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A picture reflecting community solidarity in action for health matters: Jesus heals a paralytic (Mt 9: 1-8 or Mk 2: 1-12).

Addressing the Challenges of Access to Health Care for the Rural Population of the Informal Sector in Northern Provinces of Burundi from 2010 to 2017

A thesis submitted by **Félix BANYANKINDAGIYE** in partial fulfillment of the requirements for the degree of **Master of Arts** in **Organizational Leadership & Management**

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DEDICATION

To my parents,

To my spouse,

To our children,

To my relatives and friends,

I dedicate this work.

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Many people helped me in the completion of this work, but some of them deserve special attention.

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ABSTRACT

Access to adequate and affordable health care for all is still difficult for many low-income countries including Burundi where 90% of its population belong to the informal sector and also live in the rural area. In this work, I have chosen to explore how community members of the northern provinces of Burundi managed to cope with challenges of access to health care. Specifically, they faced three challenges: lack of community-based health insurance (CBHI), shortcomings in governance and management in such schemes, and insufficient financial and technical support from the government and donors. Following a qualitative and inductive approach in the case study, I collected data using interview, reports and field visits. After the analysis of data and considering the literature review, the study concludes that the rural population of the informal sector within the northern provinces of Burundi really need the mechanism of access to health care with a system of prepayment, risk sharing and solidarity among population. I also found that leaders of local farmers' associations as internal change agents managed to mobilize community members and to set up CBHIs thanks to their commitment and dedication. Those leaders addressed shortcomings observed in the governance and management of their schemes. In their lifespan, CBHIs relied mostly on the technical and financial support of Louvain Coopération au Développement (LC) and its Burundian partner Union pour la Coopération et le Développement, Appui au Monde Rural (UCODE AMR) because the support from the government is still little. However, those schemes are perceived as mechanisms contributing to achieve universal health coverage if there is scaling thanks to the contribution brought by community members to the health financing. Since those CBHIs are still young with moderate membership, they need more support from the government, NGOs and other donors in order to achieve good performance yet preserving their autonomy.

Key words: community-based health insurance, leadership, ownership and performance

TABLE OF CONTENTS

DEDICATION i

ACKNOWLEDGEMENTS ii

ABSTRACT iii

TABLE OF CONTENTS iv

ACRONYMS AND ABBREVIATIONS vi

CHAPTER I: GENERAL INTRODUCTION 1

I.0. Introduction 1

I.1. Background to the Problem 1

I.2. Statement of the Problem 3

I.3. Research Objectives 4

I.4. Research Questions 4

I.5. Scope and Delimitation of the Research Study 4

I.6. Limitations 5

CHAPTER II: REVIEW OF RELATED LITERATURE 6

II.0. Introduction 6

II.1. General Literature 6

II.1.1. International Call for Community Involvement in Health Matters 6

II.1.1.1. The Bible 6

II.1.1.2. ILO Declaration of Philadelphia, 1944 7

II.1.1.3. The Universal Declaration of Human Rights, (Paris, 10 December 1948) 7

II.1.1.5. The OTTAWA Charter for Health Promotion, 21 November 1986 8

II.1.1.6. The BAMAKO Initiative, 1987 8

II.1.1.7. WHO Declaration by World Health Assembly, 2005 9

II.1.2. Governance and Management of Nonprofit Organizations like CBHIs 9

II.1.2.1. Governance 9

II.1.2.2. Management 20

II.1.3.1. Role of Government 25

II.1.3.2. Involvement of Supporting 0rganizations like LC & UCODE 26

II.1.3.2.1. Louvain Coopération au Développement (LC) 26

II.1.3.2. 2. Union pour la Coopération et le Développement (UCODE) 28

CHAPTER III: METHODOLOGY 33

III.0. Introduction 33

III.1. Description of the Research Area 33
III.2. Research Population 34
III.3. Sampling Method 35
III.4. Data Collection Instruments 36
III.4.1. Interview 37
III.4.2. Reports 38
III.4.3. Field Visits 39
III.5. Data Analysis Procedure 40
III.6. Difficulties Encountered 41
CHAPTER IV: DATA PRESENTATION, ANALYSIS AND FINDINGS 42
IV.0. Introduction 42
IV.1. Data Presentation and Analysis 43
IV.1.1. Challenge N0.1: Lack of Health Insurance 43
IV.1.2. Challenge N0.2: Shortcomings in Governance and Management 57
IV.1.3. Challenge N0.3: Little Financial Support from the Government and Donors 66
IV.1.4. Challenge N0.4: Insufficient Technical Support from the Government and Donors 69
IV.2. Findings 77
CHAPTER V: CONCLUSION AND RECOMMENDATIONS 87
V.1. Conclusion 87
V.2. Recommendations 94
VI.2. 1. To community members and CBHI leaders 94
VI.2. 2. To supporting organizations 94
VI.2. 3. To the government 95
BIBLIOGRAPHY 96
A. DICTIONARIES 96
APPENDICES viii
APPENDIX 1: MAP OF BURUNDI WITH TARGET COMMUNES viii
APPENDIX 2: OUTSTANDING COMMUNITY MEMBERS INVOLVED IN ix
SENSITIZATION FOR MEMBERSHIP AND OTHER DEEDS ix
APPENDIX 3 : QUESTIONNAIRE FOR INTERVIEWS xii

ACRONYMS AND ABBREVIATIONS

3ASC	: Association d'Appui aux Activités de Santé Communautaire (Association Supporting Activities of Community Health)
ADISCO	: Association pour le Développement Intégré et la Solidarité sur les Collines (Support to Integrated Development and Solidarity on the Hills)
BADEC	: Bureau d'Appui au Développement et à l'Entraide Communautaires (Catholic Diocese's Office for Community Relief and Development)
BIF	: Burundi franc
CA	: Community Animator
CAM	: Carte d'Assurance Maladie (Card of Health Insurance) which became Carte d'Assistance Médicale (Medical Assistance Card)
CBHI	: Community-Based Health Insurance
CNDD-FDD	: Conseil National pour la Défense de la Démocratie – Force de Défense de la Démocratie (National Council for the Defense of democracy – Force for the Defense of Democracy)
CNPS	: Commission Nationale de la Protection Sociale (National Social Protection Commission)
CRS	: Catholic Relief Services
DPAE	: Direction Provinciale de l'Agriculture et de l'Elevage (Provincial Directorate for Agriculture and Livestock)
DRC	: Democratic Republic of Congo
FVS AMADE	: Famille pour Vaincre le SIDA – Association Mondiale des Amis de l'Enfant (Family to Defeat AIDS – World Association of Children's Friends)
GDP	: Gross Domestic Product
i.e	: that is
IFAD	: International Fund for Agricultural Development
ILO	: International Labor Organization
INSS	: Institut National de Sécurité Sociale (National Social Security Institute)
Km^2	: Square kilometer
LC	: Louvain Coopération au Développement (Louvain Cooperation and Development)
MA	: Master of Arts
MFPTSS	: Ministère de la Fonction Publique, du Travail et de la Sécurité Sociale (Ministry of the Civil Service, Labor and Social Security)
MOH	: Ministry of Health

MSPLS	: Ministère de la Santé Publique et de la Lutte contre le SIDA (Ministry for Public Health and Fight against AIDS)
MUNASA	: Mutuelle Nationale de Santé (National Health Insurance)
NGO	: Non-Governmental Organization
OOP	: Out-of-pocket payment
PNDS	: Plan National de Développement Sanitaire (National Plan for Heath Improvement)
PPASS	: Projet de Promotion de l'Accès aux Soins de Santé (Project for Promotion of Access to Health Care)
$	: Dollar
SEP/CNPS	: Secrétariat Permanent de la Commission Nationale de Protection Sociale (Permanent Executive Secretariat of the National Social Protection Commission)
SILC	: Savings and Internal Lending Community
UCL	: Université Catholique Louvain-la-Neuve (Catholic University of Louvain-la-Neuve)
UCODE asbl	: Union pour la Coopération et le Développement Association sans but lucratif (Union for Cooperation and Development – nonprofit organization)
UCODE AMR	: Union pour la Coopération et le Développement, Appui au Monde Rural (Union for Cooperation and Development, Supportive to Rural Population)
UCODE MF	: Union pour la Coopération et le Développement Microfinance (Union for Cooperation and Development, Microfinance Institution)
UHC	: Universal Health Coverage
UN	: United Nations
UNDP	: United Nations Development Programme
UNICEF	: United Nations International Children's Emergency Fund
USSR	: Union of Soviet Socialist Republics
WHO	: World Health Organization

CHAPTER I: GENERAL INTRODUCTION

I.0. Introduction

Health care for all is a major predicament worldwide. Access to health care for all population of a country requires political stability, political will on the part of the government, sustainable economic growth and involvement of the target groups of workers in case there is contribution of workers. Universal health coverage (UHC) takes into account workers and non-workers including the poor who cannot afford contribution. According to the World Health Organization (WHO) in its study (Carrin, 2003, pp.3-4), UHC means guaranteeing similar health care benefits to people with similar health care needs without considering the level of their contributions. That is why governments traditionally started insuring organized workers of the formal sector who earn a regular income since they contribute regular premiums from their payrolls. It is demanding to extend social health coverage to the unorganized workers who have no regular income and self-employed in the informal sector. To circumvent these difficulties, governments sought the involvement of communities in health financing. Indeed, countries recognized difficulties related to health financing and have adopted the solution of financing at the level of community. It seems easy to identify which population contributes and to collect their contributions. As Burundi has not started the policy of UHC, financing at the level of community may be the solution to allow workers of the informal sector and non-workers access to health care. Challenges of access to health care for the rural population of the informal sector in northern provinces of Burundi and the way to address them make the concern of this thesis.

I.1. Background to the Problem

Burundi has set up policies regarding social protection, yet 90% of its population mainly rural and belonging to the informal sector still face challenges of access to health care. Indeed, the Burundian constitution and other instruments recognize the freedom to health care for all countrymen. In the 2005 constitution, the article 55 states, “All persons have the right to access health care.” On April 7, 2011, Burundi adopted the national policy of social protection. The President of the Republic heads the National Commission of Social Protection known as “Commission Nationale de Protection Sociale” in French (acronym CNPS). He launched its activities in 2013 and he also appointed members of the Technical Commission known as

“Comité Technique de la Commission Nationale de Protection Sociale”. With assistance of the International Labor Organization (ILO) and United Nations Development Programme (UNDP), the Minister for Civil Service, Labor and Social Security issued a document in April 2013 in which she indicated that the policy of social protection recognized among others that the community-based health insurances (CBHI) are micro-insurances for community members as there are also health insurances for employees. The national policy of social protection (p.45) brings precision that the CBHIs are recognized also in the national vision 2025 document. In 2014, there was disclosure of the national strategy for the implementation of the national policy of social protection. In the first general assembly meeting of the CNPS held at Kayanza on April 21, 2014, the President of the Republic declared that the UHC would be a reality in Burundi in a three-year period.

In 2017, the situation remains the same and some laws seem to be out of date. As a matter of fact, the 1958 law regulates organizations of access to health care for the population of the informal sector. It is the Belgian colonial power that issued the April 15, 1958 decree for territories under its dominance i.e Congo Belge (today’s DRC) and Ruanda-Urundi (today’s Rwanda and Burundi). It was complemented by the ministerial ordinance No. 570/519 of May 9, 2011 issued by the Minister for Civil Service, Labor and Social Security. Burundi introduced a health insurance mechanism called “Carte d’Assurance Maladie (CAM)” or Health Insurance Card by the ministerial ordinance No. 620/57 of March 20, 1984 (MSPLS, 2014, p. 49). The ministerial ordinance No. 630/172 of May 23, 1996 replaced the ordinance of 1984. It was re-organized in 2012 since on January 25, 2012, the Second Vice-President issued a law No. 01/VP2/2012 about the new CAM standing for “Carte d’Assistance Médicale” or Medical Assistance Card which became operational in May 2012. In its article 1, it is stated that the Medical Assistance Card is a transitional mechanism adopted by the government before the extension of CBHIs is accomplished nationwide. Therefore, CBHIs and CAM are two mechanisms of health protection for workers and non-workers of the informal sector mainly in the rural area. Both mechanisms compete in the community. CBHIs are private entities which are recognized in the draft of the new code of social security of 2016, and the ministerial ordinance No. 225.01/761 of May 9, 2017 issued by the Minister for Human Rights, Social Affairs and Gender.

Since workers of the informal sector are not organized by the government to access health care by paying contribution, people in need of access to health care have to initiate their own organizations. They can seek assistance from organizations which help them to reach this goal.

I.2. Statement of the Problem

According to ILO (2014, p. 102), 38.9% of the world population have no legal health coverage. In the Sub-Saharan Africa, 80% of the population is excluded from legal health coverage. ILO defines legal health coverage as affiliation to a health system or scheme and access to health care that meets specific criteria. The rights-based approach advocates universal access to social health protection (ILO, 2008, p. XI). ILO (2008, p.1) states that "worldwide, millions of people are pushed into poverty every year by the need to pay for health care." To ILO, having effective access to at least adequate health care is a key mechanism to alleviate the burden caused by ill health such as death, disability and loss of income. In the ILO 1952 Social Security (Minimum Standards) Convention (N0. 102), health ranks first among the contingencies covered (ILO, 2008, p.2).

Access to adequate and affordable health care for all is still a major problem for many poor countries including Burundi. Involvement of community in health financing is still low in Burundi. However, it is needed to increase access to health care because about 90 % of its population live in rural area and belong to the informal sector. According to the Ministry of Health (MSPLS, 2014, p. 115), CBHIs covered 22 304 households of 124 191 beneficiaries making 2% of the country's population in the year 2012. Since 2012, CBHIs faced competition of CAM in community because they both target community members. This shows that the contribution from the community to access health care is still insignificant even at the time of research.

In 2017, the government does not organize workers and non-workers of the informal sector in CBHIs causing them to face many challenges to address especially in a context of lack or shortage of such schemes. Therefore, one of the challenges for the rural population of the informal sector is to set up a CBHI. Then, once the CBHI exists, the other challenge is to ensure good governance and sound management of contributions and other resources. Finally, as the

governance and the management of a CBHI require specific skills and resources, CBHIs face the challenge of having financial and technical support from the government and donors.

I.3. Research Objectives

The objectives of this research are:

(1) To gather information about what the rural population of the informal sector can do to have their own organization allowing them access to health care;

(2) To identify actions the rural community members of the informal sector can undertake to improve the governance and management of their organization of access to health care;

(3) To obtain information about the kind of contribution external stakeholders – mainly the government and donors – can bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization.

I.4. Research Questions

There are three research questions:

(1) How can unorganized workers of the informal sector in the rural area manage to set up a community-owned mechanism of access to health care?

(2) What do the rural community members of the informal sector need to do to ensure good governance and sound management of their mechanism of access to health care?

(3) Which kind of support the external stakeholders – mainly the government and donors – could bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization to ensure its performance?

I.5. Scope and Delimitation of the Research Study

This case study is about the plight of access to health care the rural population of the informal sector in northern provinces of Burundi witness. It analyzes the context of that area in the field of health care in the year 2010 and the actions undertaken by community members from 2010 to 2017 to address challenges of access to health care including what needs to be done in the near future. Thanks to the support from the international Non-Governmental Organization (NGO) Louvain Coopération au Développement (LC) or Louvain Cooperation and Development and its Burundian partner organization Union pour la Coopération et le

Développement, Appui au Monde Rural (UCODE AMR) or the Union for Cooperation and Development, Supportive to Rural Population, community members initiated schemes to access health care in some communes of the northern provinces of Burundi namely Kayanza, Ngozi and Kirundo. The study focusses on CBHIs from six communes from the three provinces: Gahombo of province Kayanza; Busiga, Gashikanwa and Mwumba in province Ngozi; Kirundo and Busoni in province Kirundo. All of them started in 2012 although schemes of Kirundo and Busiga started in the second half of the year 2011. LC and UCODE targeted those communes because they are most affected by the killer disease malaria and most patients suffer from that disease. It takes much of the funds contributed by households for payment of consumed health care by insured beneficiaries. I have chosen to consider only CBHIs from those communes for two reasons. One reason is that those schemes started or existed in 2012 and all of them are still operational in 2017. The other one is that, as an employee of LC, it is easy for me to visit them for research when I am on duty without extra time or resources.

I.6. Limitations

There are misfortunes that affected CBHIs and my research in a way or another. Some CBHI members who started CBHIs in 2012 died. They could supply valuable information about their personal commitment. Others fled the country owing to the political unrest which started in 2015. For literature review, I encountered good titles of books I wanted to use for reference, but I could not access them because they were to be sold. Finally, during the period I was collecting information about some concepts (ownership, leadership, health coverage, governance and management), the librarian managing books in virtual library was not available during two periods making four days I went to read in that university library. It was a great loss for me because I wasted time and resources.

CHAPTER II: REVIEW OF RELATED LITERATURE

II.0. Introduction

Literature review is very important to not only case study researchers but also all researchers. According to Yazan (2015, p.141) citing Merriam (1988) and Yin (2002), the reason is that they need it for the construction of the theoretical framework that will guide their inquiry. They have to write literature reviews for their research works. It helps them to conceptualize their inquiry and to construct a theoretical framework on which they can build their entire research process.

This chapter comprises two parts: the general literature and the empirical research literature in CBHIs. In general literature, there is a presentation of different elements: the international call on community members to get involved in health matters, aspects of governance and management of nonprofit organizations including CBHIs, existing mechanisms of access to health care in Burundi, role of government and donors in the improvement of CBHIs' performance, case study and qualitative research in social sciences. In empirical research literature, there is a discussion of a thesis written by an MA student on CBHIs of the northern provinces of Burundi.

II.1. General Literature

II.1.1. International Call for Community Involvement in Health Matters

II.1.1.1. The Bible

When it comes to care for people's lives, community members need to be involved and this is reflected in the Bible. For example, when Tabitha died (The Acts 9, 36-42), community members of Joppa dispatched two men to the city of Lydda where the disciple Peter was preaching. The disciples asked Peter to hurry so as to perform a miracle and Peter brought Tabitha to life. In Matthew 9, 1-8; Mark 2, 1-12 or Luke 5, 17-26, we see what the community members did to a paralytic man. They took him to Jesus on a mat, but they could not reach Jesus in a house where he was preaching. There was a big crowd and there was no room left

not even outside the door. Therefore, four people took the man on a mat up to the roof of the house, made an opening in the roof above Jesus, dug into the roof and lowered the mat and the man on it. Other people inside the house received it and they put it before Jesus. This is what is illustrated in the picture on cover page of this thesis. Jesus was struck by their faith and he healed the man. This case proves that solidarity among community members is a factor which affects their health conditions. Community members can do a lot of things in order to enhance health care. Therefore, they have to organize themselves. This passage also proves that Jesus Christ is the best healer the world has ever witnessed.

II.1.1.2. ILO Declaration of Philadelphia, 1944

In the ILO Declaration of Philadelphia, it is stated that it guarantees that medical care, both general and specialized, would be available for all, whether employed, self-employed, dependent, or indigent. Such care would be provided either through social insurance, with a supplementary provision for social assistance to meet the requirements of needy persons not yet covered by social insurance, or through a public medical care service. Complete preventive and curative care, the declaration stated, should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature.

II.1.1.3. The Universal Declaration of Human Rights, (Paris, 10 December 1948)

The Article 22 of the Universal Declaration of Human Rights, states that every member of the society has the right to social security and to realization “of the economic, social and cultural rights indispensable for his dignity and the free development of his personality” thanks to national effort and internal cooperation.

The Article 25 paragraph 1 states that every human being has the right to “a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services …”.

II.1.1.4. Declaration of Alma-Ata, USSR, 1978

The Declaration of Alma Ata made statements about access to primary health care for all including the definition of health, the right of community and individuals regarding health care and the role of governments about health care. The Conference defined health as “a state of

complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity". It stated that health is a fundamental human right and that its attainment is "a world-wide social goal". Its realization is obtained thanks to "the action of many other social and economic sectors in addition to the health sector". The Conference called upon all people "to participate individually and collectively in the planning and implementation of their health care". It recalled that governments have the "responsibility for the health of their people" and they can fulfill it "by the provision of adequate health and social measures". The Conference urged governments, international organizations and the world community to reach a goal of adequate level of health care of all the people by the year 2000. This could be achieved by making primary health care available as close as possible to the place where people live and work and "universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".

II.1.1.5. The OTTAWA Charter for Health Promotion, 21 November 1986

The first International Conference on Health Promotion was held in the city of Ottawa from November 17th to November 21st in 1986. It made a declaration on November 21, 1986 when presenting the CHARTER for action seeking to achieve "Health for All" by the year 2000 and beyond. In its view, it wanted to strengthen community actions by promoting health by involving the community "to achieve better health". The community is to set priorities, make decisions, plan strategies and implement them. According to the Ottawa Charter, this can be achieved when there is "the empowerment of communities – their ownership and control of their own endeavors and destinies". In this case, community development relies on both human and material resources existing in the community "to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters". Participants to the Ottawa conference took the pledge "to accept the community as the essential voice in matters of its health, living conditions and well-being".

II.1.1.6. The BAMAKO Initiative, 1987

The Bamako initiative was sponsored by UNICEF and WHO and it was adopted by ministers of health from African Countries. Its aim was to increase access to primary health care by raising the effectiveness, efficiency, financial viability and equity of health care. Health centers were

to implement integrated minimum health care package to meet basic community health needs. The Bamako initiative could allow community members access drugs and ensure regular contacts with health care providers. Moreover, it was based on the concept that communities should directly participate in the management and funding of essential drug supplies and village committees involved in all aspects of health facility management. In 1999, the Executive Director of UNICEF Carol Bellamy in her speech at the occasion of the review of the 1987 Bamako initiative reaffirmed that hard work and solidarity of dedicated people could lead to accessible and affordable health care for all thanks to informed involvement of local communities. In addition, communities have the capacity to participate in the management of their health care services.

II.1.1.7. WHO Declaration by World Health Assembly, 2005

The Fifty-eighth World Health Assembly gathering on the 25 May 2005 made a declaration about "Sustainable health financing, universal coverage and social health insurance". It urged WHO member states "to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of result of seeking care". Each country has the right to decide on which health system to select provided that it guarantees everyone access to necessary health services.

II.1.2. Governance and Management of Nonprofit Organizations like CBHIs

ILO (2008, p.41) states that "The success of social health insurance schemes depends on the generation of stable resources as revenues, strong support of the population, provision of a broad package of services, involvement of the social partners and redistribution of risk and income groups". It adds that "schemes are administratively complex, and governance and accountability can be problematic."

