explored the health actors in managing health services in the camp and 12 Bunia Quarters as policymakers, hospital management, and responding agency staff employed in Ituri during the COVID 19 pandemic and Ebola disease outbreak.

In phase 2, Investigate the community health delivery policy.

Study area

Bunia internal displaced people's camp, health services and 12 quarters composing Bunia Town in Ituri province.

Study population

The study population made of health actors (health authorities, hospital management, responding to international and local non-governmental organizations, and the local in Bunia Town.

Study duration

The study duration covers from July 2020 to October 2020 (3 months).

Sampling methods

Probabilistic sampling used for sampling methods through random and stratifying factors used to identify the geographical location. Respondents were selected occasionally in Bunia internally displaced camp, health services, and 12 quarters to determine the sample size of the study.

Sample size

The formula described by Kothari (2004) used to determine the sample size of this study of 400 respondents selected using occasional random sampling.

$$s = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Where:

Z = Z value (e.g., 1.96 for 95% confidence level)

p = percentage picking a choice, expressed as decimal

(.5 used for sample size needed)

c = confidence interval, expressed as decimal (e.g., .05 = 5%)

Study tools, various schedules, checklists, etc., to be used

For the present study, we used an interview guide and questionnaire made of open questions letting the respondents give his or her inputs or description on a specific issue. To have quality data researcher trained and pretested before collecting data.

Pretesting

The interview guide pretested on ten trainees selected before data collection to make sure all questions are clearly understood.

Variables

Were considered as variables:

i) Principal health actors,

ii) Level of engagement actors,

iii); Respondent knowledge of health policies in Ituri province.

Collection of data

Data were collected using a semi-structured interview and a guide questionnaire. Each interview session took about 45 minutes to 1 hour per patient.

Ethical considerations

Attempt to collect data, approval to conduct the study obtained from the local authority in charge of local administration, and each participant is informed about the purpose of the study, his right to refuse to participate in the anonymity and confidentiality of the information

gathered. Participants assured not penalized for not participating if they wished not to participate and that their responses to the questions would have no effect on their care. A consent was prior allowed by each participant to confirm their participation. Confidentiality ensured.

Data Analysis

Data collected were analyzed through Microsoft Excel by using numbers and percentages.

Inclusion criteria

Considered as a population of the study respondents of Bunia Town, displaced people in the camp: health authorities, hospital managers, international and local non-governmental organizations, and respondents of Bunia 12 quarters.

To be considered for the study, we took a minimum duration of one (1) month or plus in the selected location. Respondents' not being seriously ill, Male or Female, 18 years or older can read and write either French, Swahili, Lingala, or can speak and hear the local spoken language. Able to share his/her experiences on the health delivery system in Ituri, and willing to give his/her contribution during the data collection.

Exclusion criteria

Were excluded respondents not fulfilling inclusion criteria.

Results

Table 1. Respondents according to principal health actors (Non-governmental or governmental actors)

Variables	Non-Governmental Governmental Total		
	Effect %	Effect %	Effect %
I&NGOs	30 75	10 25	40 100
Bunia Health Zone	35 70	15 30	50 100
12 Bunia Quarters	45 26	125 74	170 100
Internal Displaced People	45 32	95 68	140 100
Total	155 39	245 61	400 100

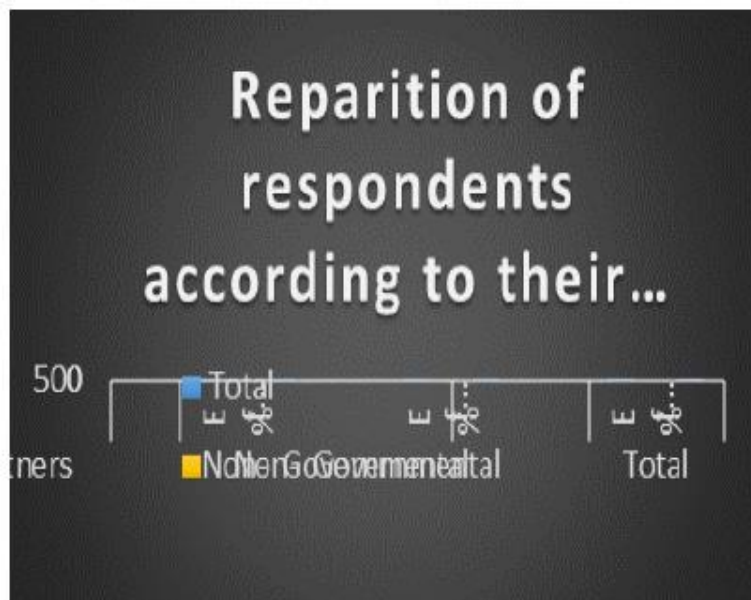

Figure 1. Principal health actors

In table 1, the findings show that principal actors in Bunia Health Zone are non-governmental actors 75% followed by governmental partners 73, 53%. This situation has been acknowledged by 70 % of respondents in Bunia Health zone followed by 67, 85% respondents of Djugu Internal Displaced People (IDP's) respondents in Bunia Hospital.

