Annals of Public Health and Research

Research Article

Health Policy Response to Health Care Needs of Victims of Sexual Violence

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Submitted: 17 January 2019

Accepted: 13 February 2019

Published: 15 February 2019

Keywords

- Health care management
- Health policy
- Health system
- Sexual violence
- Victims

Abstract

Background: Sexual violence (SV) against women is a serious problem and healthcare plays a central role in assisting the victims. The Congolese government has pursued health policies to address the effects of sexual violence and improve healthcare conditions. Its current policy document, the National Health System Strengthening Strategy, aims to reform the health sector in accordance with Health for All.

Objective: To explore the current health policy that supports healthcare dealing with sexual violence in Goma, in the Democratic Republic of Congo (DRC).

Design: A qualitative approach was used in this study. Data was collected through interviews with stakeholders who were involved in the sexual violence health policy development process. They were also involved in reviewing key planning and policy documents that were analyzed using thematic analysis.

Results: The DRC Government's policy response was as a result of international strategies from the United Nations Security Council. It expresses a clear vision towards medium and long term responses to sexual violence. The respondents demonstrated an understanding of the importance of collaboration among stakeholders or partners as a key element of implementing the national strategy. It was also noted that competition for the limited resources available led to the demoralization of some stakeholders. Nevertheless, the informants acknowledged the positive influence since the intervention of the government.

Conclusion: Existing government policy limits the development of health services in Goma. This article suggests that the country needs to review its national health policy to reflect the principles of development of health services for all.

ABBREVIATIONS

SV: Sexual Violence; WHO: Health World Organization; IPAS: International Projects Assistance Services;UNFPA: United Nations Population Fund; NGOS: Non-Governmental Organizations; DRC: Democratic Republic of Congo; HZ: Health Zone; HC: Health Centers; GBV; Gender Based Violence; ULPGL: Université Libre des Pays de Grands Lacs; CEDAW: Convention on the Elimination of All forms of Discrimination Against Women; SNVBG: Strategy National de Violence Basée sur Genre; ABA: Association of American Bar; FFC: Fund For Congolese Women

INTRODUCTION

Sexual violence (SV) against women is a serious and prevalent problem worldwide[1] perpetrated by adherents of all religions and of all social classes [2].However, studies have proven that SV is more prevalent in societies where there's lack of women's rights or where these rights are not keenly pursued [3]. Not only is SV a violation of human rights, but it also damages the physical and psychological well-being of individuals and families [4].

In order to provide access an adequate care, the World Health Organization (WHO) launched an initiative in 2001 that underpins the development of guidelines for care services to victims of sexual assault [5].

A number of policy and guideline documents highlight the assistance required to respond to the needs of the survivors of sexual violence [6]. Research reveals that health professionals are often the first to receive victims of sexual violence [7]. It further indicates the availability of post-rape treatment services[8]. Initiatives to respond to SV within the health sector have been relatively limited to those in other sectors within the health system while very few initiatives have been rigorously evaluated [9]. Research undertaken in health organizations in Mexico's public hospitals and health units in collaboration with local and international organizations, including International Projects Assistance Services (IPAS) and the UN Population Fund (UNFPA) have developed a model known as the "Model for Integrated Attention to Victims and Survivors of Sexual Violence". The model includes detection of violence, information recording, and referral to legal and social services [10].

Over the past decades, many African countries have begun to

recognize the importance of preventing SV and responding to the needs of the victims at a national level. South Africa and Kenya have led the continent in the development and implementation of national guidelines on the clinical management of sexual assault. Several Non-Governmental Organizations (NGOs) in Zambia have undertaken small-scale efforts to address SV in different settings [11].

Since March 2006, a Protocol of Assistance for Victims of Sexual Assault has been operationalized in Mauritius, which makes the provision of prompt and timely assistance to victimsmandatory. It obligates the government to ensure that psychological and legal assistance are promptly provided to victims of sexual assault [12].

Organization and management of the DRC health system

Currently, the decentralization of health systems in the DRC has led to the establishment of provincial public-sector structures for better management of the health sector to enhance service delivery[13]. The underlying concern of adequate correlation between health policies and the expectations of the population aims at ensuring quality services, efficiency, and equity of the health systems[14].

