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Evaluation of the impact of the single contract and the provincial approach in the implementation of the health system reform at intermediate level in upper Uele

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Abstract

Introduction: The right to health is guaranteed by the Constitution of the Democratic Republic of Congo. The Health Promotion Fund created in DR C is financed by public authorities, community contributions, national and international solidarity, approved partners and innovative financing.

Methodology: This is an analytical, retrospective, cross-sectional study. An inductive approach was used, with recourse to the survey method. This facilitated the collection of information on the knowledge, attitudes and practices of strategies (effects/impacts) on health system reform, the single contract and the provincial approach. The qualitative survey used an active participatory method. Thus, the use of an attitude questionnaire or opinionnaire as an investigative tool seemed the logical way to gather information on the opinions, interests, values and attitudes of the interviewees. Documentary analysis enabled us to collect other information to complement that gathered by the survey.

Results: After analyzing the data, we arrived at the following results: 1. the main reasons for implementing the reform are: pooling of resources to support activities (54.8%); decentralization of funding negotiation points and health functions from central to provincial level (47.6%); strengthening the capacities and skills of the Division's agents (41.7%) and avoiding the retention of funding at national coordination level (28.6% of cases). 2. compliance with and monitoring of the reform are not fully respected in the Haut-Uélé health province (78.6%).

Conclusion: Not all Technical and Financial Partners have yet aligned themselves with the single contract approach, and continue to fund activities (Provincial Health Division Offices and Programs) in isolation.

Keywords: Evaluation; Impact; Single contract; Provincial approach; Reform; Health system; Intermediate level; Upper Uele

1. Introduction

Health is one of life's precious commodities. As individuals, if conditions allow, we will not hesitate to preserve it with the means at our disposal. The constitution of the World Health Organization (2006 version) states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". However, this better state of health concerns not only a better life expectancy for the individual, but also his or her enjoyment of leisure and capacity for productive activity [1].

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Achieving the highest possible level of health has become the goal that guides national and international health policies (WHO, 2016). Similarly, health is not just an individual good, but also a collective good, especially as resources are limited. The use of these resources therefore needs to be both efficient and equitable to cope with large and growing demand [2].

Population health is a crucial development issue. The health sector in developing countries is extensively supported by foreign aid agencies, and long-term or resident technical assistance is a common instrument of cooperation [3].

The right to health is guaranteed by the Constitution of the Democratic Republic of Congo. A Health Promotion Fund has been set up to support the National Health System. The Health Promotion Fund is financed by public authorities and community contributions, national and international solidarity, approved partners and innovative financing [4].

Around the world, governments have embarked on health system reforms because the status quo has become unsustainable. The Division provinciale de la santé is the administration in charge of healthcare provision in each province of the Democratic Republic of Congo. Its administration has been reformed to contribute to an efficient, high-quality public sector [5].

Decentralization implies, on the one hand, the partial transfer of powers, competencies and responsibilities, as well as financial burdens and resources, to the Provinces and Decentralized Territorial Entities, and, on the other, the participation of the population in the decision-making process. Thus, for example, the Provinces enjoy exclusive powers in twenty-nine areas, including health, primary, secondary and vocational education, rural development and agriculture, and customary affairs, and concurrent powers with the Central State in twenty-five other areas [4].

The Democratic Republic of Congo is rich in natural resources, but it is also one of the poorest countries in the world. As a result, it faces a number of socio-economic problems that severely limit its ability to improve its healthcare system. Primary healthcare services, including maternal and child health and family planning, are under-resourced. These problems of health financing and governance have led the government of the Democratic Republic of Congo to embark on a series of health system reforms in recent decades, including the decentralization of health functions from the central to the provincial level [6].