Table 2. Overall respondents Level of engagement (Non-governmental or governmental actors)

Variables	Health management system Good Not Good Total		
	Effect %	Effect %	Effect %
I&NGOs	10 42	14 58	24 100
Bunia Health Zone	30 29	72 71	102 100
12 Bunia quarters	30 29	74 71	104 100
Internal Displaced People	50 29	95 68	140 100
Total	120 30	280 70	400 100

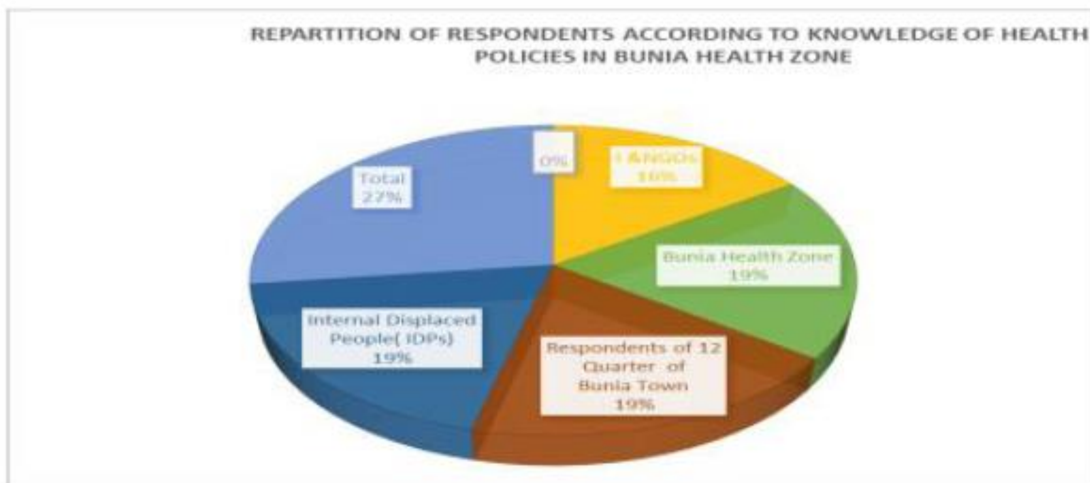

Figure 3. Level of engagement of different actors

In table 1, the findings show that principal actors in Bunia Health Zone are non-governmental. Seventy -five (75%) followed by governmental partners 73, 53%. The situation acknowledged by 70 % of respondents in the Bunia Health followed by 67, 85%

Table II. Overall respondents Level of engagement (Non-governmental or governmental actors), 70,59% of response of Bunia Health workers responded that many things need to increase in the zone in terms of the health management system.

Table 3. Knowledge of health policymaking in Bunia Health zone

Variables	Non-Governmental Governmental Total		
	Effect %	Effect %	Effect %
I&NGOs	30 75	10 25	40 100
Bunia Health Zone	35 70	15 30	50 100
12 Bunia quarters	45 26	125 74	170 100
Internal Displaced People	45 32	95 68	140 100
Total	155 39	245 61	400 100