The DRC Health System is inspired by the Alma Ata Declaration of 1978, based on the Alma Ata primary health care strategy and the Bamako Initiative of 1987 that emphasizes the involvement of the population in the management of the health system and participation in budgeting for health services. In this strategy, the operational unit is the Health Zone (HZ) made of two levels interlinked by a system of referral and counter-referral [15-17].

The first level is a network of 8,266 Health Centers (HCs) that offer a Minimum Activity Package. This includes curative, preventive, promotional, and support activities. The second level is composed of approximately 393 General Referral Hospitals that offer a Complementary Activity Package. The Package includes health activities organized in the fields of internal medicine, surgery, gynecology-obstetrics, and pediatrics within the General referral hospitals[18].

The constitution of the Third Republic of the DRC provides for the transition from 11 to 26 provinces. The intermediate level of the HC will include 26 provincial divisions which are already being created, following the orders issued by the Minister of Public Health[19]. The intermediate level HC provides technical support to the health zone covering activities such as co-ordination, training, supervision, monitoring, evaluation, inspection and control.

The central level is made up of the Minister of Health supported by his office, the General Secretariat with the central departments which include 57 national hospitals, 4 university hospitals, 32 specialized hospitals and integrated structures. This level plays a normative and regulatory role, performing functions of co-ordination and strategic direction[20].

Human Resources for Health are indispensable for the delivery of health care services, but the recruitment, retention and motivation of health professionals still remain a challenge [21]. The number of recorded doctors rose from 6,000 in 2004 to over 18,000 as per the latest available data.

Evidently, 12,000 more doctors were trained in 11 years (2004 to 2015) compared to 6,000 trained in 43 years (1962 in 2004). Regarding the nursing staff, it is observed that there are 12,049 nurses in Central Congo Province (2,984,553 inhabitants) against 4,276 in the City of Kinshasa Province (6,320,798 inhabitants). With regards to the ratio of one nurse per 5000 inhabitants, the above information indicates a plethora of nurses in the Central Congo Province, and more likely in other provinces, as well [20]. While currently there seems to be adequate number of doctors and nurses, there is a shortage of other medical professionals such as pharmacists.

Health workers in DRC play a central role in the delivery of health care [22]. The DRC government published and presented its Health Systems Strengthening Strategy in 2006 [23]*, which recognized the poor budgetary allocation for health and the weakness of these funds.* Because of the minimal state involvement in health financing and service provision, the private and in particular, the not-for-profit faith-based sector is especially prominent [24]. As indicated, health financing is still characterized by low public expenditure (12% of the total health expenditure), high out-of-pocket payments (47%) and the fragmented yet relevant contribution of external aid (37%)[25].

The Health System Strengthening Strategy of 2006 intends to re-organize the health system in order to increase access to quality health care [26]. In 2009, the Ministry of Gender, Family, and Children issued the National Strategy Against Gender-based Violence (*Stratégie Nationale de Lutte Contre les Violences Basées sur le Genre*). It pleads for the enforcement of laws and actions against impunity, as well as for the prevention and protection of GBV [27]. The healthcare system does provide the female victims of sexual violence with a safe environment where they can confidentially disclose their experiences and receive support

There is a multiplicity of starting points of the victims: the family, community relays, police, health structure, a legal clinic, and so on, as illustrated in Figure 1.

Despite the existence of the strategic plan on sexual violence that aims at ending this vice, very little progress has been noted. The cases of rape and violence are still rampant in the city of Goma [28].

Aim

This study aims at exploring the current health policy that supports healthcare dealing with sexual violence in Goma.

MATERIALS AND METHODS

Qualitative research was considered the most appropriate approach focusing on health professional and the provider's services to the abused women. It is being recognized as increasingly important to both academics and clinicians, for its contribution to health sciences research [29].Qualitative offer insights into how a given person, in a given context, makes sense of a given situation.

