A Case Study of OFDA Health Facility Support in North Kivu

Case studies are empirical inquiries that investigate contemporary phenomena in real-life settings. This case study focuses on health service financing approaches used by partners funded by Office of U.S. Foreign Disaster Assistance (OFDA) to support public sector health services amidst ongoing conflict and insecurity in North Kivu, Democratic Republic of Congo with a focus on user fees.

Balancing commitments to reinforce and strengthen local health sector capacity with aims of ensuring crisis affected communities, particularly IDPs, receive free primary health care is a challenge. There have been recent calls for more coherent approaches and stronger commitments to expand universal health coverage in fragile and conflict affected settings. Sphere Standards dictate that affected people have access to free primary healthcare services for the duration of an emergency, yet there are also pressures to maintain systems prescribed by national policy.

Primary data collection was conducted between April and July 2018, just prior to the Ebola outbreak. This included (1) health facility visits (comprising of semi-structured individual and group interviews with health facility staff, client exit interviews, and observation checklists); (2) semi-structured interviews with Ministry of Health officials, (3) focus group discussions with community members in health facility catchment areas; and (4) semi-structured individual and group interviews with NGO health program staff. Interviews were not recorded, but detailed notes were taken, and teams held debriefing meetings to review notes and cross-check findings from each activity. Findings were translated to English and analyzed using thematic content analysis methods. In addition, a literature review was conducted to contextualize findings within the local and global evidence base.

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Examination of OFDA-funded programs implemented by four international NGOs in North Kivu revealed a complex health financing situation, with great variability in the cost of delivering services, differing abilities and approaches of NGOs to subsidize costs of care for internally displaced populations, and wide ranges of health care costs reported in different locations. Despite NGO efforts to sensitize health facility staff and communities to the temporary nature of free services, the short duration of NGO engagement with facilities led to community perceptions of transient support in an area of constant conflict, confusion on the types of services that are covered and unreliability of free services.

Key Similarities and Differences in NGO Support Models

 Similarities	Free care for any pregnant women, lactating mothers, and children under five plus additional services were covered for IDPs. Drug shortages and delays in obtaining medicines and basic supplies. The Memorandum of Understanding development process between NGOs, health zones and health facilities had key similarities across all NGOs, including community input and health zone approval.
 Differences	Though most NGOs covered general ambulatory care, vaccination, and family planning for IDPs, some services were unique to each NGO such as hospitalizations, tuberculosis care and health promotion. Among NGOs that had a differentiated payment system as part of their model, services that were covered for the host community population and/or targeted vulnerable groups also varied. For example, some organizations had malaria treatment, vaccination and/or family planning free for all whereas other had in-kind contributions to help with facility rehabilitations, equipment Process for incorporating community input in Memorandum of Understanding development differed. Monitoring and accountability mechanisms varied from one facility to another; some facilities had community outreach and consistently checked with IDPs to hear care experiences and manage health facility issues as needed whereas others did not.

Ensuring access to essential health services with financial protection for the most vulnerable in fragile and conflict-affected settings is a major challenge. Challenges documented in this case study – including unreliable government payment and supply management systems, high variation in user fees, little sustainability of strategies to improve access and quality of health services, and limited awareness of benefits packages and fee structures - have been persistent challenges for decades and are not unique to areas of North Kivu reliant on humanitarian assistance for basic health service provision. In this context, focusing humanitarian efforts on addressing immediate life-saving needs without consideration for these underlying health system constraints may limit program reach and effectiveness. Recommendations for future health service support in eastern DRC are to:

1. Ensure all conflict-affected populations in have access to basic primary health care services, regardless of residence status as internally displaced or as a resident of an affected community.
2. Assess and document variations in formal and informal fee structures at health facilities before the introduction of support packages. Consider how fee structures will be reinstated or modified after humanitarian assistance ends, and plan for a gradual re-introduction of user fees if free health services cannot be sustained.
3. Encourage greater transparency and coordination of financing strategies among NGO implementers and donors. Promote the engagement of local health authorities in this process to improve consistency in support to the health sector across different health zones and territories.
4. Distinguish and strengthen linkages between flexible, shorter-term funding for emergencies and ongoing health sector financing experiments or reforms with the aim of a more cohesive long-term strategy for health service support.
5. Establish simple, functional systems for facility, project and donor portfolio-level cost analysis.

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