The mobilization, coordination and efficient management of healthcare funding are essential to the implementation of Universal Health Coverage. However, health financing is essentially based on development aid and a significant household contribution to healthcare costs. The coordination of various sources of funding is the main challenge raised by researchers interested in the issue of health financing in countries in crisis and fragile states. A recent study of health system reforms in five sub-Saharan African countries that have experienced armed conflict (Angola, Eritrea, Ethiopia, Mozambique and Rwanda) shows that decentralizing health systems, strengthening community health workers and reforming government health financing are the reforms that have contributed to reducing maternal mortality (a reflection of the quality of care) by at least 50% in these countries [7].

Regarding health sector funding, a survey carried out by the Ministry of Public Health in 2014 had shown a disparity in the distribution of Technical and Financial Partners and in the allocation of funding at provincial level. Some provinces had more than 15 Technical and Financial Partners, while others had only two or three. Also, over 55% of the funding allocated to the provinces was directed towards specialized programs, and only 18% of this funding was directed towards supporting the operational action plans of the Provincial Health Division. The DPS management team was overwhelmed by the number of contracts signed with different projects and Technical and Financial Partners. The provinces were not involved in funding negotiations, because everything was planned from Kinshasa, often on the basis of a standard planning framework for all the provinces, without taking into account the specific features of each one [8].

In response to the health system's problems, the Ministry of Public Health and its partners initiated the reform process in the post-conflict period, drawing up the Health System Strengthening Strategy in 2006, revised in 2010, which takes into account the different pillars of the health system. With regard to the "financing" pillar, the reform advocated by the Health System Strengthening Strategy consists of a new approach aimed at decentralizing coordination and negotiation of funding to the provinces, with a view to setting up provincial "basket funds" through single contracts, and avoiding the retention of funding at central level by national coordination structures, deemed too bureaucratic and costly [9].

The aim of this reform was to implement an approach aimed at pooling the various resources intended to support the activities of the Provincial Health Division in a transparent manner, in order to provide overall support for the achievement of the Division's missions as a structure responsible for coordinating, supervising and providing technical

support to the health zones, with a view to improving the quality of the care offered and the health conditions of the province's population (funding from partners, government funding and other potential sources of funding) [10].

1.1. In view of the above, we would like to answer the following questions:

- What are the main reasons for implementing complementary strategies to health system reform at intermediate level in Upper Uele Province?
- Has the health system reform process initiated at the intermediate level in Haut-Uélé Province as a theory of structural and organizational change been respected and followed to explain the performance or counter-performance observed?

Research objectives

- To identify the main reasons for implementing strategies complementary to the health system reform at the intermediate level in Upper Uele Province;
- Verify compliance with and monitoring of the reform process with the single contract and provincial approach initiated at the intermediate level as a problem analysis for solutions approach, resource mobilization, training and ownership in Upper Uele Province.

2. Methodology

2.1. Description of research field

This study was carried out in the Haut-Uélé province, located in the central-eastern part of the Democratic Republic of Congo. It lies between 1° 15' and 5° 30' north latitude and 26° 20' and 30° 40' east longitude. To the north, it borders South Sudan and the Central African Republic; to the east, Ituri; to the south, Ituri and Tshopo; to the west, Bas-Uélé.

The provincial capital is Isiro, with a surface area of 91,624 km^2, i.e. 3.8% of the country's total surface area, Haut-Uélé comprises six territories: Dungu, Faradje, Niangara, Rungu, Wamba and Watsa.

Its fauna includes a rich tourist biodiversity, with the Garamba National Park and the extension of the Okapi Wildlife Reserve from Epulu to Penge, home to a host of protected species: Okapi, Elephants, White Rhinoceroses, Giraffes, Hippos, Pangolins, etc.

The boundaries of the Division provinciale de la santé correspond to those of the administrative province of Haut-Uélé, with Isiro as its chief town, where the Division Provinciale de la Santé du Haut-Uélé is headquartered.

The main economic activities developed in Upper Uele are: subsistence farming, agri-busine projects and perennial crops of Robusta Africa coffee and cocoa, large and small livestock breeding, game hunting, artisanal fishing, trade and artisanal, semi-industrial and industrial gold mining.

In terms of health, Haut-Uélé province has 13 health zones out of the 519 in the Democratic Republic of Congo.