The thematic analysis was based on the interviews of key informants and on secondary data in the form of previous studies

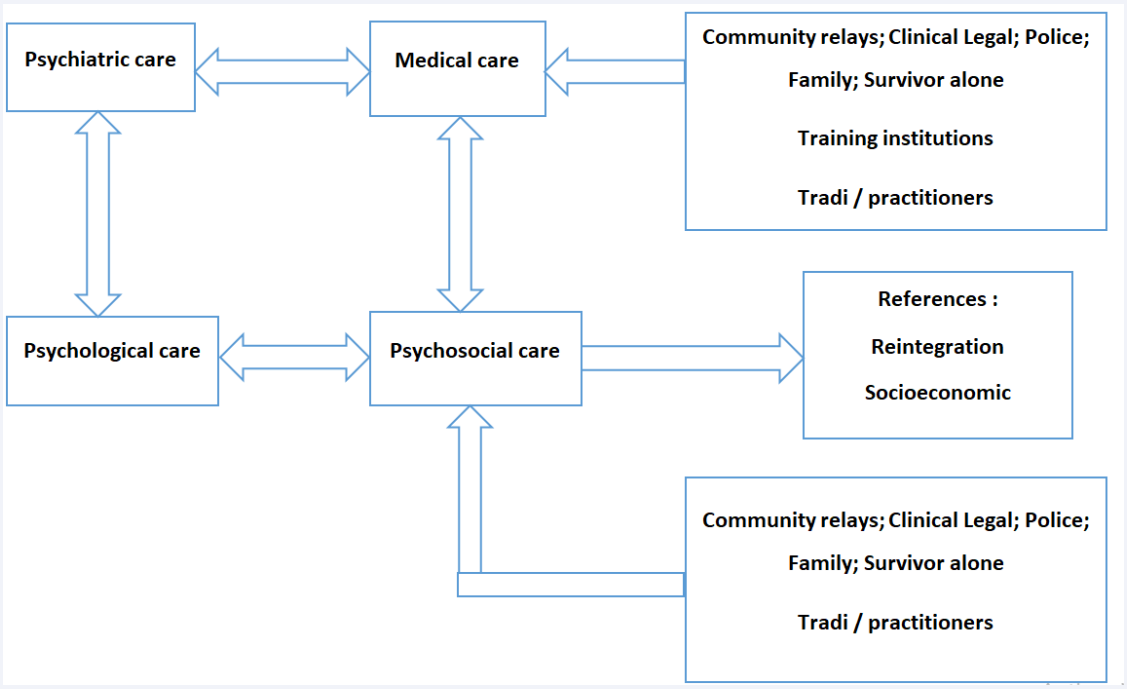

Figure 1 The starting point of the victims of sexual violence model to seek support.

on health policy analysis, official reports from health ministries and departments in DRC, international agencies, and reports from seminars and conferences on health policy. By applying Walt &Gilson's policy triangle framework it provided guidance as themes were categorized into content, context, actors and process [30]. Using this framework the analysis of the content of the policy, the actors involved in decision making, the contextual factors that influenced the policy and process by which the policy was launched, formulated and communicated were investigated. This analysis has discussed the three fields of the health policy in DRC and underscored the role of important actors involved in the health policy process.

Samplings

The researcher acquired a purposive sample by recruiting key informants, who are lead persons in the Ministry of Health, local/national and international NGOs. Cormack (2000) suggests that qualitative researchers use a small selective sample, because of the in-depth nature of the study and the detailed analysis of data required [31]. As the researcher purposively selected a sample, she also used the snowballing technique [32], requiring that some inclusion were specified as shown below.

Inclusion criteria:

- Healthcare professionals, social workers or managers working with female victims of SV
- Minimum of three years' work experience in SV (so as to obtain the opinions of those most experienced and exposed to this area of care)
- Registered Organizations (because of the aim of the study)

Prior to gaining consent from the participants, Université Libre des Pays de Grands Lacs (ULPGL) had granted the researcher permission to carry out the study. In the letter of invitation, a short explanation about the aims of the study, the level of participation required, and the rights of the participants as well as assurance of confidentiality, were given. The consent form accompanied the invitation. Those persons who were willing to be participants read, signed and returned the form to the researcher. Their positions and /or titles are given in Table 1 below.

Data collection

The first step involved the review of existing policy documents: UN Security Council Resolutions 1325 and 1794 on Women, Peace and Security that were adopted respectively on 31st October 2000 and 21st December 2007; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); National Strategy of DRC 2006 and 2010; DRC National Legal Reference Protocol for Survivors of Sexual Violence as well as the National Health Reproduction Program.

The second step involved conducting key informant interviews. These informants work in areas that respond to the needs of sexual violence victims in Goma. The first key informant was identified with the assistance of the research supervisor (NE). Snowballing sampling was then utilized, asking each informant after the interview if they knew anyone else who could provide information for the study. Key informants, such as a doctor, a nurse, project managers and so forth, were identified and contacted either physically at their office or through the telephone and invited to participate in the study, and if they agreed, an appointment was set up. Data collection for the study was carried out between June 7th and June 29th, 2017. A total of sixteen (16) key informants participated in the study (Table 1).

