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Children Family Break and Access to Health Care Law: What Knowledge and Attitudes in the City of Mbujimayi Democratic Republic of Congo

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Abstract

Introduction: In the Democratic Republic of Congo, the right to health care is recognized to all children at both constitutional principles of the law on protection of the latter. Despite the existence of these instruments, access to health care continues to be a problem again. Thus, our study focuses on children with family breakdown and the right of access to health care: What about knowledge and attitudes in Mbujimayi/Democratic Republic of Congo. **Methods:** The study is the quantitative correlational type and focused on 600 children from broken homes in the city of Mbujimayi. She performed for a period of four months which is from 18 March to 18 July 2018. A questionnaire consisting of closed and open questions was used as an instrument for data collection. The Epi-Info software version 3.5 in 2010 was used for data analysis. **Results:** The majority of children in family breakdown is composed of those with more than 14 years with (52.8%); the average age is 15.5 years; 67.8% are male; 53% live east of the City of Mbujimayi; 60.5% are non-monogamous families; 53.8% are without levels; 67.5% are Christian and 71% cannot read or write. **Conclusion:** Knowledge of the right of access to health care and the question that access to health care den is an exclusive right granted to children from broken families is low. The attitude of children from broken front right of access to health care Mbujimayi is negative. So to improve this knowledge and attitudes, we suggest that parents support their responsibilities by supervising their children. Social actors and other stakeholders in the protection of children, help them reintegrate into society by providing them with a minimum of education/training to continue to do

their fieldwork by sensitizing these children on their rights and especially on the right of access to health care to the Congolese State.

Subject Areas

Nursing, Public Health

Keywords

Children from Broken Homes, Access to Health Care, Access to Health Care

1. Introduction

Access to health care is a right of every individual including children. The right of access is a moral imperative directly related to human rights. In the Democratic Republic of Congo, access to health care is still a problem and the universal care coverage for the population in general and children in family breakdown in particular is far from Revenue Is. Thus, the ultimate goal in terms of the right to health and access to health care throughout the world is to ensure universal access to health care to anyone with children [1].

Based on this, the DRC established through the presidency of the republic since 2010 a commission of up to study how to achieve universal coverage of health care for the entire population and took out a law N˚ 09/001 of 10/01/20009 concerning child protection [2]: Upon completion of this law in Article 23, it is known to all children whatever the right of access to health care and healthy nutrition. However, the absence of monitoring mechanisms and awareness to this legislation ensures that the child does not yet have that right. In the industrialized countries, access to child health care is estimated at ±70% and in developing countries, this rate is 30%. According to a study in the DRC about access to children's health care, only 12% have access to health care [3]. Saving the Children [4] in one of its surveys Mbujimayi about access to basic social services for orphans and vulnerable children (OVC), revealed that 70% of this population had no access to Health care. Anaclet Mbuyi [5]. In its study Mbujimayi about access to health care as a right of every child without exception found that 19% of these children had access to health care. Given the precariousness of children's lives in terms of access to basic social services, including health care, and in view of the marginalization of children in family breakdown in our society, only a study on the right of access to care children in a general way and on those at break of family could situate us on the effectiveness of the law n° 09/001 of the 10/01/2009.

2. Method

Our study was conducted in the City of Mbujimayi. She was involved 600 children from broken drawn as convenience sample in 15 public places of the city including 8 in the east of the city and 7 west. The method used was the question-

naire survey supported by the semi-structured interview technique. The questionnaire was used for data collection equipment after having been tested in 5 places including 3 and 2 in the East to the West. The data were collected by 20 previously trained investigators.

In order to analyze the data, percentages and proportions averages were calculated using the Epi-Info software. The links between the independent and dependent variables were tested using the chi-square statistical test (kh^2). Among the variables considered in this study we have:

1) Dependent variables: Knowledge and attitude of the right of access to health care.

2) Independent variables: socio-demographic and cultural characteristics:

a) sex;

b) age;

c) level of education;

d) residence;

e) family status;

f) literacy.

3. Ethical Considerations

The aspects relating to respect for study subjects and their comments were kept anonymous. The data we present reflect that we have collected. Finally, an effort was made not to translate our own feelings in this study.

4. Results

1) Results of the descriptive analysis.

2) Results of the bivariate analysis.

5. Discussion

5.1. Results Descriptive Analyzes

This study aimed to determine the knowledge and attitudes of children from broken front right of access to health care Mbujimayi. The male dominates in our series with 67.8% vs. 32.2% for females. The average age of children in our study was 15 years, ranging between 12 and 18 years. 60.5% of children from broken homes are from non-monogamous families (**Tables 1-5**). This result corroborates that of Riccardo Luchini [6].

Regarding education, 53.8% have no level. In terms of religion, 67.5% of children from broken families are Christian and 71% of them cannot read or write. These results are in the same direction as those Malemba G [7].

5.2. Results of the Bivariate Analysis

In this study, we also check the association between socio-demographic and cultural characteristics and the knowledge and attitudes of children from broken front right of access to health care [8].

Table 1. Distribution of subjects by socio-demographic and cultural characteristics.