Generally speaking, the health system in this province, as elsewhere in the Democratic Republic of Congo, is currently characterized by the deterioration of health infrastructures, the obsolescence of equipment, the poor distribution of staff, a highly demotivated workforce, the politicization of the sector, while the province is faced with several pathologies at the root of morbidity and mortality, and many other problems linked to its functioning [11].

2.2. Type of study

This is a cross-sectional study of the analytical, retrospective type on the evaluation of the impact of the single contract and the provincial approach in the implementation of health system reform at the intermediate level in Haut-Uélé.

2.3. Study population

Our field of study is made up of actors from institutions at the intermediate level of the health system in Haut-Uélé province. Specifically, these are the animators working in the Provincial Health Division, the coordinators of specialized integrated programs and the Provincial Health Inspectorate, comprising 44, 78 and 25 managers and agents for Haut-Uélé Province, i.e. a total of 147 subjects forming the study population.

From this population, we drew a sample of 84 study subjects, including 58 men and 26 women.

2.4. Studied variables

Within the operational framework of this study, the following variables were studied:

2.4.1. Antecedent (or independent) variables

These are the variables we manipulated to obtain the result.

- Knowledge of Health System Reform, Single Contract and Provincial Approach at intermediate level in Haut-Uélé Province;
- Reasons for implementing health system reform in Haut-Uélé Province;
- Compliance with and monitoring of health system reform in Haut-Uélé Province.

2.4.2. Consequential (dependent) variable

The consequent (dependent) variable is the resultant of the independent variables. The dependent variable, which is good governance of the health system through the single contract and the provincial approach at the intermediate level, is to be observed from the reasons for the implementation of the health system reform; compliance with and monitoring of the health system reform in Haut-Uélé Province.

2.5. Data collection methods and techniques

2.5.1. Data collection methods

The study is based on two methods: interrogative and documentary.

However, in this study, the inductive approach was used, with recourse to the survey method. This facilitated the collection of information on knowledge, the main reasons for implementing complementary strategies to health system reform at intermediate level in Haut-Uélé Province, and compliance and monitoring to explain the performance or underperformance observed on health system reform, the single contract and the provincial approach. This logic places this research in the basket of quantitative research.

The survey method was used in our research. It is one of the most common methods used in quantitative research.

Specifically, the aim was to gather their personal views on the reasons for, compliance with and follow-up to the health system reform, the single contract and the provincial approach at intermediate level in Maniema Province.

To obtain the information, the survey or poll was carried out using direct and indirect questioning, given the specific nature of our study.

The active participatory method makes use of several techniques and tools in the qualitative search for reliable results. It is this latter property that supports its inclusion in the methodological arsenal of this work.

2.5.2. Data collection techniques

The phenomenon under study (the reform of the health system, the single contract and the provincial approach) involves hidden and latent realities of the respondents that cannot be apprehended using direct questions.

Thus, the use of the attitude questionnaire or opinionnaire as an instrument of investigation seemed logical to us, as it is a self-reporting instrument used to collect information relating to the opinions, interests, values and attitudes of respondents.

In this study, documentary analysis enabled us to collect other information to complement that gathered by the survey.

However, the qualitative research undertaken at this stage made use of the active participatory method, which is a specific form of research developed as an alternative and complement to conventional survey research methods.

2.6. Data processing and analysis techniques

For closed questions, we used frequency counting. For open-ended questions, we used content analysis.

In any study or research, the choice of a data processing technique depends on both the objectives pursued and the data collected.

Our research also uses content analysis for open-ended questions, and leads us to collect frequencies for closed-ended questions.

3. Results

3.1. Socio-demographic data

3.1.1. Sex of respondents

Table 1 Distribution of study subjects by gender

Gender Upper Uele Province	**Total**	
	f	**%**
Male	58	69
Female	26	31
Total	84	100

Analysis of the data contained in this table shows that male subjects are in the majority with 58 cases, i.e. 69% of all cases, while females represent only 31% of the subjects studied.