II.1.2.1. Governance

II.1.2.1.1. Definition and Characteristics of the Nonprofit Sector

The nonprofit sector is made of voluntary, private and nonprofit organizations and associations. According to Anheier (2005, p.4), the nonprofit sector is a sector beside the public sector on one hand and the business or forprofit sector on the other hand. It is referred

to as a “third sector” when the government and its public administration agencies is the first and the forprofit or business is the second. It has developed most prominently in the 1980s and after in the USA. It encompasses different fields and activities such as education, health, agriculture, environment, art and culture, religion, international relations, labor, research, humanitarian relief, human rights, peace, and community development. When speaking of the nonprofit sector, people “tend to refer to the organizations, foundations, and associations first and foremost. Yet at the same time, the sector also covers individual activities and the values and motivations behind them” (Anheier, 2005, p. 8). For example, there are “people’s concerns, commitments to, and compassion for others outside their immediate family, respect for others, caring about their community, their heritage, the environment and future generations”. Specific terms are used to refer to these aspects: volunteering, giving, charity, philanthropy, civil society, and social capital (Anheier, 2005, pp.8-9).

In Africa, nonprofit organizations focus mainly on community and economic development (Anheier, 2005, p.82). Anheier also affirms that the nonprofit sector is small in economic terms in developing countries because of several reasons including low per capita income, lack of support of state to nonprofit organizations, low levels of government spending on welfare services, small urban middle class, existence or legacy of authoritarian political regimes, and roles of religion in institution building.

II.1.2.1.2. Shared Values in a Nonprofit Organization

Kouzes & Posner (2003, pp.129 – 130) say that “Community is the new metaphor for organizations”. In an organization, members have shared values and people know what they have in common. There is also compelling purpose justifying their commitment to the community of the organization. Leaders in an organization need to energize people “to take actions that support higher organizational purposes rather than self-interests. Leaders show how everyone’s interests will best be served by coming to consensus on a collective set of shared values and common purpose”. Among shared values, there are: leadership, commitment, trust, honesty, credibility, ownership, communication, and volunteering.

a. Leadership

« Leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Tariguan, 2012, p.119 citing Northouse, 2009, p.3). Tariguan (2012, p.120) states that "Leadership is an art of mobilizing others so that they could move by their own initiatives and inner motivation". To Tariguan, leadership is a process meaning that there must be communication of the leader to his followers. In addition, leadership implies influence which means how a leader affects followers. Moreover, leadership occurs in a group which means that a leader involves in group processes. Finally, a leader focusses attention to common goals not his or her own interests.

Power and authority are closely related to leadership. Leadership is the ability of an individual or a board to influence people's decisions and behaviors so as to do what they would not otherwise. As Tannenbaum et al put it, "Leadership is a behavioral process in which one person attempts to influence other people's behavior toward the accomplishment of goals" (Anheier, 2005, p.161 citing Tannenbaum, 1961, p.24). A leader must also adapt his or her style to different situations (Tariguan, 2012, p.122). This requires courage on the part of a leader because "Leadership lifestyle means the courage to speak up, even when it is easier to stay silent" (Borthwick, 1989, p.73). A leader must be exemplary in whatever he or she does because he or she serves as a model. In fact, "… there is no room for abusing leadership power by declaring oneself an exception to the rules. Exemplary conduct means encouraging others to imitate us, even in the smaller matters" (Borthwick, 1989, p. 70).

b. Commitment

Nonprofit organizations operate in a task-environment with high degrees of uncertainty (Anheier, 2005, p.229). They undertake activities in "difficult" areas like care to older people, service to people with disabilities, advocacy groups, assistance to minorities, humanitarian assistance, and community associations. Therefore, operating in these fields requires trust and strong commitment to enhancement of public good. A leader must build commitment and mutual trust among members, respect their opinions and inputs, and show concerns for their personal lives and feelings (Anheier, 2005, p.162). Leadership has also to do with conceptualizing, guiding, planning, decision-making and accomplishment. In addition, a leader values social, emotional and human relation taking into account their frustrations and

aspirations. Servant leadership is the main and most expected characteristic in a leader. As a matter of fact, “Leadership lifestyle means commitment to serve” (Borthwick, 1989, p. 74). Kouzes & Posner (2003, p. 191) recall what to do to other people: “To serve others well, leaders must be in touch with them, listen to them, and respect them”. Finally, it is important to stress that leadership is not static but dynamic. Tariguan (2012, p.123) points out that the purpose of every leadership dynamic is the maturity and autonomy of the followers. They become mature, if they have high degree of competence and commitment, so that the leader delegates tasks to them. We call someone a mature follower, if he participates actively and critically in the leadership process and accomplishes tasks by himself without direction of the other. About commitment expected in the leader’s followers, commitment “is a combination of motivation, endurance and work ethics. To Tariguan (2012, p.122), with the “follower situation”, commitment means motivation, concern, involvement, etc whereas competence is skill, eloquence, virtue, talent, etc.

c. Trust

Leaders have to engender trust among their constituents. According to Kouzes & Posner (2003, pp.107-108), “Trusting other people encourages them to trust us; distrusting others make them lose confidence in us”. Therefore, for the sake of enhancing the reputation of being reliable, you need to deal honestly with problems before they happen. As long as a problem is not reoccurring, you build confidence about your trustworthiness by demonstrating your initiative and by reassuring the other party that you care about the situation and are doing something about it. To be trusted, we have to extend ourselves by being available, by volunteering information, by sharing our personal experiences, and by making connections with the experiences and aspirations of our constituents. We need to allow our constituents to know us as both parties need to enter into dialogue and conversations. Trust is built during many encounters of short period (from time to time or moment to moment) and good relationship existing between leaders and their constituents. In addition, to make oneself trustworthy as a leader, one has to examine his daily actions taking the four following elements into consideration (Kouzes & Posner, 2003, p.109): (1) Make your behavior predictable (not erratic), (2) Communicate clearly (not carelessly), (3) Treat promises seriously (not lightly), and (4) Be forthright (not dishonest).

d. Honesty

By being honest, you enhance your credibility. There is rationale for telling the truth. Kouzes & Posner say, “You can’t be honest because you’re afraid that they are going to find out anyway; you have to be honest for the sake of being honest, not because you think you’re going to get caught if you’re not.” He adds that “Honesty is in fact primarily a moral choice” (Kouzes & Posner, 2003, p.108).

e. Credibility

Leaders gain credibility of their followers thanks to their behaviors and deeds. Actually, credible leaders turn their constituents into leaders (Kouzes & Posner, 2003, p.p.156-157). They get extraordinary things done in their organizations because “they enable people to act. It is not a case of a leader doing something or even telling others what to do but of everyone wanting to work together for a common purpose, one that is aligned with shared values.” They are also the first to act. As a matter of fact, “Credible leaders set the example for others; they are willing to hold themselves to the same set of standards as others. Credible leaders go first. They truly walk the talk. Leaders take the first step because doing so demonstrates their faith in the idea, program or service. Going first provides tangible evidence of the leader’s commitment” (Kouzes & Posner, 2003, p.187).

Owing to their deeds and behaviors, leaders can lose credibility with a possibility of regaining it. Indeed, “Despite our best intentions, despite our pursuit of flawless leadership, despite our efforts to be open and humble, we sometimes fail” (Kouzes & Posner, 2003, p.203). This is due to certain situations: “Sometimes circumstances change, and we can no longer do what we said we would do. Sometimes we don’t have the competence or resources to do what we said. Sometimes we make errors in judgment or choose the wrong strategies. Sometimes we just mess up. No human being is exempt from failure” (Kouzes & Posner, 2003, p.203). They find that “The trouble is that leadership failures and human frailties can seriously damage our credibility” (Kouzes & Posner, 2003, p.203). Therefore, we need to understand what we can do to regain credibility. Kouzes & Posner affirm that there is a possibility of regaining credibility by following six conditions of leadership accountability. To Kouzes & Posner (2003, pp. 204-205), “It is possible to regain credibility. When leaders satisfactorily respond to their failures of leadership, constituents are willing to continue to follow.” To recover lost credibility, there

are six conditions to be met by the leader and Kouzes & Posner call them the six A's of leadership accountability: (1) accept, (2) admit, (3) apologize, (4) act, (5) amend, and (6) attend. Kouzes & Posner believe that after those six different steps, constituents are ready to forgive up to a point. If it is the first mistake, trust in the leader will be recovered soon.

f. Ownership

Taking ownership means taking initiative (Tanner, 2016, p.1). You take ownership when you "believe that taking action is not someone else's responsibility. You, as an individual, are accountable for the quality and timeliness of an outcome, even when you're working with others. You care about the outcome the same way you would care as an owner of the organization." You may need to involve others in order to realize results. For instance, you may have a great idea of how to save the money of your organization, but you do not have time and it is not within the scope of your role. You may even be short of needed resources to complete a given task. In that case, you can call upon others for help and put that idea forward to someone who has got more time and necessary resources to get the idea done and the result fulfilled. That is taking ownership within an organization. To Tanner, taking ownership means "You can trust me to do the right thing."

In an organization, members need to think and act as owners rather than employees. They are not told what to do because they can figure it out for themselves. They have knowledge, understanding and information needed to make a decision. If they have motivation, they will act fast. According to Kouzes & Posner (2003, p. 161), "Ownership is not a set of legal rights. It's a state of mind". Therefore, choice is required for the organization and employees to provide exceptional customer service and extra employee efforts. All they need is latitude and discretion. In the Dictionary Dicos Encarta, latitude means "enough scope or leeway for some freedom of choice, action or thinking" while discretion means "the freedom or authority to judge something or make a decision about it." In Oxford Advanced Learner's Dictionary (Hornby, 2010, p.839), latitude means "freedom to choose what you do or the way that you do it" while discretion means "the freedom or power to decide what should be done in a particular situation" (Hornby, 2010, p.417). Here, leeway (also = latitude) is to be understood

as “the amount of freedom that you have to change sth or to do sth in the way you want to” (Hornby, 2010, p.848). As a conclusion, Kouzes &Posner (2003, p.164) find that “Choice is central to feeling ownership and expanding people’s capacity to act on the values that they espouse”. Taking ownership implies accountability (Tanner, 2016, p.1). It is about acknowledging that your action impacts other members’ abilities to accomplish their goals. Accountability requires sound communication within an organization and it is then considered as a major factor in building trust.

g. Communication

Communication (Kouzes & Posner, 2003, pp. 171-172) is needed to increase ownership in an organization. Instead of having few people of the rank of executives set up their own agenda, it is wise to share information so that everyone knows what to do and why. In that case, everyone in the organization is involved in developing the plan and people are committed to it. Everybody knows the rules of the game including the way the company raises money and spends it. By sharing information within an organization, members feel included and respected. Then they feel they are involved, and they take much interest in what is going on as they see and experience the effects of what they do.

h. Volunteering

As said earlier, volunteering is not an individual but a social act because people tend to volunteer as they seek to join others. Volunteers have to contribute time for the fulfilment of varied community and public purposes like food distribution and visiting the sick or helping the needy and especially when they have functions in their organizations. Because there must be efforts of mobilizing volunteers and of structuring their involvement, organizations must have permanent paid staff for that. In a nonprofit organization, volunteering is unpaid or paid under the equilibrium wage because it is assumed that volunteering is based on special motivation and devotion to the causes of the organization (Anheier, 2005, p.215). That is why most of the time there is no monetary motivation nor monetary compensation for voluntary work. In addition, through volunteering, there is an expression of underlying values such as altruism, commitment and dedication. Some of the motives are: solidarity for the poor, compassion for the needy, hope and dignity to the marginalized, personal satisfaction,

religiosity (moral or religious duty), contribution to local community, and repayment of duty to community (Anheier, 2005, p.223). That is why volunteers are willing to donate time, skills and money to the organization without asking for compensation.

II.1.2.1.3. Good Governance in a Nonprofit Organization like a CBHI

Governance is different from management. Management is a staff function when governance is a steering function. The board is the focal point of governance while the chief executive officer is the focal point of management. However, in many small and medium-sized organizations, functions of governance and those of management overlap. For Hudson (1999, p.42), governance of a nonprofit organization is "about ensuring that the organization has a clear mission and strategy, but not necessarily about developing it. It is about ensuring that the organization is well managed but not about managing it. It is about giving guidance on the overall allocation of resources but is less concerned with the precise numbers." Governance (Anheier, 2005, p.231) is about responsibility for performance and direction. It is also a steering function related to the notion of stewardship. Anheier adds that typical criteria for assessing governance include: legitimacy, representativeness, popular accountability and efficiency with which public affairs are conducted.

The board of trustees (or the equivalent) is the governing body of a nonprofit and the locus of the governance function. It also represents the organization vis-à-vis legal authorities in particular and the general public in general. As it is entrusted with the organization, its main task is to ensure that the agreed-upon mission is well carried out "without the objective of making profit and with the promise not to distribute the organizational assets to benefit individuals other than the clients the nonprofit was formed to serve. All nonprofits, even associations, have a binding legal commitment to this overall principle" (Anheier, 2005, p.231 citing Bryce, 2000, p.31).

About decision making in a nonprofit organization (Anheier, 2005, p.235), the board has the final authority. Its main obligation is to see to the organization's mission and performance. The other one is to remain accountable to the organization's stakeholders for which it acts as a trustee.

In a CBHI, there must be administrative and institutional efficiency. It can be achieved through leadership, transparency and economic responsibility. Good governance in a CBHI refers to decision-making based on elements (ILO, 2008, p.46) such as: (1) existing legal frameworks, (2) accountability, (3) transparency, (4) effectiveness and efficiency (= contracting with providers of health services), (5) equity and inclusiveness, (6) participation and consensus (= participatory decision-making at the level of the insured population; increase responsiveness to the members' needs as there are community animators at the level of a hill). It is worth mentioning that accountability is different from transparency. According to Anheier (2005, p.239), transparency is about access to information and provision of information about the organization to the general public and to stakeholders.

About accountability, the board of a CBHI (adapted from Anheier, 2005, p. 237) is accountable to the following stakeholders:

1. members because they entrust the board with the governance of the organization;
2. supporters like individual donors, church leaders, government agencies (like communal administrator), and other groups that contribute financially and otherwise like LC and UCODE which are promoting organizations of CBHIs;
3. beneficiaries and users like households' members, health care institutions and the community members in general as they receive services in one way or another or benefit from the activities of the CBHIs;
4. contractors and cooperating organizations such as health care providers (including contracting health centers and hospitals) and the umbrella organization PAMUSAB;
5. paid and voluntary staff like the CBHI manager;
6. public agencies such as oversight and regulatory agencies like the National Permanent Secretariat of the National Commission for Social Protection (SEP/CNPS).

Individual board members and the board in general hold the fiduciary trust (Adapted from Anheier, 2005, pp.237-238) that the organization operates in a legal and responsive way. Apart from the accountability to stakeholders, there is also the internal board accountability. Some individual members are accountable to the board as a whole or to other individual members of the board. For instance, the treasurer is accountable to the president and to the

whole board at the same time, and so is the clerk of the organization. At the same time, the paid staff (the manager of the CBHI) is accountable to the board and to the staff of UCODE. In conclusion, there is much demand of better governance and accountability in nonprofit organizations in general and in CBHIs in particular for the sake of increasing trust in general public and among community members. There is much expectation of control over the institutions instead of relying on confidence in them.

II.1.2.1.4. Responsibilities and Duties of Trustees

Basic responsibilities of the board of trustees in a CBHI (adapted from Anheier, 2005, p.232) are:

1. determine the organization's mission and purpose stating in clear terms its goals, means and primary constituents served;
2. select the chief executive, design his or her responsibilities and search for the most qualified for the position;
3. provide financial oversight by developing annual budget and ensure financial controls are in place;
4. provide resources to the organization so as to fulfill its mission;
5. ensure adherence to legal and ethical integrity and maintain accountability;
6. ensure there is the overall organizational planning and the actual implementation and monitoring of its plan's goals;
7. recruit (board renewal), orient new board members and evaluate the board's performance;
8. supply information about the organization's mission, its accomplishments and goals to the general public and win support from the community;
9. bring moral and professional support to the chief executive and assess his or her performance (in relation to job description and employment contract).

Basic duties of individual board members in a CBHI (adapted from Anheier, 2005, p.234) are:

1. attend all board and committee meetings and functions;
2. be informed on the organization's mission, services and policies;
3. review agenda and supporting materials before actual board and committee meetings;

4. serve on committees and offer to take on special assignments;
5. make a personal financial contribution to the organization;
6. inform others about the organization;
7. suggest possible nominees to the board that may make significant contributions to the work of the board and the organization;
8. have updated information about developments in the field of community health insurances;
9. follow conflict of interest and confidentiality policies;
10. assist the board in carrying out of its fiduciary responsibilities (ex: reviewing annual budget)

II.1.2.1.5. Ownership of a Non-profit Organization like a CBHI

Few organizations are not dependent on external resources. That is why external actors exercise control over resources, attempt to influence organizations and even threaten their managerial autonomy. They therefore comply with the external demands but at the same time they use different strategies to manage dependencies and seek to recover their managerial freedom and autonomy (Anheier, 2005, p.150). Organizations must also strive to reduce dependence on government resources in order to increase their managerial scope of action. Nanus and Dobbs (1999) as cited by Anheier (2005, p.163) suggest four dimensions on which leaders in nonprofits need to focus:

1. Internal organizational aspects: the board, staff, volunteers, members and users that the leader has to inspire, encourage and unite behind a common mission;
2. External organizational aspects: donors, policymakers, the media and other constituencies whose support the leader needs for financial resources and legitimacy;
3. Present operations: organizational performance and service quality, demand, information flows, organizational conflicts and motivation, and community support;
4. Future possibilities: a leader addresses questions of sustainability and potential threats and opportunities that may have important implications for the organization and its direction.

II.1.2.2. Management

A CBHI as a voluntary entity is a private initiative relying on participation of its members and their contributions for their establishment and ongoing operation. Like nonprofit organizations, CBHIs (Anheier, p.140 adaptation referring to nonprofit organizations) have moral values as a distinct feature. They maximize non-monetary returns such as adherents or members and the monetary performance is not the main goal. Their members must follow objectives and undertake activities that benefit a broader public and serve public interest instead of a narrow group of owners and avoid the pursuit of pecuniary interests of owners or their equivalents. Besides, they must observe the non-distribution constraint in the treatment of financial and other surplus.

II.1.2.2.1. Bottom Line of a Nonprofit Organization like a CBHI

Concerning the bottom line, Anheier, (2005, p.227) makes precision. For profit organizations, the bottom line is profit or loss. Nonprofit organizations have no bottom line. They are driven by mission not profit. Actually, they have no bottom line at all. Because a nonprofit organization has many stakeholders, it also has many bottom lines. Stakeholders are people or organizations that have a stake or involvement in an organization. Among people there are employees, trustees, volunteers, customers, and funders. Organizations include community groups, associations, government, and oversight agencies. They help an organization achieve performance and sustainability. Although CBHIs have many bottom lines regarding stakeholders, in their management, they must balance their books as private businesses do. They may make profits and losses in a year, but they should reduce discrepancies over a period of time.

II.1.2.2.2. Resources of a Nonprofit Organization like a CBHI

Nonprofit organizations have resources. According to Anheier (2005, p. 204), they are of three kinds: (1) *monetary*: grants, donations, revenue from sold material (coffee), investment income (interest on its capital or investments), dues (money levied on members of an organization as a condition of membership); (2) i*n kind*: office, motorcycle, bicycles, computers, printed tools and material, printers, digital cameras; and (3) l*abor*: paid staff and volunteers.

II.1.2.2.3. Sustainability of a Nonprofit Organization like a CBHI

Any organization including a nonprofit one must strive to ensure sustainability. CBHIs must guarantee their capacity to pay for consumed health care of their members and dependents but also administrative costs. ILO (2008, p.31) estimates that such schemes can work successfully and that they can play a major role to accelerate progress towards coverage in informal economy workers (unorganized workers). They are "an efficient mechanism to collect non- salary-related contributions and reduce costs for the poorest at the point of delivery" (ILO, 2008, p.41). Nevertheless, ILO finds that they are accused that they have to struggle with management capacity. The need for administrative and management capacity is very important in a CBHI. There is a notice that CBHIs are short of some skills such as: setting contribution, collection of contribution and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems, and accounting. They affect the viability of CBHIs. Although the availability of administrative and managerial skills in a CBHI has no specific connection to health financing in particular, it remains a prerequisite for good performance. Another indicator of a CBHI's overall sustainability is its lifespan. Among CBHIs supported by LC and UCODE, six have been operating for six years and they have kept ongoing. There are reasons for poor financial viability of financial and administrative kinds: adverse selection, small scale of a CBHI, and important administrative costs.

WHO (Carrin, 2003, p.25) brings precision about what financial sustainability means to a CBHI. In a CBHI, financial sustainability is not to be understood as self-financing because it is commonly accepted that CBHIs can receive funds from different sources including government, national and international NGOs and other donors. The benefit package is another important factor that affects financial viability as a CBHI may exclude some health services (especially those entailing high costs) from the benefit package. However, there is a need to offer health care from the benefit package considering the patient's need for treatment.

Financial sustainability is also dependent on the performance of a CBHI as it must meet the criteria of a viable scheme.

II.1.2.2.3. 1. Criteria of Performance in CBHIs

There are three criteria taken into consideration for performance of CBHIs i.e enrolment & contribution collection, pooling and purchasing.

a. Enrolment to a CBHI and Collection of Contribution

WHO (Carrin, 2003, p.7) presents situations of enrolment to CBHIs. When contribution is determined on basis of really consumed health care, healthy households may refuse to join arguing that the proposed amount of money for contribution seems exaggerated when they consider low care costs they incurred before. On the contrary, the less healthy households may be more interested in joining the scheme for the opposite reason. This is referred to as the problem called “adverse selection”. It thus happens that CBHIs are more attractive to ill-health people instead of having a good mixture of households with good health risks and those with bad health risks. Therefore, there may be discontinuation of the CBHI if there is much adverse selection, bad impact of adverse selection on health care costs and increasing contributions. Indeed, if the required amount of money for contribution is high, the scheme may utterly cease to attract potential members. Then, low membership would be a warning sign that adverse selection is taking place while broad membership is really needed to make the scheme viable in the long run. A CBHI should also avoid being a scheme for better off people but it should also be open to vulnerable groups. Prepayment of health insurance contributions including subsidies and grants from donors and the government to health expenditure is a prerequisite to ensure avoidance of financial consequences of treatment costs. This can allow a CBHI to have enough prepayment ratio to prevent the negative impact of out-of-pocket payments and even reduce co-payments from scheme members. In LC and UCODE supported CBHIs, only households contribute prepayments.

b. Pooling

By risk pooling, collected contributions from all members of a CBHI allow them to access health care in an affordable and timely manner because financial resources are used to pay health care services for the healthy and the sick. It can be a more effective way of protecting households from excessive health care expenditure in case health care becomes costly. A CBHI should ensure that there is adequate financial protection of all members thanks to an adequate overall pooling of all sources of funds (including grants and donations) in order to

avoid that households carry the full burden of health care costs. Furthermore, risk-pooling may help prevent deficits.

c. Purchasing

A CBHI receives from its members the authority to: (a) set up a list of health care providers from which members can freely choose, (b) establish the set of insured health services or benefit package, (c) set quality standards of care, and (d) propose the provider mechanisms of payment. Thus, a CBHI is entitled to choose best services to purchase at lower costs, best providers to purchase from and best payment methods with best contractual arrangements. It is worth noting that the benefit package should comprise pharmaceutical products and the inpatient care including ambulatory care and hospitalization. This can reduce the risk of impoverishment of households and allow them to avoid catastrophic health spending. To enhance the cost effectiveness of care in a CBHI, the referral system and the use of generics should be encouraged.