Table 1: Summary of key informants' title and organization.

Interviewee	Position and/ or Title
Interviewee 1	Lawyer dealing with sexual violence in the Provincial Ministry of Justice
Interviewee 2	Project Manager in the Ministry of Gender
Interviewee 3	Project Manager at Heal Africa
Interviewee 4	Lawyer in charge of sexual violence at female lawyer corporation
Interviewee 5	Head of Department, of Sexual Violence, Ministry of Social Affairs
Interviewee 6	Bible Society: Project Manager in charge of sexual violence
Interviewee 7	Program Manager for a Local NGO
Interviewee 8	Baptist Church (CBCA): Project Manager in charge of addressing matters of sexual violence
Interviewee 9	Project Manager, Gender Division in the Ministry of Gender
Interviewee 10	Health Manager in charge of managing victims of sexual violence at GESOM (hospital)
Interviewee 11	Chief nurse in charge of victims of sexual violence at KESHERO hospital
Interviewee 12	A representative of international organizations responsible for dealing with matters of sexual violence at ABA (Association of American Bar)
Interviewee 13	Medical doctor in the Health Ministry
Interviewee 14	Medical doctor in a Provincial Hospital
Interviewee 15	A representative of DRC national organizations
Interviewee 16	Head of the national organization, FFC (Fund for Congolese Women)

Abbreviation: NGO: Non-Governmental Organization; CBCA: Communauté Baptiste au Centre de l'Afrique; GESOM: Groupe d'Entraide et de Solidarité Médicale; ABA: Association of American Bar; FFC: Fund for Congolese Women

Interview questions:

What does the National Health Policy say about women who are victims of sexual violence in the Democratic Republic of Congo?

A. What are women's health problems that the policy addresses?

B. How is the policy in conformity with the council resolutions on the health of women victims of sexual assault?

2. How do the political, economical, and socio-cultural factors impact on the health of women in DRC?

3. How does the process of the policy affect the results on the ground?

Data analysis

A thematic analysis approach using concept and data driven coding[32]was used for the study. First, all documents were read for familiarization. Special attention was given to the section in the documents that addressed health at large which was relevant to the document of the study. A brief summary of the document was then made and read in a critical manner to identify the key concepts (codes). The identified key concepts were then categorized as deductive in view of the general idea that they represented. These categories were then analyzed and grouped according to pre-determined themes from the policy analysis framework. The categories that were developed from the document analysis were applied to the data from key informant interviews. However, if new concepts arose during the analysis of the transcripts, these were also noted and added to the existing categories. If they were not covered in the existing categories, new categories were established.

Ethical issues and approval

As mentioned, ethical approval was granted by the Ethics and Research Committee of Université Libre des Pays de Grands Lacs (ULPGL). The respondents were informed from the onset that their participation in the survey and the qualitative interview was entirely voluntary, and were at liberty to withdraw their participation at any time. The interview setting was appropriately chosen, ensuring total privacy. Confidentiality was practiced; all respondents were assured that the information they provided would not be used for purposes other than research, and participants' names would not be listed as an appendix to the study. Before the commencement of the interviews, verbal and written consents from the respondents were received.

RESULTS

Overview of the components of the United Nations Security Council and the National Strategy of DRC

The United Nations Security Council has issued a series of resolutions advancing greater involvement of women in peace and security (Res 1325), strengthening the UN's protection, prevention and response to sexual violence (Res 1794), protecting children in armed conflict from sexual violence (Res 1882) amongst other things such as calling for the appointment of a Special Representative for the Secretary General on Sexual Violence (Res 1888). A further resolution led the Security Council to confirm the link between conflict-related sexual violence and sustainable peace and security (Res 1820)[28,33].

The National Strategy thus appears as a relevant framework in line with the transformation of the problems in the country. It expresses a clear vision of middle and long term responses.

In addition, the National Strategy on Sexual and Gender-Based Violence (SNVBG) is also part of the dynamics of the UN Security Council, in particular in its resolutions (Res 1325, 1794, 1882) mentioned above. Moreover, the victims of SV are overwhelmingly women and girls who recognize themselves among the following five key areas: Combating Impunity, Protection and Prevention, Security Sector Reform, Multi-sectoral Assistance for Survivors, and Data Mapping. SNVBG addresses these areas through its holistic approach of prevention and care.