3.1.2. Level of education

Table 2 Distribution of study subjects by level of education

Education level	***f***	***%***
State graduate	9	10.7
Graduate	44	52.4
License and Master 2	31	36.9
Total	84	100

Analysis of the data in this table gives us the impression that there are a large number of graduates (44 or 52.4%), followed by bachelor's and master's graduates (36.9%) and state graduates (10.7%).

3.1.3. Assignment of respondents

Table 3 Distribution of study subjects according to assignment of respondents

Upper Uele Province	***Total***	
	f	***%***
Provincial Health Divisions	37	44.1
Integrated Specialized Program Coordination DPS	28	33.3
Provincial Provincial Inspectorate té	19	22.6
Total	**84**	**100**

Table 3 shows that, out of a total population of 84 intermediate-level health agents and managers in Haut-Uélé province, 37 agents (44.1%) were assigned to the Provincial Health Division, 28 agents (33.3%) were used in the various

coordinations of the integrated specialized programs of the Provincial Health Division, while 19 agents (22.6%) were assigned to the Provincial Health Inspectorate.

3.2. Study variables

3.2.1. Knowledge of Health System Reform, Single Contract and Provincial Approach

Table 4 Distribution of study subjects according to their knowledge of Health System Reform, Single Contract and Provincial Approach

Knowledge	**f**	**%**
Limited	38	45.2
Not at all	26	31
Perfect	20	23.8
Total	84	100

Looking at the results in Table 4, it can be seen that 38 agents, or 45.2%, had limited knowledge of the Health System Reform, Single Contract and Provincial Approach in Haut-Uélé, while 20 agents, or 23.8%, had perfect knowledge of the reform.

3.2.2. Reasons for implementing health system reform in Haut-Uélé Province

Table 5 Distribution of study subjects according to reasons for implementing health system reform in Haut-Uélé Province N=84

Reasons for implementing the reform	**f**	**%**
Pool resources to support Provincial Health Division activities	46	54.8
Decentralization of funding negotiations and health functions from central to provincial level	40	47.6
Strengthening the Health System and the capacities and skills of Provincial Health Division agents	35	41.7
Avoiding the retention of funding at central level by national coordination structures	24	28.6
Better support for good governance	19	22.6
Equitable funding for sectors less supported by technical and financial partners	11	13.1
Ensuring Universal Health Coverage for the population	9	10.7

In analyzing the contents of this table, we note that the main reasons for implementing the reform in Haut-Uélé Province would be the pooling of the various resources intended to support the activities of the Provincial Health Divisions (54.8%); Decentralization of funding negotiation points and health functions from central to provincial level (47.6%); strengthening the Health System and the capacities and skills of Provincial Health Division agents (41.7%) and avoiding the retention of funding at central level by national coordination structures with 28.6% of cases.

3.2.3. Compliance with and monitoring of health system reform in Haut-Uélé Province

Table 6 Distribution of study subjects according to compliance and monitoring of the Reform

Compliance and monitoring of the reform	***f***	***%***
Compliance and monitoring of the reform is not total in the health province of Haut-Uélé.	66	78.6
Undecided	18	21.4
Total	*84*	*100*

This study showed that 78.6% of health workers in the Haut-Uélé health province did not fully comply with and monitor the reform.

4. Discussion and comments

4.1. Sex of respondents

Analysis of the data contained in this table shows that male subjects are in the majority with 58 cases, i.e. 69% of cases, while females represent only 31% of the subjects studied.

The total number of healthcare staff recorded in 2017 was 161,966, of whom 38.6% were female and 61.4% male. Of this total workforce, 59.39% are healthcare professionals and 40.61% are administrative and support staff [12].

In our opinion, this low representation of women in these health structures can be explained by the fact that the social situation of most female managers is unfavorable to administrative functions. As many women have not attained the academic level of master's degree to merit managerial positions, they take care of household chores.

4.2. Level of study

Analysis of the data in this table gives us the impression that there are a large number of graduates (44 or 52.4%), followed by bachelors and masters (36.9%) and state graduates (10.7%).

