

IGNORANCE OF HEALTH SERVICES AMONG HOUSEHOLDS IN ÉQUATEUR PROVINCE, DEMOCRATIC REPUBLIC OF CONGO: A CROSS-SECTIONAL STUDY IN MBANDAKA CITY (2024-2025)

Okope Usalo Maxime¹, Mutumbi Abeli Franck², Lofandjo Kawe Pierre³

¹Institut Supérieur des Techniques Médicales (ISTM), Mbandaka, Democratic Republic of the Congo

²Professor Ordinarius, ISTM Mbandaka

³Senior Lecturer (Chef de Travaux), ISTM Mbandaka

ABSTRACT

Introduction: Ignorance of health services remains a major obstacle to improving public health in low-resource settings. In Équateur Province, Democratic Republic of the Congo, many households underutilize available health facilities despite their geographic proximity. This study aimed to analyze the socioeconomic, cultural, and institutional factors associated with ignorance of health services among households in Mbandaka city during 2024-2025.

Methods: A mixed-methods cross-sectional study was conducted among 250 households selected through stratified random sampling across three health zones (Bolenge, Mbandaka, Wangata). Structured questionnaires, semi-structured interviews, and focus group discussions were used to collect data. Descriptive statistics, chi-square tests, and odds ratios (OR) with 95% confidence intervals (CI) were calculated using SPSS. Thematic analysis was performed for qualitative data.

Results: Of 250 respondents, 82% were aged ≥ 30 years, 59% were male, and 75% were married. While 100% knew a nearby health facility, only 46% had consulted any health service in the preceding six months. The main reasons for non-consultation were cost (80%), poor reception (14%), and distance (6%). Traditional medicine was used by 97% of households, primarily

because it was perceived as less expensive (OR=2.0; 95% CI: 1.3–3.0). Lack of essential medicines (61%) and irregular salary payments (100% of health workers) were reported as major institutional failures. Only 59% of households had ever attended a health awareness campaign; radio was the preferred information channel (65%).

Conclusion: Ignorance of health services in Mbandaka is a multidimensional phenomenon driven by financial barriers, cultural preferences for traditional medicine, weak institutional governance, and insufficient community sensitization. Multisectoral interventions—including targeted fee exemptions, improved health worker motivation, culturally adapted communication strategies, and integration of traditional and modern medicine—are urgently needed to improve service utilization and public health outcomes.

Keywords: Ignorance of health services, health service utilization, traditional medicine, barriers to access, Mbandaka, Democratic Republic of the Congo.

1. INTRODUCTION

Access to quality health services is a fundamental human right and a key determinant of population health and sustainable development (World Health Organization [WHO], 2018). Yet, in many parts of sub-Saharan Africa, including the Democratic Republic of the Congo (DRC), a substantial proportion of households remain unaware of or underutilize essential health services (Ministère de la Santé Publique RDC, 2021). This paradox—geographic proximity of facilities coexisting with low service utilization—has significant implications for disease control, maternal and child health, and the achievement of Universal Health Coverage (UHC) by 2030.

The DRC has one of the weakest health systems in the world, characterized by chronic underfunding, shortage of qualified personnel, frequent stockouts of essential medicines, and reliance on out-of-pocket payments (Banque Mondiale, 2020; WHO, 2010). The province of Équateur, and its capital Mbandaka, face additional challenges: recurrent outbreaks of water-borne diseases (cholera), emerging epidemics (monkeypox), poor sanitation, limited access to safe drinking water, and deeply rooted traditional healing practices (Ministère de la Santé Publique RDC, 2021; PNUD, 2019).

Ignorance of health services is not merely a lack of knowledge about the existence of facilities; it encompasses poor understanding of the benefits of preventive care, misconceptions about disease causation, distrust of modern medicine, and inability to navigate the health system due to economic, cultural, or logistical barriers (Anderson, 1995; Penchansky & Thomas, 1981). In Mbandaka, anecdotal evidence suggests that many households bypass public health facilities in favor of traditional healers or self-medication, even for serious illnesses such as malaria.