II.1.2.2.3. 2. Existing Mechanisms of Social Health Protection in Burundi

In Burundi, there are three kinds of mechanisms of social health protection i.e. the “Mutuelle de la Fonction Publique”, commercial health insurances and community-based health insurances.

a. The national health insurance called “Mutuelle de la Fonction Publique” or MFP in acronym established since June 27, 1980 by the decree No. 1/28 and No. 100/107. Its members are mainly civil servants i.e workers of the public sector, the military and the police. Contributions come from employees and their employer mainly the government and enterprises. Employees belong to the formal sector including the public sector and private enterprises. It comprises individuals and households whose members (heads of households and individuals) contribute on a monthly basis. The mandatory contribution is collected from the payroll and they cover health care for the formal economy workers and their family members. It also targets retired people formerly employed in the public sector and retired people supported by the National Social Security Institute or Institut National de Sécurité Sociale (acronym INSS), university students, employees in private schools and public administration including communes (MSPLS, 2014, p. 107).

b. Private commercial health insurances are made of members from private enterprises and non-government institutions such as employees from non-government organizations. Members belong to the private sector and their contribution is regular. It is collected on a monthly basis from payroll. Employers may also contribute a share of the total premiums. Existing commercial health insurances are: SOCABU, SONAVIE, Jubilee, SOLIS, etc. They cover health care for workers and their family members. For some insurances, family members who are covered by another health insurance are not taken into account. Access to health services depends on needs in consideration of conventions between the insurance and the contributing organization representing workers who are members. Private commercial health insurances are subject to government regulations.

c. Community-based health insurances known as “mutuelles de santé communautaires” are nonprofit and most of them have been set up in or after 2008. Their members are individuals and households from the informal economy (i.e economic activities not covered by government regulations and laws like agriculture and handicraft) sector mainly farmers of the rural area and workers of odd services like shopkeepers and craftsmen (carpenters, bricklayers, etc.). They are basically self-employed workers in and outside agriculture. Because of low annual contribution, CBHIs have set models which limit members immediate access to hospitals and private service providers. However, the CBHI ensures that its members in every locality have access to health services with dignity and without discrimination. In 2010, organizations which promote CBHIs in Burundi formed a national network called “Plateforme des Acteurs des Mutuelles de Santé du Burundi “(PAMUSAB).

II.1.2.2.4. Collaboration between Governance and Management

In nonprofits, the relations between the governance and the management become complex because of the intricacies existing between the two aspects of such organizations (Anheier, 2005, pp.229-230). The governance sets the mission (not the financial bottom line primarily) while the management deals with operational aspects and financial matters in the running of such organizations. The organization’s mission gives the long-term view and its ambition (Anheier, 2005, p.228). In a nonprofit organization, it is the board that emphasizes its mission while the management deals with its running. In addition, different stakeholders have a multiplicity of performance indicators of different interests reflecting different bottom lines.

It is also found that a nonprofit organization presents a combination of different motivations, challenges, practices, and standards because of its governance and management.

The relationship between a board and the Chief Executive Officer (CEO) as described by Anheier (2005, p.236) is of paramount importance because it reflects the interface between governance and management functions. They must act together for the good of the nonprofit and its clients or users. Although the governance hires, fires and supervises the CEO, it is the CEO who becomes the "educator" to the board because a CEO has more and more current information in the field of the nonprofit. Besides, even if it is the board that makes the final decision, the CEO keeps the functional authority. The risk is that a strong CEO may "capture" the board and the latter should avoid it. The same, a board must avoid dominating a CEO because this may stifle initiative and dampen performance.

Middleton (1987, p.152) cited by Anheier (2005, p.236) states that the relationship between the board and the management is paradoxical for these reasons: "For many important decisions, the board is the final authority. Yet, it must depend on the executive for most of its information and for policy articulation and implementation. The executive has these emergent powers but also is hired and can be fired by the board and needs the board for crucial external functions."

II.1.3. Role of Government and Donors to Improve Performance of CBHIs

II.1.3.1. Role of Government

To achieve universal health care coverage requires a lot of actions on the part of the government. Organizing and financing health care protection are not enough alone. There must be social and economic measures and attempts to reduce poverty. Furthermore, there is a need to develop specific regulations and arrangements aiming at the efficiency of organization. They include purchasing and provider payments, quality, participation of social partners and civil society. Such arrangements impact among others on the adequacy and availability of care, and on access to health services (ILO, 2008, p. 6). Benefit package in low-income countries like Burundi should reflect health challenges to be addressed. They are relating to primary health care, maternal and child care and infectious diseases like HIV/AIDS, TB and malaria (ILO, 2008, p.43). Governments in low-income countries like Burundi cannot

finance health coverage alone. They should seek technical and financial support from outside organizations and donors. Burundi has not achieved UHC yet. It has to update its laws and regulations. That is why there is already the May 9, 2017 ministerial ordinance and there is a draft of social security designed in 2016. The 2017 ordinance recognizes CBHI as a community organization contributing to achieve health coverage in Burundi along with commercial health insurances and the "Mutuelle de la Fonction Publique". In Burundi, SEP/CNPS defines rules of the game by designing policies regulating the field of CBHIs and they affect their development.

Senegal is one of the best examples in Sub Saharan Africa for efforts to achieve UHC including providing health care protection to the 80% of its population from the informal sector of the rural area. Although, the subscription to the CBHI is not mandatory, the Senegalese Ministry of Health (MOH) is involved in the improvement of the sector by providing assistance to those community organizations. In Senegal, CBHIs have been active since the 1990s. In 2009, the government made them subject to regulation (USAID, 2014, p.23). In 2012, the MOH also created a technical unit to provide assistance to CBHI schemes. For instance, it helped to determine the minimum benefit package each CBHI has to provide to its members and their dependents. CBHIs are free to offer a better package. This is included in the National Strategy for UHC in Senegal. The government brings financial support to CBHIs by paying 50% of the annual contribution for each member of the CBHI. This is a way of helping CBHIs to grow and realize performance. It is worth mentioning that Senegal has a policy of providing free health care (USAID, 2014, p.24) to the poor and vulnerable groups, the children under five, the old, and patients suffering from specific diseases (such as malaria, tuberculosis and HIV AIDS). Besides, in 2013, President Macky Sall and his government designed a strategy plan with a goal of having 100% municipalities being endowed with a CBHI by 2017 (USAID, 2014, p.25).

II.1.3.2. Involvement of Supporting 0rganizations like LC & UCODE

II.1.3.2.1. Louvain Coopération au Développement (LC)

LC is an international non-profit organization founded in 1981 by a Belgian Catholic University called the "Université Catholique de Louvain-la-Neuve" (acronym UCL) in its Department of Agriculture. It is based in the city Louvain-la -Neuve in Belgium and it has obtained recognition

as a development NGO of the UCL. It is active in three main areas of intervention: (1) food and economic security, (2) access to health care by supporting community-based health insurances, and (3) health care. For its health care program, LC focuses on chronic non-communicable diseases and mental health. For the area of access to health care, LC focuses on the promotion and development of community-based health insurances. LC's overall objective is to improve the well-being and dignity of poor, marginalized or excluded populations from undeveloped countries. It implements development projects in 8 countries in the world namely Togo, Benin, the Democratic Republic of Congo (DRC), Burundi and Madagascar in Africa; Cambodia in Asia; Bolivia and Peru in Latin America.

LC is active in the Africa Great Lakes -DRC and Burundi- since the year 2000 mainly in the fields of food and economic security and health care. The country office headquarters are in Bukavu and Bujumbura respectively for DRC and Burundi. The country office of Burundi has four regional offices: (1) Ngozi for provinces of Kayanza, Kirundo and Ngozi; (2) Ruyigi for provinces of Cankuzo and Ruyigi; (3) Makamba for provinces of Rutana and Makamba; and (4) Bujumbura for provinces of Cibitoke and Bubanza.

In Burundi particularly, LC has implemented projects pertaining to the three above-mentioned areas of intervention since 2004 mainly in northern provinces. From 2004 to 2008, it implemented the project "Fight against Poverty in the Provinces of northern Burundi" or "Lutte contre la Pauvreté dans les Provinces du Nord du Burundi (LPPN)" in French. It was followed by the project "Fight against Food Insecurity and Malnutrition" or "Lutte contre l'Insécurité Alimentaire et la Malnutrition (LIAM)" in French from 2009 to 2013. With the two projects, LC managed to strengthen two partner organizations i.e (1) UCODE providing technical support to local farmers' associations belonging to the peasant federation UCODE, and (2) UCODE Microfinance (acronym UCODE MF) providing savings & credit services to population of the northern provinces. In the provinces of northern Burundi, LC has implemented projects belonging to the field of access to health care. From 2014 to 2016, it was the "Project for the Promotion of Access to Health Care" or "Projet de Promotion de l'Accès aux Soins de Santé (PPASS)" in French. From 2017 to 2021, there is the current project "Health Is more Important than Wealth" or "Amagara Aruta Amajana" in the national

language Kirundi. There is also a project of mental health “Be Hopeful” or “Izere” in Kirundi to be implemented from 2017 to 2021. It is implemented by the Catholic Church Bureau of the Diocese of Ngozi for Development and Community Solidarity named BADEC, acronym for the “Bureau d’Appui au Développement et à l’Entraide Communautaires”**.** The project of access to health care is implemented by the local partner organization UCODE. This partner organization provides daily support and follow-up to 7 CBHIs in 7 communes of 3 provinces.

II.1.3.2. 2. Union pour la Coopération et le Développement (UCODE)

UCODE is a non-profit peasant federation of about 1.250 associations whose members are 60.000 small farmers from the rural area scattered in 6 provinces of Burundi. There are 4 provinces (Kayanza, Ngozi, Kirundo and Muyinga) in the north and 2 provinces (Cankuzo and Ruyigi) at east. Its headquarters is in the northern province Ngozi with a liaison office located in the capital city Bujumbura. It was recognized as an organization involved in rural development on February 20, 2001 by the ministerial ordinance N0. 530/097. Indeed, UCODE strives to fight poverty in the rural area as it provides assistance to households among grassroots associations of small-scale farmers to increase food production in chain value and income so as to meet their needs. It also targets marginalized groups of people such as demobilized soldiers and ex-combatants. To fulfill this mission, UCODE gets support from different partners and donors such as the World Bank, the Netherland’s Government, the European Union, the Belgian Government, the Ministry of Finance, the Ministry of Agriculture and Livestock, and the Belgian NGO LC along with the UCODE Microfinance.

The partnership with LC began in 2004 when UCODE started to implement most of the projects (LPPN, LIAM, PPASS, Amagara Aruta Amajana) described in the previous section about LC. UCODE has implemented diverse projects in different fields such as food production and its commercialization, strengthening small farmers’ associations, health insurance, literacy and water management.

The federation UCODE is structured from grassroots to national level. Small farmers from the same hill gather in an association of about 25 farmers. There may be many such associations in one hill. Then such associations from one commune make a union at the level of a commune and it is known as “UCODE Commune”. Finally, all associations from different communes make

the national federation for cooperation and development called UCODE. It is worth mentioning that UCODE started in 2001 as one organization targeting rural population and split into two separate organizations in 2007. From 2007, there are 2 kinds of UCODE: (1) UCODE Microfinance which provides savings and credit services to population in general, and (2) UCODE Association sans but lucratif (UCODE asbl) or UCODE nonprofit organization which became UCODE Appui au Monde Rural (UCODE AMR) or UCODE Supportive to Rural Population in March 2014 which brings support to rural population to improve living conditions. The federation UCODE has governance and management units. Its executive director is appointed by the President of the federation for a 4-year term, which is renewable on set conditions.

II.1.4. Case Study and Qualitative Research in Social Sciences

Case study is one of the most used qualitative methodologies in social science research. In his article "Three Approaches to Case Study Methods in Education: Yin, Merriam, and Stake", Bendrettin Yazan (2015) affirms that Robert Yin, Sharan Merriam and Robert Stake are seminal methodologists who worked on case study method. Yin (2002, p.1) asserts the following: "In general, case studies are the preferred strategy when 'how' and 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context." In the 5th edition, Yin (2014, p. 16 cited by the Reviewer Trista Hollweck, University of Ottawa, 2015, p.109) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon (the 'case') in depth and within its real-world context". According to these definitions, the case study is a description of a contemporary phenomenon occurring in the real world.

Different authors gave characteristics of case study method. For Merriam (1988, p. 27), the defining characteristic of case study research is the delimitation of the case study. Merriam (Yazan, 2015, p.139) gives three distinctive attributes of case study: Particularistic (it focuses on particular situation, event, program, or phenomenon); Descriptive (it yields a rich, thick description of the phenomenon under study); Heuristic (it illuminates the reader's understanding of phenomenon under study). Stake (Yazan, 2015, p.139) on the other hand mentions four characteristics of qualitative research which are valid for qualitative case

studies as well. They are: “holistic”, “empirical”, “interpretive”, and “emphatic”. Holistic means that researchers should consider the interrelationship between the phenomenon and its contexts. Empirical means that researchers base the study on their observations in the field. Interpretive means that researchers rest upon their intuition and see research basically as a researcher – subject interaction. Lastly, emphatic means that researchers reflect the vicarious experiences of the subjects in an emic perspective.

Case study may be linked to inductive method. Gabriel gives the main difference between the deductive and the inductive approach in research. She states that in the following sentences (see *http://deborahgabriel.com/category/research-guides/*). A deductive approach is aiming at testing a theory while the inductive approach is concerned with generating a new theory emerging from the data. In addition, a deductive approach begins with a hypothesis while an inductive approach uses research questions to narrow the scope of the study. The aim of the inductive approach is to explore a new phenomenon or to explore a previously researched phenomenon from a different perspective. The other difference is that the inductive approach is generally associated with qualitative research while the deductive approach is associated with quantitative research. However, some qualitative studies can have quantitative aspects.

II.2. Empirical Research Literature in CBHIs Initiated by LC and UCODE

In 2015, Claire Henrioul, an MA student in the area of Anthropology in UCL, wrote a thesis entitled “La mutuelle de santé de UCODE AMR au Burundi, un « terrain » à la croisée des incertitudes. Quels enjeux pour sa pérennité?” meaning “Health Insurance Initiated by UCODE in Burundi Facing Uncertainty. Which Stakes for Its Sustainability?”. She questioned possibilities of sustainability of CBHIs initiated by UCODE. Her thesis is based on her experience in her three-month practicum (Henrioul, 2015, p.3) within LC when UCODE was implementing a three-year project (PPASS) supporting CBHIs from 2014 to 2016. She arrived in September and left in December 2014. She studied CBHIs from an anthropological perspective. She wanted to learn from a former Belgian colony and perhaps witness any impact of the colonial past. Incidentally, she conducted research work in Burundi in a Belgian NGO i.e LC in the field of CBHIs. She yearned to see the way a project is implemented also. That is why her methodology focused on observation without prior research questions or

questionnaire. She finally abandoned her first intention of discovering the impact of the colonial era, but she had more attention to the events of the country after independence.

Henrioul (2015, pp.51-56) described the methodology she followed in her research work. She was in contact with the project team and the members of that team were her main informants. She found a Burundian student from the National Institute of Public Health or the "Institut National de la Santé Publique" (acronym INSP) in Burundi where she was a BSC student in the field of Health Environment. She was having also a practicum in LC within the same project and doing research too, and she could bring her needed support. Observation was the main method for her research. It enabled her to witness the reality in community as an anthropologist since she could be in contact with target community members of the study. She could meet CBHI members and talk to them. In addition, she had a researcher's diary in which she wrote down what she noticed during her field visits and other encounters. Her interest was to understand the Burundian culture. Besides, she recorded semi-structured interviews she had with the Head of UCODE and LC, the expert of CBHIs in LC at its headquarters in Belgium, the project manager from UCODE, the assistant project manager, and the LC technical assistant. During her free time, she could talk to her landlady and her friends and have more information on the political context in general and particularly on the pre-electoral period.

Among her main findings, Henrioul noted that the activity of sensitization was a way leading to enrolment and collection of the annual contribution during the period from May to September 2014, which continued up to December. She realized that sensitization was an activity deserving priority to ensure sustainability of the CBHI. Besides, she understood that the actual enrolment of community members was unpredictable because it remains voluntary in a particular context. Furthermore, she noted that the context of political unrest due to the 2015 electoral period, poverty, competition with other CBHIs initiated by other organizations, competition among organizations promoting CBHIs in the same geographical area, CAM and lack of support to CBHIs by health facilities were some of the factors hindering sustainability of CBHIs. Moreover, she noted that the government and the administration agents made distribution of CAM or asked voters to pay for CAM because voters could afford to pay 3,000 BIF rather than 15,000 BIF required to be insured in a CBHI in 2015. After all, voters should not

be frustrated before elections. This situation showed her that the government was not determined to promote CBHIs as schemes allowing accessibility to health care even though the government and potential donors noted that CAM is not financially sustainable. She also pointed out the way the 2015 elections could affect the CBHIs because nobody could tell whether the policy of social protection could be followed after that period.

In Henrioul's thesis, the researcher noticed that she made a description of CBHIs in accordance with what she witnessed during her three-month practicum in a year before 2015 elections. She depicted the way PPASS project was implemented in the 2014 and 2015 particular context of uncertainty. It was a period of political instability when there was much political unrest. She concluded that the viability and sustainability of CBHIs were at stake. My thesis is about the involvement of community members in health matters. It emphasizes the role of community leaders in organizing unorganized workers of the informal sector in the rural area in order to access health care at affordable costs. The analysis of the CBHIs initiated by LC and UCODE begins early before the CBHIs' birth mostly in 2012 and live up today in 2017 including the year 2014. It elaborates on shared values of ownership, leadership, trust, commitment, honesty, credibility and communication which affect the governance and management of CBHIs and their performance during their lifespan. Henrioul was pessimistic while I will make recommendations to different stakeholders involved in the promotion of CBHIs in order to bring such organizations realize more performance. The aim is also to make CBHIs schemes contributing organizations in the achievement of UHC in a low-income country Burundi. Such aspects have not been completely tackled in Henrioul's thesis. This is the reason why I judge necessary to undertake this study. The methodology I follow is described in the following chapter.

CHAPTER III: METHODOLOGY

III.0. Introduction

The methodology that the researcher used is both qualitative and exploratory. He conducted this case study following an inductive approach in order to know how the rural population of the informal sector in the northern provinces of Burundi addressed the challenges of access to health care. In this chapter, the presented elements are: the description of the research area and the research population, the sampling method, the data collection instruments, the data analysis procedure, and the encountered difficulties.

III.1. Description of the Research Area

In this thesis, the provinces of Kayanza, Ngozi and Kirundo make the research area. They are located in the northern part of Burundi (see appendix 1). Burundi itself is a land-locked country (about 1 100 km from the Indian Ocean and about 2 100 km from the Atlantic Ocean) of the Africa Great Lakes region situated in the southern hemisphere. Its neighboring countries are Rwanda in the north, the Democratic Republic of Congo (DRC) at west and the United Republic of Tanzania in the south and east. It is located at 2°20' and 4°27' at latitude south and 28°50' and 30°53' at longitude east (source: Ministry of Education, 2017, p.27). It has a surface of 27 834 km^2 (2 150 km^2 occupied by water and 25 680 km^2 for land area) and a population of 8 053 574 inhabitants among which 51% are women with a demographic density of 310 inhabitants/ km^2 (source: MSPLS, 2014, p.43). That population is about 11.2 million inhabitants in 2017 with a density of 470 inhabitants/ km^2. The provinces of Kayanza and Ngozi alone hold 20% of the total population occupying only 10% of the whole land area. In Burundi, about 90% (89.9%) of the population live in the rural area and live on agriculture (source: Ministry of Education, 2017, p.38).

The three target provinces (Kayanza, Ngozi and Kirundo) are among the 18 provinces of Burundi. Kayanza is bordering Rwanda at north, Ngozi at east, Cibitoke and Bubanza at west and Muramvya and Gitega at south and south east. It is located at 2°47'16" and 3°13'78" at latitude south and 29°25'11" and 29°55'95" at longitude east. Its surface is 1 233.24 km^2 and a population of 585 412 inhabitants (source: census of Burundi population in 2008). Gahombo

is one of the nine communes of Kayanza with a surface of 80.64 km². Ngozi is bordering Rwanda at north, Kayanza at west, Gitega at south, Kirundo at north east, and provinces Muyinga and Karusi at east. It is located at 2°39'19" and 3°5' at latitude south and 29°37'57" and 30°11'35" at longitude east. Its surface is 1 473.86 km² and a population of 660 717 inhabitants (census of Burundi population in 2008). Communes of Busiga, Mwumba and Gashikanwa are three of the nine communes of province Ngozi. Kirundo is bordering Rwanda at north, Ngozi at west and Muyinga at east and south. Its surface is 1 703.34 km² and a population of 628 256 inhabitants (census of Burundi population in 2008). Communes of Kirundo and Busoni are two of the seven communes of province Kirundo. They were most affected by the political unrest which broke out in Burundi in 2015. As a result, some of their population including CBHI members were compelled to seek refuge in neighboring countries.