The Ministry of Health of the Province of Ecuador, in its 2020 report, pointed out that its agents are made up of young professionals who have finished their studies and are embarking on working life; this would justify the employer's policy of using a qualified young workforce (graduates) to better supervise health zones for better patient care with good performance. As for the predominance of men, this is a matter of chance, dependent on sampling, as the medical profession has always been predominantly female [13].

The Provincial Health Divisions and Inspectorates are intermediary bodies for planning, coordination, control and decision-making in health matters. In our opinion, they should use qualified and competent personnel to ensure the inspection (control) and ongoing training of basic structure personnel, so that communities benefit from irreproachable health care.

4.3. Assignment of respondents

The survey revealed that, out of a total population of 84 intermediate-level health agents and managers in Haut-Uélé province, 37 agents (44.1%) are assigned to the Provincial Health Division, 28 agents (33.3%) are used in the various coordinations of the integrated specialized programs of the Provincial Health Division, while 19 agents (22.6%) are assigned to the Provincial Health Inspectorate.

The intermediate level of health care is the level of technical support, supervision and monitoring. It is made up of the supervisory and coordinating structures of the Health Zones. It includes provincial inspectorates and health districts [4].

In fact, the intermediate level of health care in the Democratic Republic of the Congo is a structure which, in our opinion, must deploy personnel in terms of numbers, quality and skills to effectively and efficiently provide all the Directorates and Coordinations of specialized integrated programs within a Provincial Health Division. The aim is to ensure technical supervision, monitoring and translation of directives, strategies and policies in the form of instructions and data sheets; to ensure inspection and control of health care, pharmaceutical and health science establishments.

4.4. Knowledge of the Health System Reform, Single Contract and Provincial Approach

In this study, we found that 38 agents, or 45.2%, had limited knowledge of the Health System Reform, Single Contract and Provincial Approach in Haut-Uélé, while 20 agents, or 23.8%, had perfect knowledge of the reform.

In his 2020 study on the Reform and Performance of the Health Inspectorate and Health Division in South Kivu, Democratic Republic of Congo, Molima C reported that, worldwide, the governments of several countries have undertaken health system reform because the status quo had become unsustainable [5].

As the Health System Reform, Single Contract and Provincial Approach in the Haut-Uélé Health Province was a new development, we believe that many of the agents did not have sufficient knowledge. In our opinion, these agents needed training to bring them up to speed.

4.5. Reasons for implementing health system reform in the Haut-Uélé health province

In analyzing the contents of this table, we note that the main reasons for implementing the reform in the Haut-Uélé Province would be the pooling of different resources to support the activities of the Provincial Health Divisions (54.8%); Decentralization of funding negotiation points and health functions from central to provincial level (47.6%); strengthening the Health System and the capacities and skills of Provincial Health Division agents (41.7%) and avoiding the retention of funding at central level by national coordination structures with 28.6% of cases.

According to the constitution of the Democratic Republic of Congo, decentralization implies the partial transfer of powers, competencies and responsibilities, as well as financial burdens and resources, to the Provinces and Decentralized Territorial Entities [4].

Primary healthcare services, including maternal and child health and family planning, are under-resourced. These problems of health financing and governance have led the government of the Democratic Republic of Congo to embark on a series of health system reforms over the last few decades, including the decentralization of health functions from the central to the provincial level [6].

A survey carried out by the Ministry of Public Health in 2014 on the financing of the health sector had shown a disparity in the distribution of Technical and Financial Partners and in the allocation of funding at provincial level. Some provinces had more than 15 Technical and Financial Partners, while others had only two or three. Also, over 55% of the funding allocated to the provinces was directed towards specialized programs, and only 18% of this funding was directed towards supporting the operational action plans of the Provincial Health Division. The provinces were not involved in funding negotiations because everything was planned from Kinshasa, without taking into account the specificities of each province [8].