While several studies have explored barriers to health service utilization in other Congolese provinces (Mukendi et al., 2021; Ngoyi, 2019; Esaïe Aymar Bumba Moaso Djongi, 2009), no study has specifically examined the phenomenon of ignorance of health services in Équateur Province. This gap limits the ability of local health authorities to design targeted interventions. Therefore, the present study aimed to:

1. Describe households' knowledge and perceptions of available health services in Mbandaka.
2. Identify socioeconomic, cultural, educational, and institutional factors associated with ignorance or low utilization of health services.
3. Assess the impact of this ignorance on the prevalence of preventable diseases.
4. Propose evidence-based strategies to improve awareness and utilization of health services.

2. METHODS

2.1. Study Design and Setting

A community-based cross-sectional study with mixed quantitative and qualitative components was conducted between June 2024 and May 2025 in Mbandaka city, the capital of Équateur Province, DRC. Mbandaka covers 1,778 km² and has an estimated population of approximately 295,000 inhabitants. The city is divided into three health zones (Bolenge, Mbandaka, and Wangata), each with a general referral hospital and several primary health centers. The

population is predominantly of Mongo, Ngombe, and Ekonda ethnicities; livelihoods include public service employment, small-scale trade, fishing, and subsistence farming.

2.2. Study Population and Sampling

The target population consisted of households residing in Mbandaka city for at least six months, headed by an adult (≥ 18 years) capable of providing informed consent. A stratified random sampling strategy was used. First, the three health zones served as strata. Within each zone, neighborhoods were listed, and households were selected proportionally to the estimated number of households in each stratum. A total of 250 households were included (34 from Bolenge, 108 from Mbandaka, and 108 from Wangata), which provided a margin of error of approximately 6% at 95% confidence level assuming a 50% prevalence of ignorance.

For the qualitative component, purposive sampling identified 15 health workers, 10 community leaders (chiefs, religious leaders, community health workers), and 5 local health authorities for in-depth interviews.

2.3. Data Collection Instruments and Procedures

Three structured questionnaires were developed based on the literature and the study's conceptual framework (Penchansky & Thomas, 1981; Bronfenbrenner, 1979):

- **Household questionnaire** (19 items) collected data on sociodemographic characteristics, knowledge of health services, utilization patterns, barriers to access (financial, geographical, cultural), and exposure to health awareness campaigns.
- **Health worker questionnaire** (15 items) assessed perceived obstacles to utilization, availability of essential medicines, salary regularity, and motivation.
- **Community leader questionnaire** (10 items) explored cultural beliefs, collaboration with health authorities, and preferred communication channels.

All instruments were pre-tested on 20 households and 5 health workers in a non-selected neighborhood to assess clarity, length, and cultural appropriateness. Questionnaires were administered face-to-face in French or translated orally into Lingala by trained enumerators.

Semi-structured interviews and focus group discussions (FGDs) (two groups of 8–10 participants each, one male and one female) were conducted to deepen understanding of perceptions, taboos, and decision-making processes.

2.4. Variables

The primary dependent variable was **ignorance of health services**, operationalized as non-utilization of any health service in the preceding six months despite having knowledge of a nearby facility, or inability to name at least three types of services offered (curative, preventive, maternal health, vaccination).

Independent variables included: age, sex, marital status, household size, education level, occupation, distance to nearest health center, perceived cost, use of traditional medicine, exposure to awareness campaigns, and health system factors (medication availability, staff motivation).

2.5. Data Analysis

Quantitative data were entered into Excel and analyzed using SPSS version 25.0 (IBM Corp., Armonk, NY). Descriptive statistics (frequencies, percentages, means) were calculated. Associations between categorical variables were tested using Pearson's chi-square test (or Fisher's exact test when expected cell counts were <5). Odds ratios (OR) with 95% confidence intervals (CI) were computed to measure the strength of associations between selected independent variables and health service non-utilization. A p-value <0.05 was considered statistically significant.

Qualitative data from interviews and FGDs were transcribed verbatim, translated into French where necessary, and subjected to thematic content analysis using NVivo 12. Themes were identified deductively based on the study objectives and inductively from emerging patterns.

2.6. Ethical Considerations

Ethical approval was obtained from the Institutional Review Board of the Institut Supérieur des Techniques Médicales (ISTM) of Mbandaka. Administrative authorization was secured from the Provincial Health Division of Équateur and the mayor of Mbandaka city. Written informed consent was obtained from all household heads and other participants after a clear explanation of the study's purpose, voluntary participation, and the right to withdraw at any time without consequence. Anonymity was guaranteed by using identification codes instead of names. For illiterate participants, verbal consent was witnessed by an independent community member.