III.2. Research Population

The local population from the three target provinces (Kayanza, Ngozi and Kirundo) involved in the study is made of members of existing CBHIs since 2012 to 2017 which are supported only by LC and its partner organization UCODE. This is a portion of the total number of 418 233 households (Kayanza: 125 269, Kirundo: 146 826 and Ngozi: 146 138) of 1 874 385 inhabitants (Kayanza: 585 412, Kirundo: 628 256 and Ngozi: 660 717) living in the three provinces according to the census of 2008. It is known that 67% of the population of Burundi live under poverty line (MSPLS, 2014, p. 120) which implies that the poor are not among target population of CBHIs. Also, people using other mechanisms of access to health care such as MFP, commercial health insurance and CAM are not among the research population. Members of CBHIs are people belonging to households living mainly on agriculture (informal sector) in the rural area. In addition, they can afford financial means to pay annual contribution in their health insurance and co-payment fees in case of consumption of health care in contracted health facilities. These make the only portion of the population making the research population. Among them, selection of participants to the study is described in the sampling method section.

III.3. Sampling Method

The case study method does not have a “codified design” as other research strategies social scientists use. Yin (2002, p. 19) states, “In fact, the case study is a separate research strategy that has its own research designs. Unfortunately, case study research designs have not been codified”. Thus, there is no full consensus on its design and implementation because it lacks well-defined and well-structured protocols.

In qualitative method, it is useful to make a sample in order to prove that the sample is both credible and indicative; otherwise, the statistical representativeness is not the aim (MSF, p.9). The sampling method I chose is the purposive sampling. Gentles et al (2015, p. 1779) state that “purposeful sampling is quite prominent in the general qualitative methods literature” and “it is only significantly addressed in case study” for in-depth study. Gentles et al (2015, p. 1778) citing Patton (2015, p. 264) indicate that the purposeful sampling “yields insights and in-depth understanding”. With this method, the researcher selects participants because they can generate useful data for the project taking into account specific criteria about the study population.

Samples in qualitative work are generally small in sizes (MSF, p.9). MSF states that “around 15 people for any homogeneous group” are a good estimate when there are clearly set criteria. I selected participants on basis of criteria such as gender, years spent in a CBHI (at least 2 years since 2012), function (community animator, member of the board or manager) and location (target commune).

Considering the available resources and time, I selected participants helping to find answers to research questions and to reach theoretical saturation or redundancy (the step of data collection when new data bring no new insights to the research questions). Thus, I gathered information in two periods with different participants. For personal and focus group interviews in 2014 at the time I was searching to write a mini-project as part of the fulfilment required for the course of research methodology, I targeted 30 participants (15 men and 15

women). All of them were selected using purposeful sampling. The main criteria taken into account were: gender, years spent in a CBHI (at least 2 years since 2012), not being a member of the board and location (target commune). All of the informants were members of CBHIs from the 3 target provinces (Kayanza, Ngozi and Kirundo). I had interviews in 6 focus groups in 2016 with 60 members of CBHIs (30 men and 30 women) on the occasion of project evaluation conducted annually in 6 CBHIs promoted by LC and UCODE. Participants have the similar backgrounds and experiences in CBHIs. In 2017, I had interviews with 2 heads of supporting organizations to CBHIs namely LC and UCODE. They were targeted because they are decision makers in their respective organizations, and they influence program activities in target geographic areas. Therefore, participants in the study were 104. I selected equal number of men and women for two reasons: (1) men and women are equal partners in CBHIs, and (2) I sought balance in the expression of participants during interviews. After all, there was a need of having the contribution of all group members and of maintaining the interview's exploratory purpose.

III.4. Data Collection Instruments

For Yin, Merriam and Stake (Yazan, 2015, p.142), it is incumbent upon case study researchers to draw data from multiple sources to capture the case under study in its complexity and entirety. According to Yin, there are six evidentiary sources to make use of: documentation, archival records, interviews, direct observations, participant observation and physical artifacts. The general principles applying to all six tools and the entire data gathering process include the use of (a) multiple sources of evidence (evidence from two or more sources, but converging on the same set of facts or findings for the purpose of triangulation), (b) a case study database (a formal assembly of evidence distinct from the final case study report which the novice researchers understand how to handle or manage data), and (c) a chain of evidence (explicit links between the questions asked, the data collected, and the conclusions drawn) which helps "follow the derivation of any evidence, ranging from initial research questions to ultimate case study conclusions". Stake (Yazan, 2015, p.143) recommends sensitivity and skepticism in researchers who carry out qualitative data collection. They need them to recognize good sources of data and even to interpret them. For data collection instruments,

Stake suggests the use of observation, interview and document review in qualitative case study research.

In my research, I have chosen to use the case study strategy using mainly three instruments for data collection: interview, administrative records and reports and field visits. They are useful to the collection of qualitative data, which are actually “ideas and viewpoints from the people we study” (Neuman, 2014, p.177). Moreover, they allow to capture “the lived experiences of the people we study” (Neuman, 2014, p.218).

III.4.1. Interview

In situations where little is known or when looking for answers to specific questions such as barriers to accessing health care in the rural area for workers and non-workers of the informal sector, it is most appropriate to use qualitative methods and the interview either personal or in focus group is suitable. The interview is suitable to collect information about experiences of the target population to address the challenges of access to health care. Since my research is an exploratory study, I conducted personal interviews and focus groups. In-depth and semi-structured interviews were very helpful to find out what happened in community of unorganized workers in the rural area in a context of lack of health insurance schemes and how they managed to start one health insurance of their own. Such interviews allowed collection of data regarding community members’ opinions and beliefs about the concept of health insurance and the community-based scheme to address the challenges of access to health care. Besides, I could understand their feelings about the role of community leaders in the whole process leading to the setting up of such schemes and their achievements during their lifespan. Semi-structured interviews to heads of supporting organizations to CBHIs and their staff members were also helpful to find out what their contributions were at all stages of CBHIs’ lifespan.

During interviews, respondents answered open-ended questions to reveal their experiences and their perceptions. I used questionnaires as guides during interview conduct. Interviews in

community were conducted in Kirundi, the national language used in the whole country. Interviews with the staff of UCODE and the heads of the supporting organizations of CBHIs were carried out in French, a language which is used at work in Burundi. I translated them in English (see Appendix 3) to allow the reader of this thesis to understand the meaning of the two guides. Answers to questions and other relevant information were written on the same guide. In community, the staff from UCODE could help me take notes during interview. They could even put questions and take notes as a group. Personal interview could last twenty to thirty minutes and interview in focus groups could take one hour or more but less than two hours.

Before the beginning of the interview session, I told participants that confidentiality was guaranteed. This allowed participants to feel at ease and supply information with much freedom. I also asked them if they were eager to take part in the interview and all of them answered “yes”. They were happy to find someone who could ask them about the hardships they went through to start and maintain a CBHI. Actually, they wanted to see their specific names written in a book because they felt that their experiences were worth being reported. Six interviewees were happy to supply information about their past experience later or some days after the interview session. This was also an opportunity for me to triangulate information. I used the filled-in questionnaires as transcripts to analyze answers from interviewees.

III.4.2. Reports

I used the documentary analysis as an appropriate method to access information about how the rural population of the informal sector may have access to health care. Data came from reports produced by supporting organizations LC and UCODE. Access on archival documentation was easy because I am one of the staff members of LC that contributed to its designing since 2011. Administrative records and documents allowed to have data on the evolution of CBHIs and the context through time. Though they were not collected as data for research purposes, they were useful for this study. They brought answers to research questions focusing upon the past and changes that occurred over time in an exploratory

perspective. Records from annual reports allowed triangulation of information collected from field during interviews. Through this review, I got information about clashes that occurred between governance and management units in some CBHIs, cases of mismanagement, and some aspects of CBHIs' performance.

III.4.3. Field Visits

As an employee of LC since 2011, I have got opportunities to meet community members in general and CBHI members in particular. I had surveys in community to assess the quality of health care received by the sick among the insured members in contracted health facilities and their level of satisfaction. I attended meetings during sensitization campaigns for enrolment of community members in CBHIs, meetings of general assembly, meetings of decision-making of members of governance of CBHIs or those gathering members of CBHI committees and managers especially when there were differences to settle. I could notice the level of attendance, receive complaints, witness members showing much dedication and even the level of trust of insured members in their trustees. I carried out checking of the CBHI's management documents. I could then realize the level of meeting administration requirements and management ability of CBHIs and their impact on the CBHI's growth. Field visits were good opportunities to hear members of the ruling committee contributing ideas and making decisions for the good of the insured members of CBHI and even witness misunderstandings between the boards and managers. I also took visitors to field during monitoring visits or in case of studies carried out by consultants like the bi-annual studies of a medical doctor in CBHIs and contracted health facilities and the evaluation of projects funded by the Cooperation Unit of the Belgian Kingdom in 2015. That was an opportunity to receive observations and criticisms about the performance of CBHIs and their governance or the level of ownership. I could also notice cases of initiatives and undertakings of the board to ensure solidarity among CBHI members or to help non CBHI members. Field visits allowed me to conduct interviews and gather information about cases of ownership of CBHIs by community members. Other information was collected during meetings I had with project beneficiaries including CBHI members when I carried out evaluation of the project impact on CBHI members. Specific tools designed and validated by project staff and executive directors of LC

and UCODE were used. Data analysis followed, and the results were then written in project annual reports, which make another source of data for this thesis.

III.5. Data Analysis Procedure

During and after data collection, it was a step of data analysis. Different case study methodologists give the meaning of data analysis. Yin on one hand states that data analysis "consists of examining, categorizing, tabulating, testing, or otherwise recombining both quantitative and qualitative evidence to address the initial propositions of a study" (Yazan, p. 144 citing Yin, 2002, p. 109). Merriam (1998, p. 178 in Yazan, p. 145), on the other hand, defines data analysis as "the process of making sense out of the data. And making sense out of the data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read -it is the process of making meaning". She suggests simultaneous data collection and analysis. She argues that data collection and analysis are recursive and dynamic and that it "is not to say that the analysis is finished when all the data have been collected. Quite the opposite. Analysis becomes more intensive as the study progresses, and once all the data are in" (Merriam, 1998, p. 155 in Yazan, p. 145). The analysis is only qualitative. It is used to obtain answers to research questions; it is also based on research questions.

At the step of analyzing the collected data, I followed the thematic analysis of the data. It is a commonly advised method for the exploratory qualitative project (MSF, p.23). It is also affirmed by Neuman (2014, p.480) as he says that concept formation is an integral part of data analysis, and it begins during data collection. Therefore, conceptualization is a way of organizing and making sense of data. To Neuman (2014, p.480), a qualitative study researcher analyzes by organizing data into categories based on themes, concepts, or similar features. By following these ideas, I went through the transcripts, and I identified themes. This allowed me to make a summary of what was said by informants. I developed categories (or grouping) and I attached them to chunks of data. Categories derived from terms actually used in the field of CBHIs as they are described in literature and by international organizations such as ILO and WHO in their aforesaid studies.

The other technique was summarizing data of meaning or condensing. After I had written up the notes of the interviews, I made up a summary of key points. I kept the notes of the interviews for further reference. As it is said earlier, I used organizational documentation mainly internal LC reports to complement data for my research including qualitative ones. Such data were referred to and they were used as a means of triangulation about other collected data.

Finally, there was the technique of structuring data or ordering using narrative. During semi-structured interviews, participants told stories of their experience and feelings about the CBHIs' leadership ability. Such stories were recorded in Mwumba and Kirundo. Participants were encouraged to express themselves on the quality of their leaders in such schemes. It was an opportunity to show involvement of insured members in the management of pooled funds used for their health care expenses. Such narratives were also analyzed. Narrative analysis of such stories allowed to notice the participant's engagement, the undertaken action and its consequences including the final outcome in a specific CBHI.

III.6. Difficulties Encountered

Among limitations during the study, I did not separate women from men during focus group discussions. The main reason is that both men and women are considered as equal partners in CBHIs; it could also take more time. As a matter of fact, there are CBHIs whose presidents or deputy presidents are women. Besides, there were 50% men and 50% women in the focus group interview. Therefore, if a participant had something not to be said in that session, he or she was given a chance to talk to me in private at any time. Some respondents in interviews had much to talk about their experiences, CBHIs and their leaders and this could lengthen the interview. In Busoni particularly, there was a man who wanted to speak alone in the focus group interview. I noticed that some participants were not happy with what the majority confirmed as the truth and they were angry with the interviewer particularly in Gahombo. I then told them to cool down and collect other information to meet their wish.

CHAPTER IV: DATA PRESENTATION, ANALYSIS AND FINDINGS

IV.0. Introduction

This chapter is about addressing the four challenges which are: (1) lack of community-owned health insurance, (2) shortcomings in governance and management of such schemes, (3) little financial support from the government and donors to such organizations, and (4) insufficient technical support from the government and donors to community-owned health insurances. The first two challenges refer to the first and the second research questions respectively while challenges three and four refer to the third research question. I recall that the research questions are: (1) How can unorganized workers of the informal sector in the rural area manage to start a community-owned mechanism of access to health care? ; (2) What do the rural community members of the informal sector need to do to ensure good governance and sound management of their mechanism of access to health care? ; and (3) Which kind of support the external stakeholders - mainly the government and donors – could bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization to ensure its performance?

Chapter IV comprises two parts: (1) the data presentation and analysis, and (2) the findings. The first part is made of two sections: data presentation and data analysis. In the section of data presentation, data are presented according to each challenge of access to health care with reference to the specific instrument used to collect them. Then, there is a presentation of actions the community members undertook to address the challenge. In the section of data analysis, themes dealt with are presented per challenge with reference to the specific research question. In the second part related to findings, the researcher presents his findings in accordance with each challenge of access to health care. There are identified challenges and solutions adopted by the community members to address them. In addition, the researcher gives solutions that can be applied in the future in order to address the above-mentioned challenges.

IV.1. Data Presentation and Analysis

IV.1.1. Challenge N0.1: Lack of Health Insurance

a. Interview

Context: As it is said in chapter 2, LC and its partner organization UCODE implemented the LPPN project from 2004 to 2008 to alleviate poverty in the rural area of northern provinces of Burundi in the field of food security. During that period and before 2012, the population of the informal sector living in the rural area faced challenges of access to health care. This is reflected in the information provided during the interview. Indeed, they said that some people were forced to sell their livelihood assets to pay for consumed health care as sick people paid out-of-pocket at the spot of health care delivery. Some sick people were even unable to visit a health service facility for treatment because of the financial barrier. There was not a health insurance able to alleviate the burden of illness risk of the rural population by risk pooling and solidarity. At the same time, there was a long distance to walk before reaching the nearest health care center. Besides, the quality of treatment was not good as there was shortage of medicine and providers of health care. When asked what they knew about the existing mechanism "Carte d'Assurance Maladie (CAM)" in the years 2009 to 2012, respondents said that such a mechanism was not widely used by community members in the rural area. They added that some people in communes heard of it on radio without using it because it was not advertised by public authorities. On the other hand, community members had confidence and trust in the staff and community leaders working with LC and UCODE in the development projects because they had witnessed positive changes especially about the increase of food production and commercialization.

In 2017, access to healthcare for the rural population of the informal sector remains a predicament. There is still the burden of illness risk for the rural population who witness a lack of risk pooling and solidarity. They have to pay out-of-pocket on the spot of delivery of health care. Some renounce attending health care facilities though they are sick because they cannot afford cash money to pay on the spot of delivery of health care i.e user fees during the period of sickness. Others choose not to consult health care facilities and go to traditional healers while others resort to auto-medication buying cheap drugs anywhere or sharing doses with the sick people who have got medicines with medical prescription. Moreover, although CAM

is a transitional mechanism before CBHIs extend nationwide, it is widely advertised by politicians. Free cards are even distributed especially in the period of elections. This situation hinders CBHIs to expand and even to exist (MSPLS, 2014, p.30). Nevertheless, the government states CBHIs are meant to guarantee access to health care for the rural population of the informal sector nationwide (MSPLS, 2014, p. 115). At the same time, it recognizes that the creation of a CBHI is very demanding because it presents a high financial risk (MSPLS, 2014, p.29). The situation is still the same in 2017.

Addressing the Challenge of Lack of Health Care Insurance

As the ILO (2001, p.vi) put it, a community-based health insurance (CBHI) is "the product of local initiatives". Its setting up follows different steps (ILO, 2001, pp. 43 – 44) and the main ones are:

1. Recognition by potential members of the need to address the problem of access to health care including raising awareness and motivation, verification of preconditions, and formation of a working group;
2. The carrying out of a background study in order to determine the characteristics of the future CBHI;
3. Definition of the most appropriate formula about services provided, organization and operation of the scheme;
4. Creation of the scheme (organization of the constituent general assembly) and start-up of activities.

To address the challenge N0.1, the community members followed different steps with a goal of setting up a scheme allowing them to access health care. Their experience is worth being noted.

Toward the creation of a community-owned mechanism of access to health care: Interviewees said they needed a community-based health insurance (CBHI) as a new development component to start in community within the LIAM project. They found it difficult to understand such a concept and translate it into a working mechanism although it was very interesting. Community members were comparing themselves as civil servants who had the mechanism of access to health care known as MFP. It was noted that such a new concept

could not be introduced in isolation. Therefore, they laid foundation on what already existed in their community namely the associations of farmers whose main goal was to increase production of four selected crops (beans, banana, rice and onion) in LIAM project from the year 2009 up to 2013. This step required resources from community members. Whenever field staff of the LIAM project held meetings, there was staff from LC and UCODE to speak about the health insurance.

Indeed, for the sake of raising awareness and motivation, community leaders held meetings with community members involved in farmers' associations producing selected crops promoted by the LIAM project. In addition, they targeted members of savings and credit associations scattered in different hills of the target geographic area. Public authorities at local level including hill, zone and commune attended the meetings. It was a way of having community members to reflect on their health needs and bring them to make an association whose aim was to access health care at low cost. Raising awareness and motivation have become permanent activities as they are needed to determine the necessary health services and the related contributions. This started in 2010 and continued in 2011 onward. Other meetings were organized by field staff from PRODEMA and CATALIST projects. Staff from LC and UCODE seized such opportunities to introduce the concept of CBHIs. Other opportunities were public meetings convened and held by public authorities like heads of hills or zones and communes. These were meetings gathering community members in general. The aim was to reach community members who were not involved in the promotion of LIAM selected crops.

Informants said LIAM managed to link food production to improve nutrition and the economic situation of households and the need to address the challenge of access to health care. This increased the awareness in project beneficiaries about the need of the CBHI. Attendants of such meetings felt that the system of CBHIs was one of the development programs of UCODE allowing them to have quality health care at any time of the year and they started to register. In practice, existing community leaders from the farmers' associations benefiting LIAM project activities made the foundation on which staff from LC and UCODE built the program. In each target commune, LIAM had 4 elected leaders to represent associations involved in the promotion of each of the 4 selected crops. The 4 leaders were to sensitize their peer farmers and give a list of those who accepted to join and start a CBHI. The 4 leaders had to work hand

in hand with the existing acting members of the executive committee of the peasant federation UCODE at the level of a commune. To materialize it, each farmer who accepted to join had to give 1 000 BIF as membership fee and the annual contribution. This was possible thanks to the trust community members had in UCODE and LC as they had implemented development projects since 2004.

Each year and even in 2017, it is a big challenge to ensure the existence of a CBHI owing to difficulties described above. Since there is no food security project in the target geographic area for the target population as in the period of its creation up to 2013, new techniques are to be identified and implemented. The reason is that if there are no members in a CBHI, it is compelled to disappear. Leaders in CBHIs must make a lot of efforts to remain faithful to the scheme and ensure the enrolment of new ones and the renewal of actual members each year. Therefore, collaboration with government authorities is a prerequisite condition to reach the community members. Enrolment of community members as a group is encouraged since 2017. Moreover, managers have been given the responsibility to sensitize community members, to enroll them and collect their contribution. In order to reach them easily, they were given a motorcycle to use. Moreover, they are advised to seek synergy with other stakeholders including members of community-based organizations and international NGOs to increase membership.

Training of selected community leaders: Informants said that there were two workshops in 2010 which took place at Ngozi and Kirundo. According to them, participants were mainly heads of farmers' associations benefiting LIAM project activities since 2009 and members of the executive committee of UCODE communes. Other participants were beneficiaries of LC and UCODE's development interventions with LPPN project from 2004 to 2008. Public authorities mainly heads of communes took part in the workshops. Each target commune had at least five attendants in the workshop. They learned the concept of CBHI and they noticed the good of it in that period. After the workshop, they were assigned the task of sensitizing other community members and set up a CBHI in each target commune. From 2010 up to 2017, the training of community leaders remains a concern of stakeholders bringing assistance to the target population. It allows them to update their knowledge of the concept of health care social protection and how to improve their scheme's performance.

Selection of community animators: When attendants of the 2010 Ngozi and Kirundo workshops started to sensitize community members on the need of creating a CBHI in each commune, attendants of meetings asked them whom they would give their membership fees and annual contributions. Community leaders felt the need of having community animators (CA) who stayed with the target population in community. Therefore, they asked attendants of meetings to elect a credible person who could collect fees and contributions at each hill. Each hill got a CA; thus, each commune could have at least twenty CAs making a basis to reach community members. Community members were summoned to attend meetings; they were informed in churches about the schedule of weekly meetings. During the meetings, participants had a full presentation of what a CBHI is and the way it works. They were given criteria to take into account when electing a CA in order to choose a person of integrity for each hill as CAs have to manage funds among their activities. In 2017, it was necessary to select new community animators and encourage the most motivated ones to continue playing their role. Their intervention in community allows the schemes to have membership and the community members can have information from them about the role of such schemes regarding access to health care.

Campaign of sensitization for membership: Informants affirm that community leaders from farmers' associations were the most involved to take the lead in the process of setting up a CBHI in the target commune. In all communes, heads of the movement of sensitization were farmers involved in growing one of the selected crops promoted by LC and UCODE in LIAM project. They were backed by members of the UCODE commune. In 2017, there is no food security project. Therefore, such community organizations count on the managers and leaders in schemes to sensitize community members and have membership. In the following paragraphs, I describe what prominent leaders in communes contributed to have membership. Community leaders took advantage of different factors giving them social consideration and power in target community (see below and Appendix 2 for details) to achieve sensitization and have membership to the CBHI to be created.

Political position: In Busoni, the former head of the commune Léonidas Rugengamanzi took the lead. Even if he was no more in that position, he was still recognized by the population as a former head of the commune and community members owed him respect. When he heard of a CBHI to be started in Busoni, he felt commitment to work for its real existence by being number one to sensitize other people to join. He was popular, and people could follow him as he was head of the commune until 2010. Even though he was a civil servant earning a regular income, he was also involved in the promotion of the selected crop of banana. Therefore, he volunteered to be the leader and he registered as a member in 2011 even if he was insured in the scheme of the civil servants known as MFP.