The content

The DRC Ministry of Gender, Family and Children had developed the National Strategy Against Gender-based Violence (GBV). The strategy lays out actions, which include enforcement of laws and actions against impunity, prevention and safeguard of the population, support for reforms within the army, and police among others. In relation to the fight against GBV that affects eastern part of DRC, it should be noted that the government adopted United Nations Security Council resolutions that address the issue of sexual violence during conflict. The emphasis is put on Resolution 1325, which highlights the crucial role of women in the prevention and resolution of conflicts and calls for the participation of women and a gendered perspective in all United Nations peace and security efforts and efforts to protect women and girls from GBV in conflict.

There is a call for government actors to implement national laws and policies. At the same time, Government institutions are engaged in GBV prevention. This includes among others, the Ministry of Gender, Family and Children, the Police, the National Program for the Fight against AIDS, the Ministry of Justice, the Ministry of Education, and the Ministry of Youth, Sports and Hobbies.

Context

Practical implications of policies: The respondents reported that the policies are providing the needed support in daily life activities. Through their many years of implementing and working with the policies, it has become clear to them that they are critical in providing clarification when dealing with SV. The respondents demonstrated that they understood the importance of collaboration as a key element of the national strategy

Lack of resources is inhibiting policy implementation: Many problems arise from this category because the actors have to compete for limited resources, returning to a core service as well as incurring personal, emotional and financial costs. Some actors are exhausted and demoralized. This scarcity of government resources includes a lack of political will on the part of the authorities to ensure a strong focus and genuine engagement in addressing issues of sexual violence. The ongoing insecurity and large-scale displacement of the population in Eastern DRC hinders an effective response to sexual violence.

The interviewees were asked about their opinions and experiences concerning women's health problems. Their responses were analyzed and categorized according to their opinions and experiences. An example of this was the following remark by Interviewee 4:

I would say that, there have been changes; the mere fact that there have been denunciations in the community is already a big change, since access to justice for women was a mystery… It is really a great change as the woman breaks her silence and is open to justice; and as I said earlier on there is quite a lot of sharing, indicating that women know a lot more; ; it is already a step forward that women are opening up. (Interviewee 4)

Improving access to health

The informants expressed their experiences of improved access to health for the population in the following quotes:

In terms of the number of victims, there is no change. The number increases, since there are always wars from which people are fleeing, etc. The only thing that I could say is that there is an improvement as the victims know that they have to come before 72hrs and now 60% of the victims come before the specified timeline. They have understood that the sooner they come, the better they are treated and protected. (Interviewee 10)

The majority of the interviewees gave their opinions and comments about the influence of the political context on the health policy. The effect of the said context is clearly recognized by most respondents. Moreover, the head of State has appointed a special representative who is attached to his office to deal with sexual violence issues.

The Socio-Cultural context

In terms of social structures, it was underlined several times by the respondents that socio-cultural contexts may be characterized by women's inferior social status and low literacy levels.

According to studies carried out in some regions by some partners, one can nevertheless note some interesting findings. For example, studies on masculinity, status of women, have clearly shown that beyond the state of war, there is a cultural-social context that favors sexual violence in this part of DRC. (Interviewee 3)

All participants expressed that DRC has low literacy levels especially among women.

In fact, we lived in a culture where the woman was educated in a way that she had to be quiet, she was educated knowing that she did not have the skills that a man has, so she had to stay in the kitchen, caring for her children etc. (Interviewee 4)

The interviewees further argued that the DRC constitution states that there will be no discrimination on the basis of gender.

The government has also signed the Universal Declaration of Human Rights and ratified CEDAW. However, in practice, women in this society suffer from low status, a suppressive attitude, and various types of harassment, sexual assaults and domestic violence.

There is a problem here because there are still retrogressive customs and cultures that do not promote the development of the woman as seen in several prohibitions. Also in some customs a man who forces a woman to do as he pleases is perceived as a strong man, this encourages sexual violence and prevents women from claiming these rights in society. (Interviewee 2)

On the question as to whether they are aware of National Policies of Health for the women victims of sexual violence put in place by the government, the respondents answered in affirmative. Participation in the policy process certainly is taking place, particularly at the policy implementation level and increasingly at the policy formulation level.