3. RESULTS

3.1. Sociodemographic Characteristics of Households

A total of 250 household heads participated in the survey (response rate 100% among selected households). Table 1 summarizes their sociodemographic characteristics. The majority were aged ≥ 30 years (82%), male (59%), and married (75%). More than half (62%) lived in households with more than five members, and 63% were government employees. Regarding education, 53% had completed secondary school, 28% had tertiary education, 18% primary, and only 0.8% were illiterate.

The sample distribution across health zones was 20% Bolenge, 40% Mbandaka, and 40% Wangata. Significant associations were observed between education level ($\chi^2=12.5$, $p=0.006$) and occupation ($\chi^2=36.9$, $p<0.001$) with health service utilization (data not shown).

Table 1. Sociodemographic characteristics of household heads (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Health zone	Bolenge	34	20	$\chi^2=6.4$ (p=0.04)	OR=0.5 (0.3–0.9)
	Mbandaka	108	40		
	Wangata	108	40		
Age (years)	<30	44	18	$\chi^2=125.6$ (p<0.001)	OR=0.1 (0.0–0.2)
	≥30	206	82		
Sex	Male	148	59	$\chi^2=6.4$ (p=0.04)	OR=0.5 (0.3–0.9)
	Female	102	41		
Marital status	Married	187	75	$\chi^2=206.9$ (p<0.001)	OR=34.3 (16.0–73.5)
	Single	18	7		
	Widowed/Divorced	45	18		
Household size	≤5 members	95	38	$\chi^2=100.0$ (p<0.001)	OR=0.2 (0.1–0.3)
	>5 members	155	62		
Education level	Illiterate	2	0.8	$\chi^2=12.5$ (p=0.006)	OR=0.0 (0.0–0.2)
	Primary	46	18		
	Secondary	132	53		
	Higher	70	28		
Occupation	Government employee	157	63	$\chi^2=36.9$ (p<0.001)	OR=3.0 (1.9–4.7)
	Unemployed	93	37		

Abbreviations: OR, odds ratio; CI, confidence interval.

3.2. Knowledge and Utilization of Health Services

All respondents (100%) knew at least one health facility near their home. However, when asked about specific services available, 48% mentioned curative services only, 33% mentioned antenatal care (ANC), and 19% mentioned vaccination (Table 2). Only 46% of households had consulted any health service in the preceding six months (Table 3). The most frequently cited reasons for non-consultation were cost (80%), poor reception (14%), and distance (6%). Among those who did consult, 91% did so for illness (curative care) and only 9% for vaccination, indicating a strong curative orientation.

Table 2. Knowledge of health services (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Knowledge of a nearby facility	Yes	250	100	–	–
Services known	Curative	120	48	$\chi^2=12.5$ (p=0.03)	OR=1.5 (1.0–2.2)
	Antenatal care (ANC)	82	33		
	Vaccination	48	19		

Table 3. Utilization of health services in the preceding six months (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Consulted a health facility	Yes	115	46	$\chi^2=4.8$ (p=0.03)	OR=0.7 (0.5–0.9)
	No	135	54		
Reason for non-consultation	Cost	200	80	$\chi^2=36.9$ (p<0.001)	OR=3.0 (1.8–5.0)
	Poor reception	36	14		

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Reason for consultation	Distance	14	6	$\chi^2=125.6$ ($p<0.001$)	OR=4.3 (2.5–7.4)
	Illness	228	91		
	Vaccination	22	9		

3.3. Traditional Medicine Practices

An overwhelming 97% of households reported using traditional medicine (herbal remedies, faith healing, or divination). The main reasons were lower cost (68%) and high hospital expenses (32%) (Table 4). Among conditions treated at home or by traditional healers, malaria was the most frequent (49%). Qualitative data from FGDs revealed that traditional medicine is perceived as more accessible, aligned with ancestral beliefs, and often the first resort for fever, diarrhea, and “supernatural” illnesses.