Sex		Numbers	Percentage
	Female	193	32.2
	Male	407	67.8
	Total	600	100.0
Age			
	<13 years	283	47.2
	14 and over	317	52.8
	Total	600	100.0
Residence			
	Eastern Mbujimayi	318	53.0
	West Mbujimayi	282	47.0
	Total	600	100.0
Family status			
	monogamous	237	39.5
	Other	363	60.5
	Total	600	100.0
Instruction Level			
	without level	323	53.8
	Primary	277	46.2
	Total	600	100.0
Religion			
	Christian	405	67.5
	Other	195	32.5
	Total	600	100.0
Literacy			
	Is literate	174	29.0
	Do not read or write	426	71.0
	Total	600	100.0

In relation to knowledge, the absence of the instrument and being a practicing Christian religion are sociodemographic and cultural characteristics that would influence the knowledge of the right of access to health care for children from broken because the values of ($p < 0.05$) [9].

This result regarding the investigation, is due to the fact with minimal instruction, the child whether from the street or other may have a knowledge about the rights and duties in the community. But with religion, this result is at odds with the realities of the Christian church in our society because it is one of the churches that frames most children and is often at the forefront in raising awareness the population on its rights [10]. Taking access to care as exclusive,

Table 2. Association between knowledge of the right of access to health care and socio-demographic and cultural characteristics.

Feature	Category	Knowledge of the right of access		x^2	P	Meaning
		knows	Do not know			
Sex						
	Female	13	180	0.471	0.626	NS
	Male	34	373			
Age						
	11 - 13 years	20	263	0.509	0.546	NS
	14 and over	27	290			
Residence						
	Eastern Mbujimayi	26	292	0.110	0.763	NS
	West Mbujimayi	21	261			
Family status						
	Monogamous	19	218	0.018	0.892	NS
	Other	28	335			
Level of education						
	Without level	16	307	8.036	0.004	S
	Primary	31	246			
Religion						
	Christian	41	364	9.025	0.0026	S
	Other	6	189			
Literacy						
	Is literate	18	156	2.141	0.143	NS
	Do not read or write	26	387			

Table 3. Association between access to care as exclusive and demographics and cultural.

Feature	Category	Access to care as the exclusive right		x^2	P	Meaning
		Yes	*No*			
Sex						
	Female	145	48	7.862	0.005	S
	Male	259	148			
Age						
	11 - 13 years	186	97	0.427	0.434	NS
	14 and over	218	99			
Residence						
	Eastern Mbujimayi	180	138	35.413	0.000	S
	West Mbujimayi	224	58			
Family status						
	Monogamous	153	84	1.631	0.442	NS
	Other	251	112			
Level of education						
	Without level	235	88	10.186	0.006	S
	Primary	169	108			
Religion						
	Christian	280	175	1.840	0.174	NS
	Other	124	71			
Literacy						
	Is literate	106	68	4.583	0.035	S
	Do not read or write	298	128			

Table 4. Association between accepting access to care as exclusive, demographics and cultural.

Feature	Category	Supports access to care is a right		x^2	P	Meaning
		Accepted	*Do not accept*			
Sex						
	Female	175	18	6.143	0.013	S
	Male	338	69			
Age						
	11 - 13 years	237	46	1.330	0.296	NS
	14 and over	276	41			
Residence						
	Eastern Mbujimayi	258	60	10.412	0.002	S
	West Mbujimayi	255	27			
Family status						
	Monogamous	206	31	0.637	0.414	NS
	Other	307	56			
Level of education						
	Without level	288	35	7.615	0.022	NS
	Primary	261	82			
Religion						
	Christian	352	53	2.394	0.302	NS
	Other	161	34			
Literacy						
	Is literate	145	29	0.928	0.37	NS
	Do not read or write	373	53			

we find that gender, residence and education level would influence this exclusive right, because the values of ($p < 0.05$). These results explain that the lack of education and the fact of living in a neighborhood as is the case of the East of the City of Mbujimayi that these children are unaware that access to care is an exclusive right of every child without forgetting those in family breakdown [11].

Related attitudes, gender and the fact of living in the east of the city of Mbujimayi would influence negatively children from broken families to accept that access to health care is an exclusive right granted to all children without distinction as, the values of ($p < 0.05$). These results are explained by the fact that the eastern city of Mbujimayi abound less schools and is counted among the most remote corners and the less fortunate of the city [12]. As for being ready to assert this right of access, gender, the fact of living in the east of the city and would influence negatively education the right of access to health care as the exclusive legal right any child. These results complement that of access to care as the exclusive

Table 5. Association between being ready to claim the right of access to health care and socio-demographic and cultural characteristics.

Feature	Category	Be ready to claim the right		x^2	P	Meaning
		Be prepared to demand	*Do not be prepared to demand*			
Sex						
	Female	162	31	10.57	0.001	S
	Male	292	115			
Age						
	11 - 13 years	215	68	0.027	0.924	NS
	14 and over	239	78			
Residence						
	Eastern Mbujimayi	198	120	66.00	0.000	S
	West Mbujimayi	206	76			
Family status						
	Monogamous	182	55	0.269	0.603	NS
	Other	272	91			
Level of education						
	Without level	259	64	7.760	0.005	S
	Primary	195	82			
Religion						
	Christian	306	99	0.006	0.927	NS
	Other	148	47			
Literacy						
	Is literate	129	45	0.311	0.577	NS
	Do not read or write	325	101			

legal right to child roof after Law No. 09/001 of 10/01/2009 [13].

6. Conclusion

Knowledge of the right of access to health care and the question that access to health care den is an exclusive right granted to children from broken families, which is low. The attitude of children from broken front right of access to health care Mbujimayi is negative. So to improve this knowledge and attitudes; we suggest that parents support their responsibilities by supervising their children. Social actors and other stakeholders in the protection of children, help them reintegrate into society by providing them with a minimum of education/training. to contribute to doing their fieldwork by sensitizing these children about their rights and especially about the right of access to health care to the Congolese State.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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