…this is at the internal level because internally we put in place different strategies to counter the different challenges we face on the ground in the implementation of our projects, we always meet to find a solution to each challenge we face. We have a monitoring and evaluation department that is responsible for monitoring various programs and alerting communities of the attainment of objectives and the achievement of project indicators… (Interviewee 12)

Climate of insecurity

As referenced earlier, cases of rape and violence are still rampant in the city. The respondents revealed that women experience the worst effects of the climate of insecurity because of the political uncertainty in the country. In such cases, disorder and instability are evident and jeopardizes the already fragile situation.

We cannot intervene in our operation areas. For example, since this morning we have been informed from Beni about the problems we have to deal with, but we are stuck because of the war that is going on there. The security situation we are facing today is blocking us from making progress in our intervention. (Interviewee 8)

Lack of financial support

The interviewees expressed their frustrations towards the Government that is fails to provide adequate resources to support their policies. This could lead to a stagnation of the interventions and may create a policy gap.

When a patient is brought to the hospital, the doctor uses only his/her eyes and stethoscope to carry out the diagnostic. Lab tests are either inexistent or unaffordable for the patient. . So, the government should provide subsidies to hospitals to enable them meet these needs, which will also motivate the personnel. (Interviewee 3)

During all the interviews, it was generally agreed that the large majority of the population of Eastern Congo live in extreme poverty. Here, poverty has several facets. Unemployment as well as instances of non-payment and/or under-payment of workers in the formal sector enhance poverty levels.

On the economic front, I do not know what to say. At the level of raped women there are a lot of difficulties. When I read their reports, they often lamented. Their reports are written in Swahili otherwise it would have been best for you to read them. They say that… people are no longer doing their small businesses and prefer to stay at home which essentially increases cases of theft, poverty, and so on. (Interviewee 10)

Process

Process analysis: The respondents answered that the process on the ground is going well. Participation in the policy making and implementation process is certainly taking place. Generally, the policy process is divided into different stages, such as agenda setting, planning, implementation and monitoring.

The respondents recognized, however, that health planning is hardly flexible. The implementation process in the country is influenced by the political, economic and socio-cultural context. Health authorities in the country have not yet developed efficient monitoring systems, particularly to supervise the multi-sectoral public health projects.

…this is at the internal level because internally we put in place different strategy to face the different challenges we have on the ground in the implementation of our projects. We always meet to find a solution to each challenge. With regard to project development, we work with communities (the first beneficiaries of our services), that is to say, we start by identifying their needs, developing a theory of change, drafting the project and then moving on to the implementation phase where the victims are also involved. In the end we have to do the assessment. Internally we have a monitoring and evaluation department that is responsible for monitoring various programs and alerting communities for the implementation of objectives.(Interviewee 12)

DISCUSSION

By following the model of Walt and Gilson (1994) our health policy analysis focuses on the health policy content, context and processes. The policy intends to address the problems of insufficiencies and discrimination. According to council resolutions, equity refers not just to the provision of material resources on an equitable basis, but also to ensuring enough power and status to the people [34,35]. Furthermore, Security Council resolutions advocate for social and economic equity as a means of promoting health [36].

According to international organizations, governments should be "stewards" of their national resources, maintaining and improving them for the benefit of their populations [37], this would mean a betterment of health conditions and well-being [38]. However, as the analysis showed, in practice, government could neither offer good governance nor a favorable policy context that is able to ensure an effective health policy process. Consequently, health policies and programs lack sustainability [36,39].

The Constitution of the DRC states that there will be no discrimination on the basis of gender. The government has also signed the Universal Declaration of Human Rights and ratified CEDAW. However, as mentioned, in practice, women in the country suffer from low status in the society, a suppressive attitude towards them, and various types of harassment, sexual assault and domestic violence.

Article 45 of the DRC Constitution guarantees access to education based on equality and without discrimination [40]. Unfortunately, as described in the category "socio-cultural context "the victims of SV are characterized by social status and low literacy levels. This characterization is also described in Alternative Report to the DRC's Periodic Report to the Committee on the Elimination of Discrimination Against Women Indigenous Women in the DRC, the injustice of multiple forms

of discrimination which indicates that the rate of schooling for girls remains minimal [41]. The reasons for this lack of education of girls are: the lack of funds to pay school fees, early marriages and pregnancies among teenagers, and the concept of the inferiority of the women which is inculcated in girls at a young age. Moreover, the parents show a preference for their boys and are more concerned about their education than that of their daughters. It is also one of the reasons why reproductive health programs could not achieve their targets[42].