In Gashikanwa, the head of the zone named Didace Manirambona was an outspoken animator. He could speak about the coming CBHI to different people already in 2010 and 2011. He was the man who could tell the head of the commune about a CBHI when government authorities were promoting CAM. His colleagues could listen to him during meetings held by his supervisor who was the head of the commune. He could do that when he was not expected to show the good of a CBHI to others instead of CAM. He could even take local animators on his bicycle from one place to another for more sessions of sensitization to be held in different areas of the commune while he was head of the zone Gashikanwa only. Fortunately, he did not lose his position until his death even though there was permanent threat. In public meetings he held, he always invited members of the group of work and he urged them to take the floor and address participants. Thus, many LIAM project beneficiaries joined the scheme including administration agents like heads of hills.

In 2017, there is conviction that political leaders' involvement in community development is of paramount importance. Their influence is important, and they can influence more people. However, many political leaders are still committed to the promotion of CAM. That is why leaders of the scheme meet political leaders based in community in order to bring them accept to join the organization. Then, such political leaders may influence more community members. Still, it requires much time to fulfill this goal.

Social position: In commune Busiga, one of the most prominent figures who fought for the existence of a CBHI in Busiga is the current head of it named Emery Ntirenganya, a position he has occupied since 2011. He started sensitization in community early in 2010 as a CA and head of an association of banana producers. He bought a motorcycle and he used it to visit his fellow countrymen everywhere in his commune. He said that he could forget his work of running a shop in order to reach community members far away from his house without any form of compensation. In the period of intensive sensitization in July 2011, he wore a T-shirt with a poster in front or at the back having writings "TUGARUKIRE AMAGARA Y'IMIRYANGO » which is the name of the CBHI. He kept it during meetings. He said, "At a certain time, people said that I had gone mad, but I remained active". He managed to enroll heads of nine hills and a zone.

In commune Gahombo, Louis Nkurunziza was a civil servant employed in the field of agriculture and a trustworthy person working with international organizations i.e the Catholic Relief Services (CRS) and International Fund for Agricultural Development (IFAD) and he was a community facilitator for the two international organizations in his commune because he was very honest. Therefore, he was covered by the government insurance MFP as he paid premiums on payroll. This means that there was no need to join a CBHI. He attended the 2010 workshop held at Ngozi for heads of farmers' associations. Since that period, he was eager to speak about the good of having a CBHI to community members. He even convinced civil servants covered by the government insurance MFP to join. He encouraged other community members to speak about the scheme whenever there was a public meeting convened by local government authorities or at different occasions. He was determined to have the CBHI and it eventually started late 2012. He became the first head of it until today. He also convinced eight heads of hills even though they generally promote CAM. He moved from one place to another during the campaign of sensitization without claiming for any form of compensation. He convinced many community members to join the CBHI. He brought community members involved in manual work he supervised in his commune Gahombo and the neighboring communes Gatara and Busiga. He also initiated Savings and Internal Lending Community (acronym SILC) in his commune in collaboration with the Catholic Diocese of Ngozi with its branch dealing with community relief and development known as the "Bureau d'Appui au

Développement et à l'Entraide Communautaires" (acronym BADEC). Such organizations gathered many people especially women and they provide a savings and credit service among community members involved in SILCs. Louis Nkurunziza also targeted his colleagues who were community facilitators working for another organization which is the provincial office of agriculture and livestock known as the "Direction Provinciale de l'Agriculture et de l'Elevage" (DPAE).

In 2017, schemes have the challenge of having committed members to enhance their action in community. That is why their leaders make a lot of efforts not only to motivate and keep committed members but also to select and encourage new ones. Although some may have possibilities of influencing their peers in community, they do not feel motivated enough to dedicate themselves to the increase of membership in schemes. Therefore, leaders encourage volunteering of community members thanks to their social influence.

Leading the ruling party at the grassroots level: A leader of the ruling party in commune Ruhororo, a neighboring commune to Gashikanwa, helped animators Pélagie Nizigiyimana and Fabien Simbandumwe from Gashikanwa access to community members from that area. He welcomed them in his hill, and he took advantage of being head of the ruling party in his locality to sensitize community members to join that CBHI. As a head of the ruling party, he was obliged to sensitize people to buy CAM instead of joining a CBHI, but he did the opposite. This situation occurred also in Busiga where leaders of the ruling party in hills managed to help CAs during the campaign of sensitization in community to promote the CBHI instead of CAM, which was the opposite of what other party members did.

In 2017, informants say leaders of the ruling party seem committed to the promotion of CAM as so many government authorities are. However, leaders of schemes are aware of their influence in community. They make efforts to train them in an informal way so that they can join the scheme, but many of them are scared. Nevertheless, leaders of schemes must have good relations with them and try to ask them not to counter their action seeking the promotion of CBHIs.

b. Administrative Records and Reports

Context: The introduction of a CBHI in a community requires a context analysis. In the LIAM project document, LC described the context in the year 2009 and before in the northern provinces of Burundi regarding access to health care. According to a survey conducted in 2009 in northern provinces (LC, 2009, pp.44-45), 83% of non-vulnerable households could pay for medical treatment. In vulnerable households, 20% could afford medical treatment, 70% could seldom afford it and 4% could never visit a health center. At that time, there were few health centers in different target communes of the LIAM project because of destruction of infrastructures during the period of war. Therefore, distance was a factor hindering sick people access health care for treatment. For example, a patient spent 50 minutes of walk before reaching the nearest health center in the province of Kayanza while it took 2 hours of walk in Kirundo (LC, 2009, pp.44-45). Besides, there was poor quality health services provided because of shortage of human resources, unavailability of drugs and equipment, lack of water and electricity, poor hygiene and management of health facilities. The most severe disease was malaria; most cases occurred during months coinciding with the shortage of food in households i.e March, April, October and November. From October 2009 to May 2010, there was famine in communes of Busoni and Bugabira in the province of Kirundo causing deaths and exile of population to neighboring countries (LC, 2010 LIAM report, p.5).

The context described above indicated that there was a real need of a community-owned mechanism to access health care for the population of the target geographic area. Community members witnessed financial difficulties in accessing to health care. Beneficiaries of the development projects implemented by LC and UCODE since 2004 had trust in those organizations, their staff and the local community leaders involved in those projects. They were eager to listen and follow them even if they introduced a new component of development. Public and religious authorities were aware of the need to have a mechanism to access health care even though they had no solution. The availability of quality health services in target communes was to be questioned and perhaps worked upon. There was a dynamic socio-economic situation in general especially in provinces of Kayanza and Ngozi. Health services could be obtained in health centers (public and/or private especially in those belonging and run by churches) and hospitals which were not too distant from community

members' homes or places of work provided that a patient had the capacity to pay for consumed health care. Community members could not appreciate health care services because of repeated shortages of medicines, bad client reception, or poor hygiene.

In 2017, CBHIs are needed mechanisms of access to health care in the target area. Community members need such schemes to access health care at low cost. They also allow them to enhance the quality of health care services in health facilities as far as they gather in such schemes. In case they are not happy with health services from health service providers, they have a chance to complain and have solutions to the expressed grievances. They also have a chance to visit contracted public and private health facilities. This is possible only for community members belonging to CBHIs. Therefore, there is a need to have such schemes in communities.

Results of the campaign of sensitization in 2011, 2012 and 2013 and the starting-up of CBHIs: Membership and contracted health facilities: From 2010 to 2012, there was intense campaign of sensitization. Leaders of UCODE communes felt the need to start CBHIs in their respective communes as another development program as the program aiming at the increase of food production of four selected crops that LIAM project promoted was being implemented. The CBHI was another component of the LIAM project to promote with tangible results. At the end of 2011, the reached number of insured households in the 4 (Busiga, Busoni, Gashikanwa, and Kirundo) of the 6 target communes was 1 255 (LC, 2011 LIAM project annual report, p.43). The insured beneficiaries of Busiga and Kirundo received health care since August 2011 and Busoni and Gashikanwa since October 2011. At the end of 2012, all the 6 CBHIs were operational. They gathered 2 501 insured households with 13 686 beneficiaries (LC, 2012 LIAM project annual report, p.42). In 2013, they were 2 946 households with 15 815 beneficiaries (LC, 2013 LIAM project final report, p.56). In 2011 (LC, 2011 LIAM project annual report, p.12), there were contracts with 40 health care facilities (36 health centers and 4 hospitals) providing health care to members of newly-created CBHIs. In 2012 (LC, 2012 LIAM project annual report, p.12), 49 health care facilities (44 health centers and 5 hospitals) while in 2013 (LC, 2013 LIAM project final report, p.30) 65 health care facilities (59 health centers and 6 hospitals) had contracts with CBHIs. This was a great achievement in the LIAM project geographic area being actually the northern provinces of Burundi. From 2014 to 2016 after the LIAM project, the

membership decreased. In 2014, CBHIs gathered 1 155 insured households with 5 313 beneficiaries (LC, 2014 PPASS project annual report, p.9). In 2015, there were 1 729 insured households with 8 528 beneficiaries (LC, 2015 PPASS project annual report, p.8). In 2016, there were 1 223 insured households with 6 212 beneficiaries (LC, 2016 PPASS project final report, p.9). In 2017, the 6 CBHIs are operational though the membership is modest: 1 400 insured households with 7 037 beneficiaries (LC, 2017 AMAGARA ARUTA AMAJANA project annual report, p.4).

Recognition by the government: Recognition of the community-owned health insurance was a long process which started in 2012 up to 2013 (LC, 2013 LIAM project final report, p.14). Staff from LC and UCODE deposited the demand for recognition in the Ministry of the Civil Service, Labor and Social Security on May 9, 2012. They found that there were documents to be produced mainly the study of feasibility and the business plan. It took time to gather them as the organizations had to hire a consultant whose task was to design them after a survey in target community members. The recognition was eventually issued on July 10, 2013 with a decision materialized by the ministerial ordinance N0. 570/85. This was another great achievement for CBHIs acting in the northern provinces of Burundi. In 2017, the recognition by the government is valid. However, the governing body SEP/CNPS requires each CBHI to have its own recognition. This is a concern that each CBHI leaders will have to deal with.

c. Field Visits

Communication to the general public: During the campaign of sensitization, there was mass communication using sound instruments in order to spread information and have people who could register to start a CBHI or renew membership in the target communes. Staff from LC and UCODE and even community leaders used various means to spread information about the scheme to the public. They had meetings with the public authorities and religious ones to ensure that they had a positive attitude about the program. It was also an opportunity to plan meetings for mass communication to inform the general public. Before meetings, messages about the scheme and the schedule of meetings of a week were brought to the public in churches. Because Burundians communicate mainly orally, LC and UCODE passed messages

and programs on Radio Publique Africaine[1] (RPA) or African Public Radio, which was followed by the general public. Spread information included the good of joining a CBHI, required conditions to meet for membership, period of enjoying insurance, period to renew membership, and other related information. In meetings or after meetings, there was distribution of leaflets describing the CBHI. They were to be used in public sessions of sensitization or in private when a CA could visit a household for door-to-door collection of the annual contribution. In this country, there are community development works which take place everywhere on a precise day of the week. As they gather community members, it was an opportunity to communicate about the CBHI to the masses. All it required was to have a community leader to give the message if there was permission from the public authority who had convened them. Then there was a Kirundi song called “Ufise Mitiweli” meaning “Being a member of a CBHI” designed to convey messages about the scheme by listening when it was played on the way to and from the area of meetings and even at the spot of the meeting. Its content was about the benefit of a CBHI like how to stay in good health, social health protection, prevention of catastrophic expenditure in case of disease and solidarity among members of a CBHI. The composer of the song was also a member of a music band which was hired by LC and UCODE to play music for the entertainment of the public attending meetings and special events. The latter were opportunities to check community members’ level of understanding what a CBHI is. At this occasion, there was distribution of prizes to participants who gave the right answers to questions.

[1] RPA was a private radio station followed by the general public. It was shut down in 2015.

Analysis

Challenge N0.1 “Lack of health insurance” refers to the research question number one “How can unorganized workers of the informal sector in the rural area manage to start a community -owned mechanism of access to health care?”. The researcher asked community members what the situation looked like in the years 2009 and 2010 regarding access to health care in their area. The answers informants gave reflected the difficulties the population of the informal sector in the rural area witnessed about access to health care. The whole situation has been referred to as context, an overarching theme encompassing the whole picture of the reality for the specific population of study in their own geographic area. The same situation is presented by the staff of the supporting organization of the current scheme of access to health care. Besides, it is described in the LIAM project document. The three sources of information allow triangulation of the data. The description of the context indicates why the population under study was motivated to start a community-owned mechanism to access health care at low cost. It is clear that the population under study could bring assistance to sick community members according to their customs and the cited example from the Bible, but the biggest challenge was payment of consumed health care. Although community members had the right to health care (see the 1944 ILO Declaration of Philadelphia, the 1948 Universal Declaration of Human Rights and the 2005 Burundian Constitution in Chapter II) and felt the need to get involved in health matters according to different declarations (the 1978 Declaration of Alma Ata, the 1986 Ottawa Charter, the 1987 Bamako Initiative, the 2005 WHO Declaration), they were not aware of that. Access to health care for all had to be achieved by the Burundian government by the year 2000 according to the 1978 Declaration of Alma Ata. In 2017, the government has the same attitude: it does not organize unorganized workers from the rural area belonging to the informal sector and facing the problem of access to health care at low cost.

At the step of showing how the target population coped with the situation of lack of health insurance, there are themes of raising awareness, motivation, meetings and selection of leaders reflecting the kind of leadership needed to introduce a new component in the development of a particular population in a specific area and what actions to undertake.

Indeed, community members needed leaders (as it is in 2017) to show them how to come up with a solution to their plight of access to health care, for the government was not helping them in the way of collecting community members' contribution and pooling. After the theme of selection of leaders at the level of the commune and hills, the theme of training and mission assigned to each leader are developed. This is a way of indicating the chronology of events before the starting up of the scheme. The other theme is sensitization as a big one regarding the involvement of many people in the community working together in order to achieve the same goal of affiliating community members in one scheme of access to health care in each target commune. Here, there is reference to people who took the lead in each commune, zone or hills to bring other community members come together and build one organization. The theme of communication is also about how information reached the general public including the means they used. The theme of position (be it political or social) encompasses factors allowing people to have power to influence other community members. The theme comprises the fact of being a political leader (case of head of a hill, a zone or a commune and also being the leader of the ruling party at any level) or being a leader of an association or associations of producers of one of the selected crops in the LIAM project or the head of the peasant federation UCODE at the commune or national level. All of those people occupying such positions have much influence in the community and they have followers. They are also the internal change agents to rely on in case external change agents (such as staff belonging to the external development agencies like LC and UCODE) want to introduce the health care component in the target communities. As a matter of fact, UCODE employed a development agent based in targeted communes. That agent selected other community agents mainly those who belonged to the associations of small farmers to mobilize community members dwelling in each hill. One notices then the theme about achievements of outstanding community leaders that led to the starting up of a community-owned mechanism of access to health care in the target communes and who ruled them or those who became members of decision-making bodies.

At the end of the process, the theme is results indicating the achievements fulfilled in target communes by the year 2012 onward up to 2017. They indicate that the challenge of lack of health insurance was overcome in the northern provinces of Burundi thanks to the action of

community members and their supporters. This theme is an overarching one comprising membership and recognition of the scheme.

The setting up of the CBHI by 2012 was not enough because it had to be alive by ensuring its existence and growth up to the year 2017 and beyond. Community members devoted themselves to keep their CBHIs operational. To maintain their commitment to the CBHI remains a big challenge in 2017 and after as their level of volunteering may decrease. Besides, it is commonly known that a CBHI lives on thanks to membership and its members' annual contribution; otherwise, it collapses. Therefore, in 2017, leaders from the CBHI are advised to ensure there are active volunteers and committed members who can sensitize community members to join the CBHI or renew their membership before the end of the year of insurance. There must be incentives to motivate such volunteers. During the campaign of sensitization, it is advised to target groups of community members belonging to development organizations such as associations of growers of specific crops and self-help groups. The reason is that not only they are accustomed to associating in groups but also they have money to pay their annual contribution. They may also have incentives bringing them to join CBHIs as a group instead of joining as an individual household. However, they should not forget to sensitize the general public especially. To achieve this, they should involve government authorities, ask them to convene public meetings and even seek their own enrolment.

IV.1.2. Challenge N0.2: Shortcomings in Governance and Management

a. Interview

In governance, informants identified these: corruption of leaders, discharging functions without means, and decision making for a particular situation. In management, identified challenges were: corruption of managers, cases of fraud and abuses, miscalculation of co-payment, collection of invoices, need of forms in health facilities, absence of managers and need of plots of land for the construction of headquarters. Explanation about each challenge is given below and the way community members addressed them.

Addressing the Challenges in Governance

Informants assert that CBHI members undertook a lot of actions so as to maintain good governance in their schemes.

Giving time and resources: Members of decision-making bodies in CBHIs especially members of the Executive Committee were mostly concerned with discharging their functions when their schemes were short of financial means. Therefore, they used their own money and time to fulfil their duties and report to the other members and organs. In Busoni, Espérance Uwitonze was the treasurer from 2012 to 2015. She had to move from her home to the bank where money was kept and withdrawn. The CBHI had a current account in the microfinance institution of UCODE at Kabanga, about five kilometers away from home. The problem was that she had to visit that bank using her own means, yet she has never complained. On the contrary, she was eager to bring contribution to her scheme. She also strived for the good management of the resources of their scheme. She showed integrity in the management of the resources. The late head of the CBHI Léonidas Rugengamanzi is remembered for the use of his car for the good of the CBHI without any form of compensation. The new head of the CBHI of Busoni Laurence Mukabigoro went to CBHI members' homes to meet them using her own means. She could then notice those who had contributed but whose money had not been deposited in the scheme's account. Déo Jafari Nasagarare, the deputy head of the CBHI in Busoni, identified CAs who had collected money of annual contribution but who did not deposit it. He also denounced cases of CAs who received money from CBHI members for reimbursement of a loan but who kept it. Didace Baranderetse, a member of the Oversight Committee, used his own money for transportation when he had to attend meetings as he spent much time in the neighboring commune for his daily job. He was forced to leave his position because he fled to the neighboring country in 2015. Léonard Muvuzankima, the clerk of the CBHI since 2011, showed responsibility, integrity and altruism. He discharged two functions (treasurer and clerk) when the incumbent trustees went to seek refuge in the neighboring country in 2015. All the money he collects is well kept in the bank account. He is eager to supply information about the CBHI history in general and the management of funds in particular.

In Busiga, Emery Ntirenganya leaves his area and goes as far as ten kilometers away from his home using his own motorcycle without expecting any compensation. In addition, insured members call upon him to settle conflicts which arise between them and staff from health facilities. Moreover, the CBHI could start some months before the end of the year 2011 being the first year of sensitization.

From what is described above, one notices that the incumbent leaders discharged their functions without having any fund from the CBHI to cover their transportation from 2011 until 2017. The scheme took for granted that some people among community members are willing to serve freely by providing assistance to the community organization in different kinds (time and resources both in kind and monetary). That is due to the principles that volunteering is normally unpaid, and it is based on motivation and devotion to the causes of the organization (Anheier, 2005, p.215). The main problem is that the CBHI has no funds to use for that as most of its income is made of the members' annual contribution. This is meant to be used to pay the members' consumed health care during a year. From the beginning up to 2017, leaders have been discharging their functions using a car, a motorcycle or a bicycle of their own as another way of contributing to the CBHI's survival and growth. In addition, they could spend their own money. In 2017, some leaders do complain about this situation, and it is understandable. However, they are told that it is a way of showing both volunteering and ownership, two shared values in any nonprofit organization like a CBHI. To alleviate the burden, they have been allowed to take advantage of the existing motorcycle used by the CBHI's manager for transportation when possible. Yet, this is not a sustainable solution for the problem. The best solution is to raise funds locally which requires a broad membership, and this is still the biggest challenge in 2017.

Payment of embezzled money and replacement of leaders: In Mwumba, the president of the first CBHI Executive Committee misbehaved, and it was found that money was mismanaged. He was jailed twice for different cases of unpaid money, and this made him lose credibility. As a result, community members lost trust in the CBHI and some of them renounced joining. A CBHI member known as Manassé Ngendabanka was outspoken, and he was the first to denounce cases of mismanagement. He sensitized the insured members and members of different committees about the way to save the scheme from insolvency, and he succeeded.

He also got support from other CBHI members who did not stay silent. As a result, insured members replaced the then president in 2015. Thus, trust to the current committees was restored.

In Kirundo, the head of the Executive Committee embezzled funds belonging to the CBHI. The scheme's treasurer Maurice Koyankunze and the deputy president Virginie Musaninyana stood up and acted to save the scheme. They played an important role in the process of urging the head of the scheme to pay back embezzled money. They suggested to take him to the police station in order to force him to pay, and this measure worked. The head of the Oversight Committee also embezzled collected contribution. He fled away without paying back. Both the head of the Executive Committee and the head of the Oversight Committee were replaced in the 2015 elections.

Taking serious measures to pay consumed health care: In Kirundo, the scheme was not able to pay for the consumed health care in 2016. A CA named Damien Ndayisenga is the very person who suggested the increase of percentage co-payment. The General Assembly approved the measure and his suggestion saved the CBHI. From 2012 to 2015, Kirundo was unable to pay for the annual consumed health care because there were many cases of malaria and the cost of drugs increased. CBHI members took the measure of paying extra contribution per household in 2012 and 2013 and get a loan from the umbrella organization in 2014 to 2015. In 2016, Kirundo increased the percentage co-payment. In Gahombo, CBHI members paid extra money in 2013 to complement the contribution and the scheme took a loan from the umbrella organization in 2014 and 2015.

In 2017, CBHI leaders notice that cases of embezzlement and mismanagement in general have decreased thanks to the measure of replacing the corrupt leaders. Nevertheless, the risk still exists. That is why there is a habit of financial control on a regular basis especially during the period of collecting annual contribution. In addition, the new managers have training on techniques of managing a CBHI's funds as they are leaders' advisers. Such measures are to be applied in 2017 and after. Moreover, the Oversight Committee must remain vigilant and take any measure to combat corruption whenever there is a need to.