According to the Ministry of Public Health's 2010 Department of Studies and Planning, health system reform is a new approach that aims to decentralize coordination and funding negotiation to the provinces, with a view to setting up provincial basket funds through single contracts and avoiding the retention of funding at central level by national coordination structures, deemed too bureaucratic and costly [9].

In our opinion, the reform of the Health System at intermediate level has been implemented to develop a framework, a work dynamic and skills that will ensure sustainable prerogatives at provincial level: coordination, planning, management (of human resources, finances and health information), epidemiological surveillance, training and supervision. The purpose of the single contract is to pool and rationally manage resources within the DPS, as the structure responsible for coordinating, supervising and providing technical support to the health zones, with a view to improving the quality of healthcare provision and the health conditions of the province's population. The aim of the single contract is to pool funding from national and external sources and allocate it in a coordinated manner to the DPSs to finance their operational costs, on the basis of a single operational action plan, with a single budget and monitoring framework. It requires the participation and coordination of key stakeholders in the planning, implementation and monitoring processes. In this way, the single contract responds to the resolutions of the Paris Declaration and the Kinshasa Declaration for the harmonization of intervention plans and the alignment of funding with national priorities, as set out in the National Health Development Plan and the Government Action Program.

4.6. Compliance with and monitoring of health system reform in the Haut-Uélé health province

This study showed that compliance with and monitoring of the reform are not fully respected in the Haut-Uélé health province (78.6%).

In this single contract, certain decisions were taken. Compliance with the financial commitments formulated by the Technical and Financial Partners was formulated as follows: 1. Compliance with the commitments of national and provincial authorities and TFPs is ensured by a credible incentive mechanism aligned with national accountability systems; 2. Key stakeholders, including health zone staff and civil society/community, participate fully in the monitoring and evaluation activities of the single contract [14].

In our opinion, most of the partners did not agree that the Single Contract would have enabled a real reduction in the fragmentation of funding for their Provincial Health Division. Funding for specialized programs is still managed by the national authority (vertical programming), and the partners have not yet aligned themselves with the logic of a common funding basket. In addition, some partners do not accept that their funding be used for other programs that are not in line with their vision; and so the Single Contract does not seem to bring anything new to the funding mode of the Haut-Uélé Provincial Health Division. In addition, some partners continue to use their funds without disbursing them into the

basket fund, because specialized program funding, even though it passes through the accounts of the Provincial Health Division, is only intended for program activities, according to the directives of the program managers. What's more, the scale agreed to motivate Provincial Health Division staff under the single contract has never been followed. Some partners aligned in the payment of additional remuneration to the Provincial Health Division have withdrawn in the name of the single contract. Few partners are involved in staff remuneration. The current level of remuneration (salaries and bonuses) therefore remains unsatisfactory, especially for managers and staff without risk bonuses or salaries. Hence the observed cases of brain drain from the Provincial Health Division. So, in the Haut-Uélé Health Province, we are not yet fully out of the project-based management system. The single contract has had perverse effects on this point.

5. Conclusion

The persistent discrepancy between the budgetary planning of certain Technical and Financial Partners and the quarterly work plans of the Provincial Health Divisions is at the root of irregularities and asynchronism in the funding of the Provincial Health Divisions. For some Technical and Financial Partners, local managers do not have sufficient room for manoeuvre to make decisions on procedures for disbursing and justifying funds, or to organize a joint audit.

Not all Technical and Financial Partners have yet aligned themselves with the single contract approach, and continue to fund activities (Provincial Health Division Offices and Programs) in isolation.

Government funding (national and provincial) for the operation of the Provincial Health Divisions is not progressive.

Compliance with ethical standards

Disclosure of conflict of interest

We have no conflicts of interest. The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article. Therefore, there is no conflict of interest.

Statement of ethical approval

The research protocol had been validated by the research committee of the Doctoral School of the National Pedagogical University as well as by the Thesis framework team. Informed consent was systematically obtained from each participant before each interview. Confidentiality was observed throughout the data collection and analysis process.

Statement of informed consent

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

Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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