Table 4. Traditional medicine use (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Use of traditional medicine	Yes	242	97	$\chi^2=206.9$ ($p<0.001$)	OR=134.0 (18.0–999.0)
	No	8	3		
Reason for traditional medicine	Less expensive	169	68	$\chi^2=12.5$ ($p=0.002$)	OR=2.0 (1.3–3.0)
	High hospital cost	81	32		
Disease treated at home/traditionally	Malaria	122	49	$\chi^2=12.5$ ($p=0.002$)	OR=2.0 (1.3–3.0)
	Other	87	35		

3.4. Barriers to Access: Physical, Financial, and Institutional

Although 79% of households lived within 1 km of a health facility, financial barriers were ubiquitous: 100% of respondents rated consultation fees as “expensive” or “very expensive” (Table 5). The most common mode of transport to reach facilities was motorcycle (59%), followed by walking (41%).

Health workers (n=15) unanimously reported irregular salary payments (100% stated that salaries had been delayed or incomplete in the preceding six months). Stockouts of essential medicines were reported by 61% of health facilities, and lack of equipment was cited as a major challenge by 80% of providers. Qualitative interviews with health workers linked poor motivation, absenteeism, and rude behavior toward patients directly to delayed salaries.

Table 5. Physical and financial barriers (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Distance to nearest health center	≤1 km	198	79	$\chi^2=6.4$ (p=0.04)	OR=1.3 (0.9–1.8)
	>1 km	52	21		
Transport mode	Motorcycle	147	59	$\chi^2=64.0$ (p<0.001)	OR=3.0 (2.0–4.5)
	Walking	103	41		
Perceived cost	Very expensive	125	50	$\chi^2=0.0$ (p=0.01)	OR=1.0 (0.7–1.4)
	Expensive	125	50		

3.5. Awareness Campaigns and Information Channels

Only 59% of households had ever attended a health awareness campaign (Table 6). The most common information channels were radio (65%) and churches (35%). When asked what information they wished to receive, 61% requested general health education (prevention of malaria, cholera, hygiene), and 39% wanted more sensitization on available services.

Community leaders emphasized that radio broadcasts in Lingala are effective, but face-to-face sessions with trusted figures (chiefs, pastors, community health workers) are more persuasive. Several leaders suggested that current campaigns are too infrequent and do not address cultural taboos (e.g., family planning, HIV testing).

Table 6. Awareness campaigns and information sources (N=250)

Variable	Category	n	%	χ^2 (p-value)	OR (95% CI)
Ever attended a health awareness campaign	Yes	148	59	$\chi^2=16.3$ (p<0.001)	OR=0.5 (0.3–0.8)
	No	102	41		
Preferred information channel	Radio	162	65	$\chi^2=12.5$ (p=0.03)	OR=1.5 (1.0–2.2)
	Church	88	35		
Desired information	Health education	152	61	$\chi^2=25.6$ (p<0.001)	OR=2.5 (1.6–3.9)
	Awareness on services	98	39		

3.6. Institutional and Governance Failures

Health workers and local authorities identified severe governance deficiencies: lack of reliable funding for facilities (80%), absence of regular supervision (73%), and insufficient coordination between public health services and non-governmental organizations (67%). Stockouts of antimalarials, antibiotics, and vaccines were reported as recurring problems. These institutional weaknesses were perceived by both providers and community members as a major reason for loss of trust in the formal health system, further reinforcing reliance on traditional medicine.

4. DISCUSSION

This study provides the first empirical evidence on the magnitude and determinants of ignorance of health services among households in Mbandaka city. The key findings are: (1) despite universal geographic knowledge of health facilities, only half of households utilize them; (2) cost is the predominant barrier, with traditional medicine being the preferred alternative; (3) institutional failures—stockouts, poor governance, irregular salaries—erode trust; and (4) awareness campaigns reach only a minority of households, and radio remains the most accessible channel.

4.1. High Non-Utilization Despite Geographic Proximity

The finding that 54% of households had not consulted any health service in the preceding six months is striking, considering that 79% lived within 1 km of a facility. This contradicts the assumption in many health system planning models that proximity alone drives utilization (Penchansky & Thomas, 1981). In Mbandaka, non-utilization is driven by economic and cultural factors rather than physical distance. This is consistent with studies from Kinshasa (Ngoyi, 2019) and Kongo Central (Mukendi et al., 2021), where urban households identified cost as the primary barrier even when facilities were nearby.