Addressing the Challenges in Management

Dismissal of corrupt managers: Trustees dismissed managers of Gahombo, Busoni, Busiga, and Mwumba for wrongdoings. In Gahombo, the manager did not use funds to pay health service providers in 2013. There were unpaid invoices even though necessary funds had been given to him for that purpose. In Mwumba in 2016, the manager was fired, and he gave a plot of land to sell in case he does not pay. Trustees were about to sell the land, but the former manager paid half of the whole amount. They waited for another period before reimbursement of the remaining sum. In Busiga, the first manager was fired in 2014; he paid embezzled money in 2015. The second manager was dismissed in 2016, and he gave a coffee plantation to the CBHI in compensation of the embezzled money. In Busoni, community members complained that they paid contributions, but they did not get membership cards. Then, community leaders undertook investigations and they discovered many irregularities. They took the case to the police and the head of the commune. He gave a plot of land to sell in case he did not manage to pay. It took community leaders much time to gather evidences of the manager's embezzlement and to convince him. The former manager eventually paid the whole amount of money he owed to the CBHI. That allowed the CBHI of Busoni to secure more fund in reserve. In 2017, cases of corruption exist though they have diminished thanks to the measure of dismissing corrupt managers and the recruitment of women for the position. It takes time to discover cases of corruption. That is why there is financial control in CBHIs on a regular basis and managers receive training sessions allowing them to improve their management skills.

Denunciation of cases of fraud and abuse: In Gahombo, Balthazar Niyonkuru is a CA who identified a person who used fraud to access health care using a card of an insured member. The invoice was of 20,000 BIF; it was issued in 2016 at the health center W. It was not paid; thus, the CBHI got some money back. CBHI members denounced cases of abuse in health facilities which charged much fund to CBHIs. Therefore, CBHIs took a measure to suspend the contracts. This occurred in Gashikanwa in 2014 for the health center X, in Gahombo in 2014 for the health center Y, and in Busiga in 2017 for the health center Z. In Busiga, the head of the health center of U who used to administer a dose of one medicine for a 1,000 BIF was denounced by community members. The case was taken to the head of the health district and

the nurse stopped this practice. In Kirundo, a nurse at the health center of V administered 11 tablets of quinine instead of 21 when the beneficiary paid for 21 tablets. This case was also denounced along with a case of over-prescription in Gahombo.

Help beneficiaries for calculation of co-payment: In Mwumba, Janvière Nahimana stays near the hospital of B. An insured member asked Janvière to help him because the manager of the hospital had miscalculated the amount of money he had to pay as percentage co-payment. The problem was solved immediately, and there was reduction of paid fund by the insured member. As a result, insured members have more trust in leaders and their organization, and the staff of health facilities notice that CBHIs and their members are monitored by many leaders. Thus, they improve quality of delivered health services.

Collection of invoices from health service providers: The collection of invoices is a task of the CBHI's manager. However, because of distance between health facilities and the manager's office, the manager needs help from anyone so as to reduce time and energy. Therefore, in Mwumba, Jésus Marie Nsekambabaye collects invoices at the health center of Mwumba and the hospital of Buye. In Gashikanwa, Sébastien Shengero collects those of Muremera and Nyakabanda while Bernard Mvuyekure picks up those of Mubanga and Taba. They also do all they can to send them to the manager. Therefore, the manager does not use time and energy to do the work of collecting invoices where there are volunteering community members. This is a way of helping CBHIs to save resources. In 2017, it is still a challenge to collect invoices in health care facilities scattered in different communes, for it takes time and resources. Thus, CBHI members are encouraged to give a hand even if few accept to do that.

Provision of forms to health care facilities: Each CBHI provides forms to contracted health care providers. They use them in the treatment of sick beneficiaries. They design invoices in accordance with what is recorded in those forms. At a certain time, forms may be exhausted, and health service providers do not have tools to use; thus, they do not receive sick people from CBHIs. In case of lack of forms used by staff of health facilities, Janvière Nahimana of Mwumba phones the manager. In Busiga, Vincent Singereje takes forms from the CBHI office to the heads of health centers of Gasenyi and Maramvya using his own means. In 2017, it is still a challenge to ensure there are forms to use in each health care facility. Therefore, CBHI

members who stay near the facility are encouraged to inform the manager or even take them to the facility.

Temporary occupation of the position of the manager: There are times when there is no available manager like when the manager is sick or in a period of confinement. Although trustees are not well educated, some are able to replace managers and serve insured community members. For instance, in Gashikanwa the manager got a part-time job and he could not be at the office full time. Pélagie Nizigiyimana discharged such a function for the good of the CBHI. Insured members did not complain at all during that period. In Kirundo, when managers were fired, trustees could open the office and serve CBHI members until a new manager was recruited. In Busiga, Emery Ntirenganya, often spends time at the office to check the way money is collected and used by the manager. He is also the very person who replaces the manager when he is not available. In 2017, it is still a challenge to have someone to replace the unavailable manager in the CBHI's office. This requires integrity, trust, commitment, communication and ownership which are shared values in nonprofit organizations. That is why it is the CBHI president who replaces the manager because he or she is trustworthy.

Looking for plots of land for the construction of headquarters: CBHIs noticed that they needed to build their own headquarters. In order to reduce the whole cost, they decided to ask plots of land to the administration of communes. In Mwumba and Gahombo, heads of the Executive Committee negotiated plots of land where CBHI members would build headquarters of their schemes. Heads of communes granted them such plots of land. In Gashikanwa, the head of commune expressed a wish to give a free plot of land. Still, members of the Executive Committee found that the plots of land were at two remote areas away from the commune headquarters. Pélagie Nizigiyimana, head of the Oversight Committee, was among CBHI members who rejected the idea of taking the free plot of land and use it because she found that it would not be useful to their scheme. In addition, they found that it would be a waste of resources because community members would not visit it. What was said was also that community members visit the CBHI on the occasion they visit the commune office for different matters. Therefore, she convinced other trustees to buy a plot of land from a private land owner, but a plot located at the headquarters of the commune. They used a portion of the

money left since 2012 to 2015 after having paid consumed health care of insured beneficiaries to pay the plot. Pélagie Nizigiyimana was the very person to look for it and negotiate the price. It is worth mentioning that such an occurrence happened in 2016 and the CBHI office is built in 2017. From the experience of the CBHI of Gashikanwa, other CBHI leaders noticed the good of saving money for such an organization. Even if some headquarters are built in 2017, other buildings may be built in the future. In that case, CBHIs are requested to have their own plots of land, and they may need to buy them.

Analysis

Challenge N0.2 “Shortcomings in governance and management” refers to the research question two “What do the rural community members of the informal sector need to do to ensure good governance and sound management of their mechanism of access to health care?”.

Regarding governance, there is the theme of volunteerism comprising the need to give time and resources to an organization without compensation when discharging functions in a decision-making body. Apart from time, members of organs in governance contributed by using their own means of transportation (a bicycle, a motorcycle or a car with oil) or hire it and cash money to attend meetings, to deposit and withdraw money in a bank account, or to meet people at home. Because of money embezzlement, there is a theme of replacement of leaders because of the loss of credibility. Constituents were no more trustful and faithful to the trustees accused of mismanagement. This was possible because there were outspoken people among CBHI members who denounced such cases. They also sensitized their peers in order to bring change because elections had to take place so as to replace untrustworthy leaders. Besides, they had to take action to get back embezzled money. There is a theme on taking measures to curb deficit and be able to pay for consumed health care. Those themes indicate that members of organs of decision-making had connection with their constituents and they were eager to serve in their CBHIs in order to fulfill their mission. They were also committed to the common good, which is one of the values shared by leaders acting in CBHIs and ruling bodies.

Concerning management of the CBHIs, there is a theme of dismissal regarding corrupt managers. Community leaders made efforts to get back the embezzled money and they laid off the managers responsible for such acts. During interviews, two themes occurred: denunciation of cases of fraud/abuse and miscalculation of co-payment. Besides, there is another theme of willingness to serve. This occurs for the collection of invoices from the contracted health care facilities and for providing forms with health care providers. The other theme is serving in case the manager is absent due to different reasons like disease, vacation, confinement or for any other reasons. Members of the Executive Committee notice that there is a need to keep the office open and receive clients especially when it is a period of collecting annual contribution and membership fee. This is one of the prerequisite conditions to meet in order to have membership. It is worth noting that it is thanks to the membership that access to health care is possible and also the viability and the sustainability of the scheme. Finally, there is a theme of plots of land needed for the construction of headquarters of CBHIs. Members of decision-making bodies had to enter negotiation with heads of communes to have plots of land. Those who got well located plots belonged to CBHIs of Gahombo and Mwumba. In Gashikanwa, the CBHI chose to buy its own plot of land using its own money in reserve. This process required special skills, commitment and dedication on the part of those leaders. Yet, it was done for the good of their CBHI members and probably for the sake of visibility.

The different themes dealt with show that CBHI members are eager to serve for the benefit of CBHI beneficiaries so as access to health care remains possible by being able to pay for consumed health care at any time by their CBHIs. Therefore, their contribution is very important in order to ensure good governance and sound management of resources with the aim of having a CBHI capable of guaranteeing quality health care services to its members.

In 2017, CBHI leaders and managers must work hand in hand and ensure that CBHIs have enough cash money to pay for consumed health care. However, the first have to ensure regular financial control and take serious measures to eradicate such a bad practice of corruption. This is a sign of lack of integrity and it compels authors of corrupt acts to lose

credibility within the community and even lose the job. In case of corruption, CBHI members are encouraged to denounce cases and remain vigilant even when there is no such a case.

IV.1.3. Challenge N0.3: Little Financial Support from the Government and Donors

a. Interview

The informants find that CBHIs deserve financial support because they help the population to access health care at a low cost. Besides, they help the health system improve the quality of health services that service providers offer sick people. They also contribute to the community financing of health care protection by collecting contribution from community members as a way of bringing them to be fully involved in health matters. In 2017, informants note that they are short of means to cope with administrative costs of CBHIs. They even need financial means to contribute for the enrolment of the poor in the health insurance schemes and reduce the burden of annual contribution and co-payment on households. That is why CBHIs are perceived as schemes for the better off people while they are open to everyone who meets conditions of membership. This is a situation affecting the performance of CBHIs in general and causing the enrolment to remain low.

Addressing the Challenge of Little Financial Support from the Government and Donors

The staff of UCODE and the Executive Director of UCODE recognize support from the government in the whole process of setting up community health insurance schemes and during their lifespan. The government has been an important partner at all sequences. It recognized the CBHI “TUGARUKIRE AMAGARA Y’IMIRYANGO” in 2013 for the six target communes. Since 2011, the ministry of health has accepted collaboration between CBHIs and health service providers enabling CBHI beneficiaries to enjoy quality health services. Appointed staff at provincial level representing SEP/CNPS have close collaboration with staff from LC and UCODE since 2014. SEP/CNPS granted funds to UCODE to enroll vulnerable population in schemes in 2017 and support the realization of a campaign for sensitization in community in 2016. Since 2010, local public authorities convene meetings and they allow CBHI leaders to address participants on the topic of CBHIs. They also granted free plots of land to CBHIs in 2016 for the construction of their headquarters. These are signs of good relations

between state and CBHIs and supporting organizations. Yet, the government does not supply enough fund (about five million BIF) to support CBHIs; therefore, much needs to be done. For instance, interviewees find that there is a need on the part of the government to subsidize the annual contribution of each household joining the CBHI and pay for the poor and the destitute. For instance, Senegal pays 50% of the annual contribution to each insured household (USAID, 2014, p.24). If the government gives grants to CBHIs, then it could declare mandatory the enrolment to that scheme. Such measures would make CBHIs mechanisms of all the population (instead of better off people as it is today) and thus have broad membership allowing such mechanisms to achieve viability and sustainability. Grants from the government would ensure the reduction of the burden of contribution and even co-payment on households and access to health care would be guaranteed to every people in the country. As a matter of fact, in 2017, SEP/CNPS backed 90 vulnerable households to join CBHIs and access health care. This was perceived by CBHI members as a significant contribution to the increasing of membership in CBHIs and pooled fund. SEP/CNPS contributed funds which other beneficiaries and the CBHI could rely on to pay for consumed health care. It also proved that CBHIs are open to people of all walks including the poor. It is worth remembering that it is an overall responsibility for the government to ensure good health to the nation's population.

Because CBHIs do not receive grants from the government, they rely heavily on the financial support from donors like NGOs LC and UCODE. Indeed, for each CBHI, UCODE pays rent for the office where there is no building run by UCODE commune. It also pays for the manager's salary and fringe benefits, the equipment like a motorcycle including its maintenance and oil. In addition, UCODE provides a CBHI a technical team and money for administrative affairs. It is obvious that if there were no support from LC and UCODE, CBHIs would not cope with the situation of lack of financial means.

Analysis

Challenge N0.3 “Little financial support from the government and donors” and challenge N0.4 “Insufficient technical support from the government and donors” refer to the research question four “Which kind of support the external stakeholders – mainly the government and donors – could bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization to ensure its performance?”.

Regarding the financial support (challenge N0.3) expected by CBHIs from the government, the theme of grant (from the government) is the only theme dealt with. Informants say that it is little until today considering what needs to be done. This is clearly expressed because CBHIs received - via UCODE - funds from SEP/CNPS to enroll ninety vulnerable households into CBHIs and another grant to sensitize leaders at the grassroots level to join health insurance schemes. The two grants make a total amount of about five million BIF. Informants find that more grants are needed to pay for the enrolment of the poor in schemes and reduce the burden of annual contribution and co-payment on households. If there is enough financial support from the government, the enrolment to the community health insurance schemes should be made mandatory. Thus, universal health coverage would be achieved by the government by ensuring 90% of the population who are involved in the informal sector and living mainly in the rural area. In 2017, CBHIs need much financial support from the government. As it is stated by UNICEF (2014, p.60), if there are no state subsidies in Burundi as in other African countries, the CBHI coverage rarely exceeds 1 to 4%. Therefore, in a situation where there is little financial support from the government, CBHIs rely on resources supplied by other donors. Fortunately, CBHIs have a backup from LC and its partner organization UCODE during their lifespan. Otherwise, they could not exist unless they receive that financial support. This means that such support contributes to help CBHIs fulfill their mission of access to health care for the rural population of the informal sector because they do not use collected annual contribution to pay for administrative costs of CBHIs. On the contrary, collected money from CBHI member households is used to pay for consumed health care to contracted health facilities. This complies with the bottom line of CBHIs as nonprofit organizations.

In 2017, it is time to speak out and show that the government should refer to the 1986 Ottawa Charter urging it to enhance health promotion by considering the community as the essential voice in matters of its health. This international instrument calls upon governments to fulfill the empowerment of communities but letting them their freedom to maintain their ownership and control of their own endeavors and destinies. The fact that CBHIs of Burundi are as autonomous entities as those of Western African countries like Senegal and Ivory Coast is a good start. As Senegal is doing in 2017, Burundi can follow that example in order to increase the number of insured households (population) by CBHIs with community health financing. This is the only way leading to the achievement of the UHC in Burundi in general and for the rural population of the informal sector in particular. This is supported by WHO in its 2005 Declaration: it urged member states "to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of result of seeking care." In 2017, only the CBHIs are available for the rural population of the informal sector. Thus, the government can backup what exists and move forward 12 years after the 2005 WHO Declaration.

IV.1.4. Challenge N0.4: Insufficient Technical Support from the Government and Donors

a. Interview

From the interviews, informants from community members and the staff from UCODE stress that the need for administrative and management capacity is very important in a CBHI. They also notice that CBHIs are short of some specific skills such as: setting contribution, collection of contribution and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems, and accounting. Such skills affect the performance and the viability of CBHIs even if it may seem that the availability of administrative and managerial skills in a CBHI has no specific connection to health financing in particular. CBHIs need much support from the government before and during the campaign for sensitizing the target population to join such schemes. So far, CBHIs receive little support from the government. For instance, in 2013 on July 28, the Minister of the Civil Service, Labor and Social Security called upon people uncovered by a health insurance to join CBHIs. She used radio stations to announce that, and she visited CBHIs. These actions encouraged promoters of CBHIs and CBHI members. Then in July 2014, she appointed provincial representatives of SEP/CNPS. They closely collaborate with stakeholders involved

in the promotion and development of CBHIs. However, the government does not organize seminars for members of organs of CBHIs or perform any financial control in order to enhance the management and governance of those health insurance schemes. In 2017, the situation is the same. As a result, CBHIs rely on themselves and this hinders their growth and fruitfulness. However, there are many aspects of CBHIs for which the government should bring its backup like sensitization to the public, communication of information to the public on national media such as the radio and television stations, capacity building in different fields, financial control of CBHIs, etc ….

Addressing the Challenge of Insufficient Technical Support from the Government and Donors

CBHI leaders are happy with whichever contribution from the government. Because, such contribution remains little during the lifespan of a CBHI, the schemes backed by LC and UCODE rely heavily on the support brought by the NGOs LC and UCODE. Indeed, the two organizations undertook a series of actions for technical support.

Spreading information to community members: Community members affirm that they received the information about health insurance for the rural population of the informal sector from UCODE in the years 2009 and 2010. According to the Executive Director of UCODE, LC funded two development projects namely LPPN and LIAM from 2004 to 2008 and from 2009 to 2013 respectively. Food security was the main component, but in LIAM they added other components: fight against malnutrition, establishing grassroots health care insurances, access to savings and credit services, literacy and strengthening the peasant federation UCODE member associations. Accessibility and affordability of health care was hindered by the fact that there were no schemes or mechanisms of health insurance in the geographic area of the LIAM project for non-salaried workers. Therefore, the whole process and activities were to be undertaken from the beginning. UCODE introduced the concept of health insurance for the rural population of the informal sector in the community as it acquired experience from the West African countries Togo and Benin by the year 2010. It is worth reminding that UCODE had run a CBHI from 2002 to 2005 without success. In 2017, the contribution of the public authorities is not visible. Indeed, they seem not willing to promote

CBHIs though they do not combat such schemes openly. Instead, since the renovation of the CAM, local government authorities and the government-owned health centers have promoted it in line with official policy (UNICEF, 2014, p.59). Therefore, CBHIs stalled. Among solutions, government authorities can spread the information about CBHIs to the public if they are willing to through public radio and television network and during meetings they convene and hold in the community. On the part on CBHI leaders, they are advised not to work in isolation and involve those government authorities.

Organizing community members: Passing information about CBHIs to the large public and to community members scattered in hills of the LIAM project in 2010 to 2012 required a lot of volunteers. As said earlier, volunteers need organization, and that is why there is paid staff. UCODE hired a technical staff in each target commune whose role was to ensure the sensitization message was reaching community members and supervise enrolment of community members and of course collecting their contribution. The hired staff in each commune contributed to help community members elect CAs from each hill who could inform the community members and collect annual contribution. They also elected provisional committees whose role was to work so that the CBHI could come into being. In 2017, the observed situation indicates that local government authorities are not helping CBHIs to grow. There is the communal administrator's counselor in charge of social affairs who can play the role of organizing community members along with heads of hills and zones. They do not act in that way because nobody asks them to do that. CBHI leaders need to collaborate with political authorities in order to get their backup.

Building capacities of community leaders and managers: On one hand, UCODE trained key community leaders so as they could spread the message in community and do their work effectively. Leaders in CBHIs received training in workshops and they exchanged experience among them. Supporting organizations built administrative capabilities and governance. They opened accounts in local banks or microfinance institutions to keep collected funds for future payment of consumed health care. Community leaders were also trained on the use of an account. Some of them had been trained before as managers of nonprofit farmers' associations. On the other hand, UCODE trained managers on procedures and the use of management tools which allowed them to manage funds effectively and efficiently. Trained

staff of the supporting organizations helped in the establishment of procedures and structures. They maintained monitoring of the management of resources. They carried out training and follow-up in the area of administration and institutional efficiency. In 2017 and before, the government authorities have done nothing regarding capacity building. CBHI leaders need to stand up and ask the government's help. Meanwhile, they have to look for other stakeholders to help their schemes and seize opportunities.

Organizing democratic elections: Once CBHIs gathered required members (about 150 households), staff from supporting organizations supervised elections of members of decision-making bodies. Elections were held in meetings of the General Assembly of CBHI members. They elected members of the Executive Committee and members of the Oversight Committee. All of the members of both committees made the Board of Directors. It is worth mentioning that in CBHIs women and men are considered as equal partners. The members of the Executive Committee have the role of implementing decisions made by the General Assembly and the Board. They are helped by the paid manager and they are advised by the staff from supporting organizations for administrative and management matters. Leaders have to ensure there is renewal of members of decision-making bodies after a three-year term. The elections were held in 2012, 2015 with the help of the two supporting organizations. In 2017, the 2018 elections are being prepared. The task is to ensure the elections are held in a democratic way.

Providing funds and material: Since 2011 on, supporting organizations provided funds to ensure that schemes could really start and grow. They brought staff, paid them wages and gave them benefits; they also supplied material like a car, motorcycles, bicycles, furniture, office material, and so on. They gave subsidies to CBHIs in order to pay rent for offices and office material. Managers have been paid each month. For the sake of ownership, supporting organizations brought 85% of the manager's salary while the specific CBHI contributed 15% from the annual collected contributions of members. In areas where LC and UCODE had built warehouses for preservation of crops during the period of the implementation of LIAM project, the peasant federation UCODE at the communal level provided a free office to the CBHI. A warehouse is perceived as a community facility. Therefore, once a CBHI has an office

in the same building of a warehouse, it is a way of serving the same community. After all, farmers who kept their crops in warehouses were almost the same as those who belong to the CBHIs. In 2017, three CBHIs managed to build their headquarters. Other CBHIs are advised to look for opportunities in order to have their own headquarters perhaps with the support of government authorities and other stakeholders.

Definition of benefit package: Supporting organizations and the ministry for social protection required a feasibility study prior to the starting up of the CBHIs. The study was submitted to the ministry of social protection and it recognized the CBHI. To the ministry, the health insurance was relevant, and its development was encouraged because it ensured its viability. In addition, the scheme was a response to community members for their issues of accessibility to health care. What remained then was the definition of benefit package. It was determined according to the benefit / premium combination as it is compulsory to consider both the benefits and premiums. The definition of a benefit package was a result of broad consultation among stakeholders including other organizations supporting CBHIs, members of farmers' associations, members of CBHIs and authorities in the medical profession. These consultations allowed the determination of the "minimum benefit package". Benefits comprise covered health services and the level of coverage. Specifically, CBHIs have benefits which are equivalent to services provided in health centers both public and church or private, and services of hospitals of district and regional level. It also includes consultation with a physician, ambulatory services for ambulatory patients, hospitalization and generic drugs. There is also a referral system. The benefit package does not include reproductive health care, family planning services, preventive services like immunization, deliveries, and pediatric care for 0-5-age bracket because they are free of charge for all population nationwide. High-cost treatments are excluded from CBHI benefit package. For instance, CBHIs do not cover treatment of chronic and non-communicable diseases like diabetes, cardio-vascular diseases, tuberculosis, drug abuse, mental troubles, HIV AIDS and long-term care of the elderly. In addition, they do not cover surgical operations except in case of an emergency like a road accident. From 2010 to 2017, CBHIs received no support from the government. However, the government could help CBHIs nationwide to determine the minimum benefit package and perhaps the minimum membership.