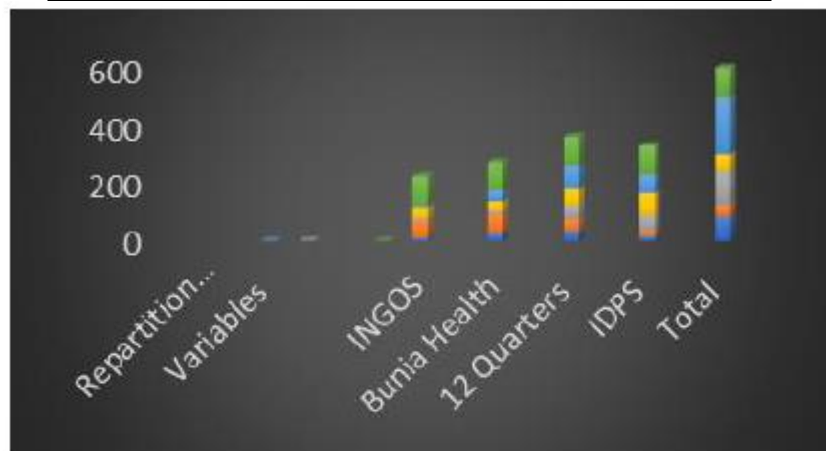

Figure 3. Knowledge on respondents on health policy making

Regarding health policymaking, in table 3, the findings show that 67,56% of practices of policymaking are good. 76,93 % of Internal Displaced People said in their response that the health policymaking in Bunia Health Zone didn't correspondents mentioned. The same responses corroborated by 58% of interviewees of 12 Quarters Bunia Town.

Discussion

The results in this project show in table 1 that principal actors in Bunia Health Zone are Non - governmental partners followed by governmental actors. Our findings show **75 %** of respondents recognized that Non-governmental partners are actors on the field in the Bunia Health zone, followed by governmental actors **(73%).** As mentioned by the WHO 2010 report, the Democratic Republic of Congo (DRC) private health sectors have stepped in to fill up health system delivery by the lack of state health care provision. (WHO, 2010).

Many NGOs, governmental partners have interacted in multiple arenas to rebuild the health sector. However, the role of these interactions in creating a governance network in the health sector has been underexplored.

In table 2, results indicate that on health policies in the Bunia Health zone, the health management system delivery is not very good **(71%).** Only **41.7 %** of best practices recognized for International and private actors. Health planning is proposed ways expected to follow to attain wellbeing. It involves setting goals, developing strategies, and outlining tasks and schedules to accomplish the goals. Planning is deciding in advance what to do, how to do, and who is to do it. It bridges the gap between where we are, where we want to go. It makes possible things to occur or not.

It has the following elements: -identification of goal and vision, undertaking strategic planning and evaluation.

In Ituri, multiple stakeholders work to manage the health system resulting in health policies is a need to conclude improvement done

efforts and resources should be to play a role in explaining the persistence of the health sector despite the weakness of the state.

In table three, the findings indicate that **67,6%** of practices of policymaking are good, despite **76, 9 % of** respondents who opposed the idea. Considering ongoing public management reform in the DRC, the health system is moving in the direction of financial decentralization, making the provinces directly responsible for health services. This policy might undermine the principle of equity and promote uneven development already decried across when the government fails to enforce equity principles. The delivery of public health at the operational level happens through the Health Zone, which is a decentralized entity in charge of planning, implementation, monitoring, and evaluation of primary health care strategy following the National Health Policy.

Conclusion

A summary of the conclusion regarding the project intitules **Community Health Delivery System in Ituri Province Democratic Republic of Congo."** The purpose of this project was to examine how the health system delivered in DRC in general and particularly in Ituri province during the critical period of clash of conflict between Hema and Lendu of Djugu Territory and during COVID -19 and Ebola outbreak to help in deciding health policies during the crisis of the period of disaster and be capable of making contingency plans during catastrophe as the only partners who intervene were private NGOs.

The study was for three months based on qualitative and quantitative data collection in the Bunia Health zone as operational levels. Policymaking interactions on the management of the health sector throughout the province, interact in Bunia Health Zone, where a high level of international engagement in health care delivery due to the presence of Djugu internal displaced people (IDPs) estimated at 50.000 inhabitants *(https://www.humanitarianresponse.info/en/operations/republique-democratique-du-congo/).*

Respondents randomly were selected from 12 quarters in order to acknowledge the relevance of governmental and non- governmental actors' interactions in Bunia Town to ensure the functioning of the health sector in Ituri province.

As Non- state actors participating in interviews and/or focus groups we included representatives of the international agencies, Civil Society (Schools, Churches, businessmen, taxi drivers, etc.) and IDPS from 3 camps: HGR, ISP, and Mudzipela.

Data were collected through interviews and focus groups with over 400 beneficiaries, in health sectors, in 12 quarters composing Bunia Town and 3 IDP camps composing Bunia Health Zone. For data analysis we used number and percentage. Our findings indicate that **75%** of respondents indicate that Non-governmental partners are the principal actors on the field in Bunia Health zone, followed by governmental actors **(73%).** For health policies in Bunia Health zone the health management system delivery is not good (**71%).** Respectively, **41.7 %**, and **67,6%** of good practices of policy making and health management were recognised by respondents for private sectors.

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