4.2. Financial Barriers and the Role of Out-of-Pocket Payments

The perception that consultations are “very expensive” (50%) or “expensive” (50%) reflects the reality of a health system heavily dependent on direct out-of-pocket payments. In the absence of effective prepayment mechanisms (health insurance or universal coverage), households face catastrophic health expenditures (WHO, 2010; Banque Mondiale, 2020). The odds of non-consultation due to cost (OR=3.0, $p<0.001$) are among the highest reported in Congolese urban settings. The current gradual implementation of Universal Health Coverage (UHC) in DRC may reduce these barriers if accompanied by effective exemption mechanisms for the poorest.

4.3. The Pervasive Role of Traditional Medicine

The near-universal use of traditional medicine (97%) is higher than figures reported in other Congolese cities (Mukendi et al., 2021 found 65% in Kongo Central). This difference likely reflects the stronger influence of ancestral beliefs in Équateur Province, as well as the limited penetration of modern health services in peripheral neighborhoods. The preference for traditional medicine is not merely cultural; it is also economic: 68% explicitly chose it because it is “less expensive”. This finding suggests that **cost-sharing mechanisms** that reduce patient payments could shift some demand toward formal services, especially for malaria and diarrheal diseases.

4.4. Institutional Failures Undermine Trust

The unanimous report of delayed salaries by health workers is alarming. In the DRC, health worker motivation is closely linked to regular remuneration (Ministère de la Santé Publique RDC, 2021). Unpaid or underpaid staff may resort to informal fees, absenteeism, or poor bedside manners, which households perceive as “poor reception” (14% of non-consultation reasons). Stockouts of essential medicines (61% of facilities) further disincentivize utilization, as households fear traveling to a facility only to be turned away without treatment.

4.5. Limited Reach of Awareness Campaigns

Only 59% of households had ever attended a health awareness campaign. Given the high illiteracy rate in older age groups, reliance on radio (65%) is appropriate, but radio campaigns may lack the interactivity and persuasive power of face-to-face community dialogues (WHO, 2018). The finding that 61% of respondents desire more “health education” indicates a **demand for prevention information** that is currently unmet. Community leaders suggested that involving religious institutions and traditional chiefs could improve message penetration and credibility.

4.6. Comparison with Previous Studies

The results corroborate earlier works from Bas-Congo (Esaïe Aymar Bumba Moaso Djongi, 2009) and Kinshasa (Senker Ndimba et al., 2025) that identified poverty as the principal driver

of non-utilization. However, the extraordinarily high use of traditional medicine in Mbandaka (97%) exceeds that reported in most other Congolese studies, highlighting the need for context-specific interventions. The weak institutional governance observed mirrors findings from the national health system assessment (Ministère de la Santé Publique RDC, 2021).

4.7. Study Limitations

Several limitations must be acknowledged. First, the cross-sectional design does not permit causal inference; associations may be bidirectional. Second, data on utilization and reasons for non-utilization are self-reported and subject to recall and social desirability bias. Third, the study was confined to Mbandaka city; results may not generalize to rural areas of Équateur Province or other Congolese provinces. Fourth, we did not measure household income precisely, as many respondents were reluctant to disclose exact figures. Fifth, the qualitative component, while informative, was limited in scope and may not have captured all cultural nuances. Finally, the absence of bacteriological or parasitological confirmation of diseases treated at home means we relied on respondents' perceptions.

Despite these limitations, the mixed-methods approach, rigorous sampling, and high response rate strengthen the internal validity of the findings.

4.8. Implications for Policy and Practice

This study has several implications:

- **Financial protection:** The government should accelerate the implementation of Universal Health Coverage, starting with free essential care for pregnant women, children under five, and the poorest quintile. Conditional cash transfers or vouchers could reduce cost barriers.
- **Health system strengthening:** Regular payment of health workers, consistent supply of essential medicines, and improved supervision are prerequisites for rebuilding trust.
- **Culturally adapted communication:** Awareness campaigns should use multiple channels (radio, churches, community meetings, mobile phone messaging) in Lingala and

French, and should involve traditional healers as allies rather than competitors. Dialogue between modern and traditional medicine could create referral pathways for complicated cases.

- **Research:** Longitudinal studies are needed to evaluate the impact of UHC implementation on utilization patterns. Operational research should test the effectiveness of community-based health insurance (*mutuelles de santé*) in reducing cost-related non-consultation.