Providing health education: In order to decrease cases of ill health, supporting organizations decided to provide health education to CBHI members by promoting health and good

environment to households and to community. Topics like the use of a mosquito net and prevention of malaria, hygiene in compounds and of water for human consumption, the use of contraceptive methods, the need of a latrine for a household were developed. The sound prevention of malaria and diarrhea, early medical consultation in case of sickness, were frequent topics dealt with in meetings. In 2017 and before, CBHIs received information from other stakeholders. However, the 1986 Ottawa Charter insisted on the part of governments promoting health to provide community members with "full and continuous access to information, learning opportunities for health, as well as funding support." Perhaps, communities through CBHIs may claim this in the future.

Designing a dashboard and other documents: Supporting organizations introduced a dashboard in CBHIs which presents many performance indicators such as the level of consumption of health care, cases of benefit, and the rate of membership. They are used for reporting and decision-making during a reporting period. It also helps to monitor the health insurance financial management and its membership. LC and UCODE designed other documents like a feasibility study, a business plan and conventions between CBHIs and contracted health service providers. In 2017 at the time of research, the dashboard is a tool which has been adapted again and again according to the needs of CBHIs in general and for the sake of monitoring performance indicators. The one suggested by the government body SEP/CNPS in 2016 needs to be discussed in order to have a usable one perhaps in 2018.

Providing services of a medical advisor: Supporting organizations hired a part-time medical doctor in 2012 onward in order to provide advice to patients, to health service providers, to trustees and to representatives of supporting organizations. He also monitors the appropriateness of services provided to patients by contracted health service providers and the compliance with the rules of reimbursement. Besides, he gives training to medical staff in presence of trustees with the aim of improving relations between medical staff and insured beneficiaries. Finally, he checks understanding of medical staff about the way CBHIs work with health care facilities. In 2017, the hiring of a medical advisor is still common. It will be maintained in order to refrain health service providers from fraud, over prescription of medicines and other abuses.

Analysis

Challenge N0.4 “Insufficient technical support from the government and donors” refers to research question number four “Which kind of support the external stakeholders – mainly the government and donors – could bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization to ensure its performance?”.

Regarding the technical support (challenge N0.4) expected by CBHIs from the government, the theme of support (from the government) is dealt with. It is an overarching one comprising radio announcements made by the Minister of the Civil Service, Labor and Social Security in 2013 calling upon people uncovered by a health insurance to join CBHIs, the visits she made to them and the collaboration with provincial representatives of SEP/CNPS since their appointment in 2014. Informants find that this support is insufficient as there are other needs to be addressed by the government in order to make CBHIs maintain good governance and sound management and thus achieve better performance. For example, they need capacity building in different topics and financial control although CBHIs are autonomous entities.

As far as technical support is concerned, the efforts of donors like LC and UCODE is of great importance to CBHIs. The theme of spreading information is expressed. It relates to what the two development agencies have done since the years 2009 and 2010 to help community members grasp the concept of community health insurance. Then, there is a theme of organization of the target population i.e the population of the informal sector in the rural area. That population needed elected community animators and elected members of decision-making bodies to spread information, enroll members, collect membership fee and annual contribution. There is also a theme of capacity building done to help managers and elected members of decision-making organs to ensure collaboration between governance and management and the good discharging of functions in sectors of governance and management. The themes of elections of members of decision-making bodies and equipment to CBHIs are tackled. Human and material resources are needed in a CBHI to ensure its existence and its growth. The theme of benefit package meant for CBHI beneficiaries indicates what such a scheme can offer to its members right from the beginning by setting the limits. Beneficiaries know what health services the scheme pays for and what it does not offer and why. There is the theme of health education designed to help community members to prevent

diseases and to consult health service providers as soon as they feel unwell. This is a way of limiting consumption of health care and thus limit the amount of money to pay for consumed health care services. Finally, there are themes of management tools and services of a medical doctor. They are important as tools allow active CBHIs monitor indicators of its performance and manage resources for the good of beneficiaries. Also, advice from the medical advisor helps to monitor health services offered by health service providers to beneficiaries and even better relations between CBHIs and contracted health facilities. In 2017 and before, the technical staff from supporting organizations has to ensure tools are well filled-in and fed with exact data, but also make reliable interpretation of data in order to take adequate measures. Unfortunately, there are no government technical services to give support in that way and show CBHIs what to do and provide them the know-how.

Therefore, the themes dealt with regarding technical support show that donors like LC and UCODE provide necessary support with CBHIs. It allows them not only to fulfill their mission of having the households access to health care at a low cost but also to ensure good governance and sound management of such health insurances. This contributes a lot to ensure their viability and sustainability. However, CBHIs need to vary supporters and the government is one of the best.

IV.2. Findings

Data collected from interviewees have been triangulated with those collected through field visits, administrative records and reports. They are presented and analyzed in the above sections of this chapter. In this section, the researcher discusses the findings in relation to each challenge.

Challenge N0.1: Lack of Health Insurance

Challenges

After presenting and analyzing the collected data, it is worthy presenting findings. One finding is that the years the LIAM project started i.e 2009 and 2010, the context was a particular one regarding access to health care for the rural population of the informal sector in the project geographic area. That population faced many challenges of access to health care: sick people had to pay out-of-pocket the health care services on the spot of delivery, and they were sometimes compelled to sell their household assets in order to pay for the bill in the health facilities. Some of the community members could not even access health care services because of financial barrier. There was no health insurance mechanism of pre-payment allowing sick people to have health care at any time of the year thanks to risk sharing, pooling of resources and solidarity among community members. The existing mechanism CAM was not used in the community because it was not advertised by public authorities. Although community members felt the need of setting up a CBHI, many of them were skeptical because a CBHI was a new concept to them, hard to understand and to introduce as another component of development.

In 2017, the existence of the mechanism CAM hinders the expansion of the CBHIs. Although CAM is a transitional mechanism before CBHIs extend nationwide, it is widely advertised by politicians. At the same time, a CBHI presents a high financial risk. Some community members renounce attending health care facilities though they are sick because they cannot afford cash money to pay on the spot of delivery of health care i.e user fees during the period of sickness. Others choose not to consult health care facilities and go to traditional healers while others

resort to auto-medication buying cheap drugs anywhere or sharing doses with the sick people who have got medicines with medical prescription.

Solutions:

The population of the northern provinces of Burundi really needed a health insurance scheme to cope with that situation of lack in the year 2010. It started in 2011 and 2012. The CBHIs are operational from that period until the year 2017. In 2017 particularly, community members struggled to maintain the existence of the CBHI thanks to its membership. There is a fact that a CBHI exists only when it has members who generate income. Owing to different challenges, membership remains modest. Community members who refuse to join such schemes can choose to buy a CAM card instead because the enrolment in a CBHI is voluntary. Therefore, there is a need of introducing new strategies to enhance membership. First, leaders resorted to launch a campaign of sensitization targeting mainly organized groups aiming at development of their households like associations of farmers and associations for savings and credit. Second, managers have been given motorcycles to use when they go to hold public meetings. They are responsible for the enrolment of members, collection of annual contribution and sound management of all income. Third, there are incentives to motivate any enrollment of organized group members as a group rather than an individual or an individual household. Although enrolling is an act from self-decision of an individual or a household, it is found that solidarity among community members is a prerequisite for keeping a CBHI active as a common goal because there must be motivated and committed individuals to make a big group. According to Huq (2012, p.45), “Community people should have incentives to participate. The individual goal behind participation could be either complementary to the common wellbeing of the community, for narrow self-interest or for both”. Community members are offered a possibility to have a scheme of their own through time in order to access health care. This is a common goal reached within their communities. As a matter of fact, an individual or an individual household or even one community member cannot have his or her voice heard and enough skills to reach that goal. He has to join other community members in order to make a big group. Finally, CAs and community leaders continue to register their peers and to collect their funds as contribution. Thus, community members gain control over their health insurance organizations making them de facto owners

of their organizations to address the challenge of lack of health insurance for the rural population of the informal sector in the northern provinces of Burundi.

Another finding is that in the past, leaders of the movement of sensitization in target communes were only accepted leaders in their respective communities. They took advantage of their state of leadership giving them power and influence on their community members to convince them to join the health insurance. Their leadership came from positions they occupied in their communities. They were of two kinds: political and social. Today in 2017, we make efforts to enroll political leaders at the level of the hill or the zone. There is a belief that they can serve as a model to follow in community when they join in their respective constituencies. They can even leave their area and go to sensitize in another area far from where they are most known. This requires commitment on the part of community leaders and the staff from supporting organizations to maintain good relations with local government authorities by involving them in specific activities. CBHIs leaders are even requested to support local government authorities' initiatives in order to keep good relations. It is the same with leaders of the ruling party at the level of a hill or a zone and even a commune. They can counter initiatives and efforts of the civil society organizations like CBHIs. Leaders can inform them about CBHIs' activities being implemented to avoid any acts of sabotage and perhaps have their support. It seems clear that most leaders of the ruling party and the government authorities support the promotion of CAM rather than CBHIs. Fortunately, CBHI leaders are also commonly accepted change agents in their communities and they can make their voices heard because they have followers. They also have the backup of the supporting organizations of their schemes acting as external change agents. Therefore, they enjoy a good social position allowing them to remain trustworthy and convince their peers to join the schemes.

There is a finding that actions taken in the past which proved effective in health schemes are to be given great consideration in the present time (2017). For instance, leaders who started CBHIs are to be respected and given a room so that they can make such schemes grow. All they need is to have credibility in their communities. They can still bring changes in their area and embody shared values among members of nonprofit organizations. For example, in case of sensitization of the masses, they volunteer to do that work because they are happy when they are doing it. They want to keep their schemes active. That is why, we advise them to pay

their annual contribution first each year so as to remain a model for the rest of the community members. This is done because it becomes an eloquent sign of commitment and leadership ability. This is supported by Kouzes &Posner (2003, p.187) by saying that credible leaders "set the example for others … go first. They truly walk the talk. Leaders take the first step because doing so demonstrates their faith in the idea, program or service. Going first provides tangible evidence of the leader's commitment". When community members notice that their leaders have already paid, they feel confident to act as their leaders do. They can then dip their hands in their pockets and pay their contribution to CBHIs. Then, communities can gather required number of members in a CBHI and remain operational.

Another finding is that there is a group of community leaders deserving special attention for the growth of the health insurance schemes in 2017. It is made of insured people in the government health insurance MFP. Because they earn regular salaries, they pay their premium on payroll. They serve in their respective communities mainly as teachers or community facilitators in agriculture and livestock. Even if they are affiliated to a scheme giving them access to health care with a good benefit package, they enjoy promoting CBHIs in their respective communes thanks to their values of altruism, dedication and commitment to the community development. Therefore, we advise them to lead such schemes, for they have adequate skills and credibility in their communities thanks to their integrity and commitment to serve. With such a social position, they can convince their peer community members to join the health insurance scheme. In this way, the scheme can secure the required membership so as to remain operational. Thus, community members can enjoy access to health care thanks to efforts and contribution of those who do not need to join the health insurance organization in reality.

Challenge N0.2: Shortcomings in Governance and Management

Challenges

In governance, there are three main challenges: corruption of leaders, discharging functions without means, and decision making for a particular situation.

In management, the following challenges were identified: corruption of managers, cases of fraud and abuses, miscalculation of co-payment, collection of invoices, need of forms in health facilities, absence of managers and need of plots of land for the construction of headquarters.

Solutions

In governance, one finding is that elected community leaders in decision-making bodies were eager to discharge their functions without compensation. Apart from their time, they gave their resources like money to hire a means of transportation, to use a car or a motorcycle with fuel for activities of a CBHI, to spend money on the way from home to the CBHI headquarters and on the way back home, to use money on communication, and so on. As part of the solution adopted is to encourage leaders to remain committed to the cause of CBHIs by proving volunteering and ownership although it is demanding. Another solution is to use the motorcycle granted to the CBHI when the manager is not using it. However, it is noted that this is not a lasting solution. The best solution is to raise funds locally, but this requires a broad membership, which is still the biggest challenge in 2017.

Another finding is that some of the democratically elected members of the Executive Committee and the Oversight Committee got caught in cases of money embezzlement. At the time of election of members of the Board members, participants in meetings of the General Assembly were given a chance to choose their leaders in CBHIs. They elected leaders who had integrity and some experience in ruling associations in civil society. Indeed, they had certain characteristics that enabled them to introduce CBHIs and lead them (adapted from ILO, 2001, p.18): (1) They were dynamic leaders and managers of their respective associations, (2) They had the trust of their members already, (3) They had experience in administration (general assembly, statutes and regulation, committees and their meetings for decision-making, and financial management (contributions, loans, reporting), (4) They had developed

relations/contacts with different authorities at different levels, (5) They had contacts with funding agencies (LC and UCODE) to finance development activities, and (6) They held regular meetings with their members creating a sense of belonging to a social movement whose result is a social control which is able to limit or even eliminate potential abuse or fraud. However, some were corrupt, and they were replaced by new ones. This is a result of leadership failures and human frailties which make leaders lose credibility owing to their behaviors and deeds (Kouzes & Posner, 2003, p.203). The other finding is that empowerment of community members is a factor which brings them to full participation in the governance and decision-making, and even provides them opportunities for shared responsibility and leadership (Huq, 2012, p.47). That led community members in general and CBHI members in particular to change leaders as heads of CBHIs of Kirundo and Mwumba in 2015. They chose those who were trustworthy and who showed more integrity. These are cases showing that full participation of community members in general and CBHI members in particular impact the governance of CBHIs by addressing the shortcomings observed in the governance of such schemes.

In 2017, we are expecting the election of new members for the decision-making bodies in 2018. Meanwhile, we remain watchful in order to prevent cases of embezzlement. Special measures may be taken against any leader who would be found corrupt even before the period of elections. The values of equity and inclusiveness are put forward, for men and women in a CBHI are equal partners. They are represented in all leading organs and even among CAs.

In management, one finding is that in all CBHIs, the manager of a CBHI has an additional function of sensitizing the public in order to have some people to join schemes since 2017. Actually, the manager has three main functions (ILO, 2001, p.39): (1) registration and monitoring of membership, (2) collection and recording of members' contributions, (3) monitoring and payment of benefits. Before the year 2017, the manager felt that he had a function of an accountant without thinking of membership. Since 2017, selected managers have a level of education allowing them to do the work effectively and ensure a good management. They have motorcycles which they use for transportation of themselves but also the members of the decision-making bodies. During the campaign of sensitization specifically,

a manager can be accompanied by a member of the Executive Committee and hold a public meeting and even visit health care facilities for collection of invoices.

Another finding is that previous measures taken but which proved to be effective have to be enforced in 2017. For instance, community members have responsibility to ensure CAs do their work of taking money from community to the scheme's account or to the manager. There were incentives to increase their motivation. They must also secure their membership cards with a seal indicating that they paid annual contribution. Thus, CBHI members deserve health care services during a year. In case money has been embezzled, they need to complain in order to take adequate measures. In a CBHI, there must be collection of maximum contribution so as to secure enough funds to pay for health care services. One has to note that, in a CBHI, the members' contribution is the main income and the benefit makes the main expenses. Therefore, dishonest CAs and managers who embezzle collected money for health care must be replaced. This happened in all CBHIs in past years because some CAs and managers were dishonest. Apart from embezzlement of contributions, there was non-payment of benefit as major signs of lack of integrity on the part of managers when the schemes' heads and committees have given required funds. CBHIs managed to get back the embezzled money. That is why CBHI members and managers have to remain watchful in order to prevent such wrongdoings.

Finally, it is found that CBHI members deserve more responsibility in order to increase ownership with an impact on management of their schemes. Since 2017, they have been encouraged to take initiatives contributing to reduce expenses in CBHIs. This is possible only when they have understood that a CBHI is a result of people exercising their freedom of association and membership for the cause of access to quality health care. After all, a CBHI attains its goal only if its members take responsibilities. Therefore, there are initiatives which are observed in members. Some collect invoices and send them to the managers while others take forms used by nurses in the process of treatment of CBHI members in health centers. They also replace managers in case of their unavailability. Finally, some community members look for plots of land where CBHIs can build their headquarters. This contribution to the management of the CBHIs increases autonomy and ownership of such organizations by their

members. These are values leading to the financial viability and sustainability of those community-based organizations.

Challenge N0.3: Little Financial Support from the Government and Donors

Challenge
The challenge is that CBHIs receive little financial support from the government.

Solutions
The main finding is that the government provides CBHIs with little financial support. Therefore, such schemes count on the backup of other donors namely LC and UCODE for their starting up and growth. It is clear that, without financial support from LC and UCODE, such schemes could not start. Moreover, even at today's stage, they would not manage to survive. Therefore, what was noticed is that funds (about five million BIF) from the government to enroll ninety active vulnerable households to CBHIs and to sensitize leaders is little contribution. According to informants, CBHIs deserve more funds from the government in order to achieve good performance. With financial support from the government, more people would be members of CBHIs including the poor and this would help such schemes have broad membership. It is one of the prerequisites to achieve their viability and sustainability.

Another finding is that, CBHI leaders and other stakeholders should raise their voices and call upon the government to comply with international instruments like the 1986 Ottawa Charter and the 2005 WHO Declaration. Both instruments urge member states to promote communities' involvement in health matters by empowering them yet to let them their freedom of ownership and control of their endeavors and destinies, ensure a method of prepayment in its system of health financing and risk sharing among the population thanks to the contribution for health care. This can help to avoid cases of catastrophic expenditure and impoverishment in case of illness. Advocacy can help Burundi to seek the contribution of community members for health financing in order to achieve UHC. This is supported by WHO: "It is demanding to extend social health coverage to the unorganized workers who have no regular income, self-employed in the informal sector. To circumvent these difficulties,

governments sought the involvement of communities in health financing" (Carrin, 2003, p.3). Then, bringing financial support to existing CBHIs and others to create would be a good start.

Challenge N0.4: Insufficient Technical Support from the Government and Donors

Challenges

CBHIs need much support from the government to increase administrative and management capacity including specific skills such as: setting contribution, collection of contribution and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems, and accounting. They also need much support from the government before and during the campaign for sensitizing the target population to join such schemes.

Solutions

The main finding is that the government provides CBHIs with little technical support. The collaboration between the appointed provincial representatives of SEP/CNPS and CBHIs is one major contribution. However, there is no contribution in capacity building in order to allow CBHIs improve their management skills and perform better in specific domains such as setting contribution, collection of contribution and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems, and accounting. Therefore, CBHIs rely on the technical support they receive from their two donors LC and UCODE.

Another finding is that the government has means to spread information about CBHIs and health education. Indeed, according to the 1986 Ottawa Charter, the government should allow community members to involve in health matters and have access to information and learning opportunities for health. As a matter of fact, the government can spread information to the public through its radio and television network and even during public meetings the public administration holds in community especially during the period of intense sensitization to join

CBHIs. Once the government has commitment, the topics of CBHIs, community financing for health and health education would be dealt with.

Finally, in case the government authorities do not act on their own, it is found that CBHI leaders should involve them in the activities of such schemes. Then, they can urge them to act and receive their backup. Moreover, CBHI leaders should vary stakeholders and seek those who are eager to cooperate for the promotion of such schemes. Besides, they should seize opportunities for technical support.

CHAPTER V: CONCLUSION AND RECOMMENDATIONS

V.1. Conclusion

This thesis focused on how workers and non-workers of the informal sector among the population of the rural area addressed challenges of access to health care. They could establish such a scheme in their communities when the need for it was a real one in the years 2010 to 2012 and up today. The reason is that members of such a category of the Burundian population do not have a regular income and they witness financial limits on the access to health care when the risk of illnesses materializes. Besides, households' sources of income can be at stake when there is an urgent need to meet a major and urgent health care. In case available funds in a family are not enough to cover the risk, it may resort to the selling of livelihood assets. Then, there is ensuing poverty that can affect generations. Their needs could be addressed by a CBHI as a mechanism allowing unorganized community members to organize themselves and achieve a common goal of access to health care. This corresponds to what the international community suggested in different declarations through messages of the international organizations such as the United Nations and its agencies mainly the ILO and the WHO. Indeed, the community must be perceived as "the essential voice in matters of its health (OTTAWA Charter)". Moreover, Burundi as a low-income country cannot fund health care for all the population by its own budget. Therefore, CBHIs are mechanisms which can contribute to achieve sustainable health financing and UHC thanks to contributions from community members also known as community health financing. Donors and NGOs are also very important for their contribution to the financing of the UHC. Other contributions would come from salaried workers belonging to the government health insurance MFP and the commercial health insurances.

This work is a result of research in the field of health promotion for the uninsured population belonging to the informal sector in the rural area. It was conducted following three research questions: (1) How can unorganized workers of the informal sector in the rural area manage to start a community-owned mechanism of access to health care?

(2) What do the rural community members of the informal sector need to do to ensure good governance and sound management of their mechanism of access to health care?
3) Which kind of support the external stakeholders – mainly the government and donors – could bring to the rural population of the informal sector at all stages in the lifespan of a community-owned health organization to ensure its performance?

The research was limited to the geographic area of the LIAM project implemented by LC and UCODE from 2009 to 2013 in six communes in the northern provinces of Burundi for space and from 2010 to 2017 for time. The research population was the local population from the three target provinces (Kayanza, Ngozi and Kirundo). The involved population in the study is made of members of existing CBHIs since 2012 to 2017 which are supported only by LC and its partner organization UCODE.

Concerning the methodology applied in this study, it was qualitative only and it was exploratory. Among data collection instruments, there were the use of interview, administrative records and reports and field visits. The sampling method was the purposive method to choose informants.

Nominal data were mainly collected without precise measurement because the topic appeals to the involvement of community members in the setting up and the running of their own organizations to achieve access to health care. Collected data were presented per challenge to address. The four challenges are: (1) lack of health insurance, (2) shortcomings in governance and management, (3) little financial support from the government and donors, and (4) little technical support from the government and donors. For the data analysis, data were grouped, summarized and structured for meaning in accordance with each of the four challenges and the three research questions and the terms used by the UN agencies ILO and WHO like community-owned health insurance, membership, governance, management, ownership and performance.