Literacy rates are very low in rural areas, although girls' enrolment and attendance in primary school is high[43]. Low literacy rates, particularly amongst women, create difficulties in creating awareness to activate participation and develop healthy lifestyles [44]. However, studies and recent investigations demonstrate that the positions of Congolese women in several sectors of national life remain worryingly low in comparison to that of men [44,45].

Early marriage is a common practice (mostly in the rural areas) and an estimated 74 percent of women between 15 and 19 years of age are married [46,47]. The legal minimum age for marriage is 15 for women and 18 for men [48,49]. Nonetheless, in practice, cases of early marriage of girls as young as 13 years old, especially in rural areas, are very common.

Timor Leste's Plan proves that it is possible to mainstream gender health concerns in all programs and monitor their impact on women's health [50]. According to the WHO, investment in social determinants and reduction of health inequalities is a "moral imperative that coincides with the commitments all countries have made to health and human rights through international human rights treaties" [51]. However, building good governance for action on social determinants in health systems is not an isolated endeavor [52].

A health system that responds adequately to health conditions associated with gender disparities is a system that has the capacity to address gender norms, roles and relations in policies, programs and health services [53]. It also requires the commitment of all political leaders; more specifically, the community and regional authorities and the involvement of many civil servants.

The content analysis has focused on how the National Strategy deals with important principles such as equity, involvement and collaboration, because the policy document has stated that the basic purpose of formulating a health policy is to renew the policy in accordance with the principles of council resolution strategy. However, in practice, the National Strategy 2010 has not sufficiently and appropriately met these principles of the Security Council resolutions. In addition, equity is absent in DRC because the ruling elite treats the health sector as a low priority, allocates minimum governmental expenditures for health in national budgets and does not use the facilities of the national health sector.

Strengths and weaknesses of the study

A positive aspect of the study is that it has considered secondary data in the form of previous studies about health policy analysis, official reports of health ministries and departments in the DRC, international agencies and reports of seminars and conferences on health policy. The researcher has visited different provincial ministries, health and other welfare departments, and hospitals in order to collect reliable information and dated.

Besides the document analysis, open-ended interviews of sixteen actors involved in the health policy process at the provincial and international levels were conducted in Goma. The international actors who were interviewed include: the officials of ABA and FFC. The national actors interviewed included: NGOs' representatives, physicians, health managers and representatives of health-related NGOs as well as health associations. This approach ensured the study received a lot of comparable data and was able to corroborate facts making the study findings more factual than theoretical.

Difficulties were experienced, particularly getting audience with leaders and top-level managers due to time constraints. The respondents also gave short responses to questions and the researcher was unable to get further explanations from them on a given issue. Perhaps a pilot study would result in more open questions that could give more explanation and broader answers.

However, the respondents credibility increased during the research since there was broad inclusion of the key informants representing various working fields. Thematic analysis has also been done for relevance to the text.

CONCLUSION

Since low socioeconomic status and low literacy levels characterize the women from the study, it is recommended that more attention must be paid to the health policy context and to prioritize the health sector in SV interventions in DRC. Concretely, DRC needs to increase its national budgetary allocation to health provision expenditures as this will facilitate interventions on SV.

To address the inferior status of women in DRC, the international declarations, conventions and the constitution must be strictly followed in order to treat women equally, when providing them with opportunities for health, education and employment.

Peace and respect for human rights must be made a living reality for all people, especially women and children in DRC in order to improve the situation.

ACKNOWLEDGEMENTS

We express our gratitude to all health care workers who have participated in the study. Our gratitude also goes to the authorities of ULPGL who arranged the interview meetings with the participants, especially to Mr. Bakenga who was driving me through the bumpy roads of Goma to look for some locations for interview. We also thank the Swedish Foundation for International Cooperation in Research and Higher Education (STINT) for making this research possible.

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Cite this article

Eale Brigitte KM, Andersson G, Edmond NN, Kaburo BB, Adolfsson A (2019) Health Policy Response to Health Care Needs of Victims of Sexual Violence. Ann Public Health Res 6(1): 1087.