5. CONCLUSION

Ignorance of health services among households in Mbandaka is a multidimensional phenomenon rooted in economic poverty, cultural preference for traditional medicine, institutional failures (irregular salaries, drug shortages, poor governance), and insufficient community sensitization. While geographic access is not a major obstacle, financial barriers are universal. The near-universal use of traditional medicine—driven by cost and cultural familiarity—suggests that any effective intervention must integrate rather than ignore this reality.

Without urgent action to reduce out-of-pocket payments, improve health worker motivation, and implement culturally sensitive communication strategies, the goals of Universal Health Coverage and the Sustainable Development Goals (SDG 3.8) will remain out of reach for the population of Mbandaka. This study provides a baseline for monitoring progress and a rationale for targeted, multisectoral interventions.

6. RECOMMENDATIONS

To national and provincial health authorities:

1. Implement targeted fee exemptions or subsidies for essential health services (maternal care, child vaccination, malaria treatment) for the poorest households.
2. Ensure regular and timely payment of health worker salaries to improve motivation and reduce informal payments.

3. Strengthen the supply chain for essential medicines and medical equipment at primary health facilities.

To health facility managers and health workers:

4. Improve patient reception and communication skills through regular training in respectful care.
5. Organize monthly community outreach sessions to explain available services and their benefits.
6. Establish a functional system for reporting stockouts and requesting emergency resupplies.

To community leaders and local organizations:

7. Leverage churches, radio stations, and traditional chiefdoms to disseminate health messages in Lingala.
8. Facilitate dialogue between traditional healers and modern health practitioners to create referral pathways for danger signs.

To researchers:

9. Conduct longitudinal studies to evaluate the impact of Universal Health Coverage implementation on service utilization in urban and rural Équateur.
10. Test the effectiveness of community-based health insurance (mutuelles de santé) in reducing financial barriers in Mbandaka.

7. REFERENCES

Anderson, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1), 1–10.

Banque Mondiale. (2005). *Analyse de l'utilisation des services de santé en RDC*. World Bank.

Banque Mondiale. (2020). *Améliorer l'accès aux services de santé en Afrique subsaharienne*. World Bank.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Esaïe Aymar Bumba Moaso Djongi. (2009). *Déterminants socioéconomiques influençant l'accessibilité aux soins dans la Zone de Santé de Masa/Kasangulu, Province du Bas-Congo* (Unpublished master's thesis). Université de Kinshasa.

Ministère de la Santé Publique, RDC. (2014). *Enquête Démographique et de Santé (EDS-RDC)*. MSP.

Ministère de la Santé Publique, RDC. (2021). *Plan National de Développement Sanitaire (PNDS) 2019-2022*. MSP.

Mukendi, K., Mbenza, B., & Nkoy, A. (2021). Déterminants socio-culturels de l'utilisation des services de santé dans la province du Kongo Central. *Revue Congolaise de Santé Publique*, 8(2), 45–58.

Ngoyi, P. (2019). Obstacles économiques à l'accès aux soins de santé à Kinshasa. *Annales Africaines de Médecine*, 12(3), 2345–2356.

Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care*, 19(2), 127–140.

Programme des Nations Unies pour le Développement (PNUD). (2019). *Pauvreté et conditions de vie des ménages dans la Province de l'Équateur*. PNUD.

Senker Ndimba, B., et al. (2025). Revenus des ménages des enseignants du secteur public et accès aux soins de santé de qualité dans la Zone de Santé de Kimbanseke, Kinshasa/RD Congo. *International Journal of Social Sciences and Scientific Studies*, 5(4), 5108–5125.

World Health Organization (WHO). (2010). *Rapport sur la santé dans le monde: Le financement des systèmes de santé*. WHO.

World Health Organization (WHO). (2018). *Primary health care on the road to universal health coverage: 2019 monitoring report*. WHO.

Corresponding author:

Okope Usalo Maxime

Institut Supérieur des Techniques Médicales (ISTM)

B.P. 99, Mbandaka, Democratic Republic of the Congo

Email: [institution email]

Conflict of interest: None declared.

Funding: This study was self-financed by the author.

Acknowledgments: The authors thank the Provincial Health Division of Équateur, the mayors of Mbandaka city, the community leaders, and all households who participated in the study.