As for data presentation and analysis, it was found that the context at the beginning of the implementation of LIAM project was a good one for the introduction of a community health insurance in target communes. There was a plight of access to health care for the population of the informal sector in the rural area. Yet, some conditions were met to get involved fully in health matters as a community and come up with a solution to their problem. Community members could base health promotion on existing solidarity for self-help and social support (OTTAWA charter). Specifically, in the LIAM project geographic area, the farmers' associations, savings and credit associations and SILCs existed in community as vivid forms of solidarity among community members in the years before and during the implementation of the LIAM project. Therefore, those were bonds of solidarity on which a CBHI could be initiated and grow. Community members of a large geographic area like a commune in case of Burundi could build strong health care schemes allowing them to share the risk of illnesses. Besides, thanks to the democratic participation of CBHI members, they adapted the scheme's organization and operations according to situations their CBHIs encountered. Moreover, the CBHI being an organization run by its members, they defined the membership, contribution, organization and expected services it could provide to the insured. Furthermore, there was sound application of the basic principles of a CBHI in terms of its governance and management to achieve a good level of performance. In addition, community members were aware that a CBHI is run as a nonprofit organization seeking to achieve financial viability and sustainability.

The establishment of a CBHI in the LIAM project geographic area was a long process. It was difficult to understand what a CBHI was and the way it should work. Its establishment required dedicated and committed community members who could give their time, energy and resources to start it. It took two years of sensitization to more than 200 leaders of the LIAM project geographic area to bring six CBHIs into being. Those were mainly leaders of UCODE communes, leaders of farmers' associations and CAs scattered in different hills. They spread messages about the insurance scheme, they collected membership fees and the contributions from community members who accepted to join the CBHIs, and they gave membership cards to those who joined. They seized opportunities of communication to the public like churches, gatherings of community members as they were convened by local public authorities and the distribution of leaflets. They took advantage of their positions be it political or social in order

to reach the public. The insurance schemes initiated by community members were de facto their own mechanisms, which were obtained after a great and hard work of community mobilization. Thus, six CBHIs were operational in 2012, and they were eventually recognized by the government in July 2013. Thus, this was the solution to address the challenge of lack of health insurance for the population of the informal sector in the rural area.

Community members were then called upon to set up leading organs of their health insurances. They elected leaders in a democratic way during the meetings of the General Assembly. The elected leaders could then hold positions in the Executive Committee, the Oversight Committee and the Board of Directors. It is worth mentioning that members of the Executive Committee and the Oversight Committee make the Board of Directors. The Executive Committee implement decisions taken by the General Assembly and the Board of Directors. Members of the schemes gathered in General Assembly to take decisions and elect their leaders. The elected community members volunteered to discharge their functions without compensation. The governance of those schemes was expressed through those leading organs. Because there was much load of work, there was a need of recruiting a minimum paid staff able to carry out the CBHI's day-to-day activities. Therefore, there was a manager for that work in each target commune for the management of each CBHI. The main source of income for CBHIs remains the members' contributions while the main expenses are benefits. CAs, members of leading organs and the manager collected membership fees and annual contributions from applicants and renewal members.

As time passed, some leaders of the community schemes elected in 2012 showed lack of integrity and they lost trust from CBHI members and community members in general. Community leaders carried out investigations and found those who were responsible for acts of mismanagement and embezzlement. Among them, there were managers and heads of CBHIs. Investigations from community members proved that they could not have their trust to lead their organizations any more. They were thus replaced through elections in 2015. The governance took decisions to dismiss unserious managers for the sake of sound management of the scheme. These are decisions which make trust in governance and management increase

in CBHIs. Community members were also involved in improving relations between CBHI beneficiaries and health service providers, in taking forms from the CBHI headquarters to health facilities, in collecting invoices from health facilities to the CBHI headquarters, and so on. They took serious measures in meetings of the General Assembly to ensure there is payment of consumed health care on a regular basis. For instance, they decided to increase percentage co-payment for a period, to ask for a loan in the umbrella organization of the six CBHIs, to ask for extra money for contribution during a reporting year, and to suspend contracts between CBHIs and private health centers which charged much fund to CBHIs. At a certain time, community members occupied the position of the managers when the latter were not available or dismissed. Besides, they denounced cases of fraud committed by community members or medical staff. They also looked for plots of land where to build CBHIs' headquarters. In their interventions, they gave their time, energy and resources in order to make CBHIs start, grow and flourish. Some used their own means of transportation (a car, a motorcycle or a bicycle) without claims while others gave their money for transportation. These were indications that the community mechanisms of health insurance are really owned by community members themselves. The payment of consumed health care by CBHIs to health service providers is also an indication that such schemes fulfil their mission. This was achieved thanks to the community members' participation. Thus, it is noticed that the participation of community members in the governance and the management of the CBHIs was the main factor in the addressing of the challenge concerning shortcomings identified in the governance and the management of their health care schemes.

The introduction of health insurances by LC and UCODE in 2010 in the target community of the LIAM project was innovation. It required involvement of potential members from the community right from the beginning of the project initiation of such schemes for the sake of ownership and autonomy. The participation of community members in the establishment of a CBHI and in its running (its governance and management) was a condition leading to its performance and sustainability. However, at all sequences of the CBHIs, there was involvement of initiating organizations i.e LC and UCODE by bringing their technical and financial support. The research indicated that the support from the government is still little although it is its total responsibility to ensure good health to the nation's population. All the

actions of donors and the government contributed to the improvement of the performance of CBHIs thanks to good working relations between community members and the government or donors. They impacted the aspects of membership and contribution of members, pooling of available funds from different sources of income and purchasing of health care from health service providers. So far, CBHIs were born and they grew thanks to the support from the two donors LC and UCODE. However, their performance would improve dramatically if they got technical and financial support from the government.

In 2017, it is noticed that CBHIs initiated by community members with the support from LC and UCODE in 2011 and 2012 are still operational. However, they have moderate membership with difficulties to collect contribution. Indeed, membership is voluntary and there is CAM which is a competing mechanism targeting the same population as CBHIs. It is cheap, and the benefits are mainly paid by the government. Among other causes, there is the increase of required contribution. Those community-based schemes based in the northern provinces of Burundi present certain characteristics (inspiration from Carrin, 2003, p. 30) which need to be stressed:

- They are young, and they need time to develop.
- Their memberships are relatively modest. Therefore, they can gather in a federation or network for more risk pooling in order to improve.
- They can contribute significantly to financial protection and access to health care of households. However, they should not work in isolation.
- They can strongly benefit different forms of cooperation developed in the sense of broad development.
- They can perform better in case they have enough support from donors and the government. In addition, their role is to be determined by the government within the context of the national health financing policy. This policy should indicate the contribution of CBHIs to reach universal health coverage.

About the future of CBHIs and the achievement of the universal health for all in Burundi, the situation is unclear. Indeed, in the area of social protection, the speed with which the

government will improve financial social protection nationwide in the future remains unpredictable and it is unknown. The economic situation is not improving, and a political stability is uncertain. Moreover, the 2014 Kayanza declaration about UHC in Burundi by the year 2017 is not translated into action yet. Therefore, it is not even easy to say that there can be compulsory enrolment of households in existing voluntary CBHIs as in other countries like Rwanda, Ghana, Ivory Coast or Senegal. There are achievements in those low-income countries like Burundi thanks to their political stability, political will of their governments and sustainable national economic growth. Such countries have got donors to support their policies owing to determination and commitment of their leaders. Today, governments have adopted policies leading to the UHC in the near future.

In brief, what is noted in this work is that community members can own CBHIs which they can run with some flexibility in their organization thanks to the democratic participation of its members. Community members can access health care, financial protection and dignity thanks to their own action. In case there is scaling, a CBHI is a scheme allowing a country to achieve UHC for all its population including workers and non-workers of the informal sector of the rural area and even the poor thanks to community financing of the national health system and subsidies from donors and the government. Therefore, developing countries in general and Burundi in particular can adopt this policy of supporting CBHIs.

This study shed light on the way community members with the support from donor organizations like LC and UCODE could overcome challenges of access to health care. This is a model which other communities can follow to ensure affordable health care at any time of the year. This can be enhanced by the governments to realize UHC. Yet, this was a beginning of the research in the field of community health insurance in Burundi in general and in the northern provinces in particular. Thus, university students and scholars interested in this field of social development are encouraged to deepen this study and even tackle other aspects of CBHIs from different perspectives. This study is a good one on which they can lay foundation for their research initiatives be it theses or dissertations. Subsequent researchers can choose to work on different aspects of CBHIs with specific topics. I suggest the following topics: (1)

The issue of administrative efficiency in CBHIs, (2) The issue of laws for the development of CBHIs in Burundi, and (3) The economic perspective of CBHIs initiated by community members with the support from donor organizations LC and UCODE.

V.2. Recommendations

To help community members achieve access to health care, increase or achieve ownership, autonomy and better performance in their health insurances, I offer a series of recommendations. They are meant for different stakeholders involved in the development of CBHIs: (1) the community members and CBHI leaders, (2) the supporting organizations, and (3) the government. Most of them are inspired from cited ILO (2008, pp. 39 and 47-48) and WHO (Carrin, 2003, pp. 26-27) studies.

VI.2. 1. To community members and CBHI leaders

- Interact with the government: CBHIs can use their experience and know-how to enable the government to understand their achievements and dynamics. They can cooperate with the government to address technical issues relating to functioning and management of CBHIs like how to avoid adverse selection, definition of benefit package, contracting with health care providers, identification of health risks, setting of premiums and establishment of managerial information system;
- Assist the government in training associations and groups interested in health insurance (SEP/CNPS may need assistance from PAMUSAB and/or UCODE);
- Avoid the often-desired self-reliance and ask for technical and financial support from the government (but set conditions) and other stakeholders like NGOs and donors.

VI.2. 2. To supporting organizations

- Assist the government in training associations and groups interested in health insurance (SEP/CNPS may need assistance from PAMUSAB and/or UCODE);
- Advocate for more funds from donors and the government to CBHIs in order to reduce contribution (and co-payment) and to include poor community members in schemes.

VI.2. 3. To the government

- Define the role of CBHIs in a policy aiming at targeting the whole country's population and address the concern about the role of community in decision making;
- Design rules allowing CBHIs to reduce the problem of adverse selection and determine the size of CBHIs in terms of minimum size of members (membership);
- Provide subsidies and financial support to CBHIs in order to allow them extend coverage to large population groups seeking the enrolment of low-income groups and the poor, achieve sustainability and even support the administration of the insurance;
- Provide logistical support to CBHIs like offices free of charge and free plots of land to CBHIs where they can build headquarters;
- Advise CBHIs and monitor their activities so as to avoid bankruptcy (design of benefit package reflecting the population's needs in health care, seek cost effectiveness, enforcement of referral system, track progress made and provide practical advice about noted problems in a particular CBHI) and even undertake capacity building so as to acquire administrative and managerial skills in the running of such schemes;
- Encourage CBHIs to make networks and supply them funds to secure a guarantee fund which can allow them to pay for health care expenses exceeding their financial capacity and to prevent financial crisis;
- Coordinate existing and future systems in order to make them more attractive, coherent and effective.

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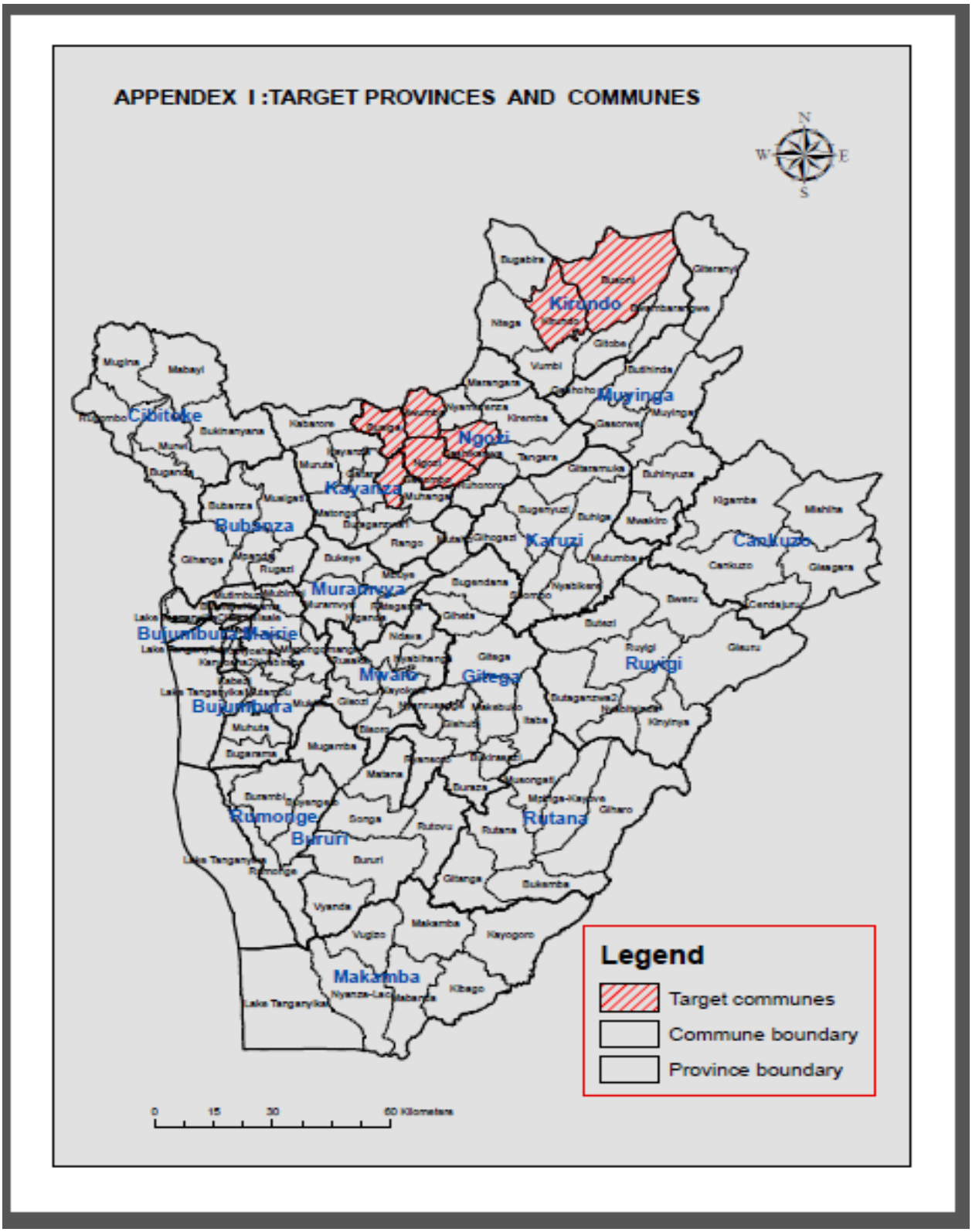
APPENDICES

APPENDIX 1: MAP OF BURUNDI WITH TARGET COMMUNES



APPENDIX 2: OUTSTANDING COMMUNITY MEMBERS INVOLVED IN SENSITIZATION FOR MEMBERSHIP AND OTHER DEEDS

A. Political position

NAMES, POSITION & COMMUNE	DEEDS
Joseph Nahimana, Head of his hill in commune Gashikanwa	He joined the CBHI in 2011. He promoted the CBHI in a hostile environment because other hill leaders discouraged him. He was told to sensitize people to buy CAM; he refused, and he got followers. He has held the position of the scheme's treasurer until today.
Janvier Hatungimana, Head of his hill in commune Gahombo	He accepted to promote a CBHI instead of CAM, joined the scheme in 2012, and remained faithful. He became a community facilitator in the field of livestock and a CBHI CA. All the members of his SILC joined it.
Innocent Minani, Chief of a zone in commune Busiga	He sensitized about a CBHI instead of CAM. He was committed to make his scheme grow in his constituency.
Pétronie Nikobamye, a woman elected Head of her hill in commune Busiga	She sensitized about a CBHI instead of CAM. Informants described her as an outspoken leader and the first member of the local administration to join a CBHI. Thanks to her efforts, many community members joined and most of the CBHI contribution was brought by her. She was also a community facilitator of women's savings and credit associations.

B. Social position

NAMES, POSITION & COMMUNE	DEEDS
Venant Hatungimana, a community facilitator in LIAM project dealing with banana production in commune Gahombo	He sensitized community members from his hill and others from neighboring hills. Members of associations of banana crop producers trusted him and many of them joined the CBHI. His CBHI started in 2012, and he became a member of the Executive Committee until today.
Marie Goreth Bivugire, a community animator in a hill of the commune Gahombo	She sensitized in four hills in her commune and she reached the neighboring commune Gatara. She therefore convinced many community members, and she has remained committed.
Daphrose Nyandwi, a community animator in a hill of the commune Gahombo	She was based in the neighboring commune Gatara, and she joined the CBHI. She sensitized in her hill and three neighboring ones. She managed to enroll six assistants to a pastor of the local church.

Manassé Mayira, Head of associations in commune Mwumba	He sensitized much in different hills and zones of the commune targeting most members of farmers' associations. He was also the first president of the scheme from 2012 to 2015.
Manassé Ngendabanka, Head of the committee managing a community warehouse in commune Mwumba	He sensitized much in different hills and zones of the commune focusing on those who kept crops in the community warehouse. He occupies the position of head of the CBHI since 2015.
Pélagie Nizigiyimana, an agent of UCODE dealing with training illiterate community members, a member of the committee running a warehouse for preservation of crops and seeds, and a representative of the associations growing beans in commune Gashikanwa	She sensitized community members in Gashikanwa, and she arrived in Ruhororo to look for more members for the CBHI. She could discuss the good of joining a CBHI during the training sessions of illiterate community members. She could reach clients of the warehouse and members of associations of farmers growing beans telling them how to join. As a result, there were many CBHI members during the period of implementation of the food security project LIAM. She became member of the Executive Committee and Head of the Oversight Committee.
Fabien Simbandumwe, Head of a farmers' association involved in production of banana in commune Gashikanwa	He volunteered to sensitize in Gashikanwa and he even reached two neighboring communes Ruhororo and Nyamurenza. He later became the head of the CBHI, and he is still in that position.
Omer Ntirandekura, Head of the peasant federation UCODE nationwide residing in commune Gashikanwa	He felt that his commune should be the first to start a CBHI. He encouraged his colleagues to do all they could in order to ensure there was the required number of one hundred and fifty households having paid membership fees and the annual contribution so that the CBHI could start paying consumed health care to its members. As a matter of fact, he was the first person to join proving a high level of leadership. He took animators from place to place of sensitization during the campaign using a motorcycle granted to him as the head of the peasant federation UCODE.
Véronique Ndereyimana, Head of the peasant federation UCODE in her commune Gashikanwa and an agricultural facilitator in her hill	She was among the first people in her commune to join the CBHI in 2011. She was not expected to join a CBHI because she is an insured member of the national government scheme MFP. Yet, she pays her contribution to the CBHI each year just to show other community members the good of it. She is referred to as an example during sessions of sensitization to convince her peers to join. Therefore, she managed to convince other swamp rice producers that she helped to use improved farming methods in her locality.

Gaspard Nsavyumuganwa, Head of the peasant federation UCODE in his commune Kirundo	He took the lead in the sensitization; he contributed much in order to have their CBHI start in 2011. He held the position of head of the CBHI up to 2015.
Virginie Musaninyana, Representative of associations growing beans in commune Kirundo	She was engaged in sensitization, and she acted as a deputy head of the CBHI since 2011 until today. She worked hard to have membership and maintain her followers.
Damien Ndayisenga, Head of an association of growers of beans in commune Kirundo	He got involved in sensitization of members of the association of producers of beans to become CBHI members since 2010. He has remained an active member of the organization.
Ladestine Batesi, Head of an association of growers of banana in commune Kirundo	She got involved in sensitization since 2010 focusing on producers of beans. She has remained an active member of the organization. She occupied the position of the treasurer in the CBHI.
Francine Hasabumutima, Head of an association of producers of beans in commune Kirundo	She sensitized members of associations of farmers producing beans since 2010. She acted as a member of the Executive Committee since 2011 up to 2015.
Louis Sabukwiyara, Pastor in his church in commune Kirundo	He encouraged followers of his church and other community members to join the scheme. He convinced members of associations producing onions to join so as to increase membership. He acted as a member of the Oversight Committee in the scheme.
Jean Bosco Nkiramihigo, Head of the association of producers of beans in commune Kirundo	He sensitized in a large area in his commune and beyond in the neighboring commune Vumbi with the aim of increasing membership.
Bernard Minani, Head of an association of producers of beans and facilitator of a group of associations in a hill of commune Kirundo	He sensitized in his associations and beyond his area. He remained a faithful member of the scheme since 2011.
Maurice Koyankunze, Head of associations of producers of rice in commune Kirundo	He convinced members of the associations of producers of rice to become CBHI members. He brought to the scheme the total amount of money from members of the associations. This was a good way of collecting contribution.
Pierre Hatungimana, Head of an association of producers of beans in commune Busiga	He sensitized community members scattered in a zone with steep hills since 2011 and he got many followers who joined his scheme.
André Ndirahisha, Head of an association of producers of onions in commune Busiga	He is located in a big zone. He moved from his hill to other areas because many CAs of his area gave up. He kept on sensitizing in his area and the abandoned one including remote hills. He gathered many households among CBHI members.
Venancie Niyonzima, Head of an association of producers of beans in commune Busiga	She sensitized community members since early 2011 and she got many followers who joined the CBHI.

APPENDIX 3 : QUESTIONNAIRE FOR INTERVIEWS

QUESTIONNAIRE POUR LE PERSONNEL DES ORGANISATIONS D'APPUI AUX MUSA

QUESTIONNAIRE FOR STAFF OF SUPPORTING ORGANIZATIONS TO CBHIs

Nom et prénom de l'enquêté / Name and Surname of informant :

Nom de l'organisation / Name of organization :

Fonction occupée / Position :

Date */ Date :*

Introduction : Dans le cadre de la recherche sur l'accès aux soins de santé de la population du secteur informel en milieu rural à travers les mutuelles de santé communautaires avec l'appui des organisations LC et UCODE, je vous demande de contribuer des réponses aux questions suivantes. N.B. Considérez seulement les 6 anciennes mutuelles (Busiga, Kirundo, Gashikanwa, Busoni, Mwumba et Gahombo); ne considérez pas Ngozi.

Ces réponses m'aideront pour la rédaction du mémoire ayant pour titre "Addressing the Challenges of Access to Health Care for the Rural Population of the Informal Sector in the Northern Provinces of Burundi".

Introduction*: I am doing research on the topic "Access to Health Care for the Rural Population of the Informal Sector" thanks to the existence of community-based health insurances initiated by LC and UCODE. I would like to have your answers to the following questions.*

Your answers will help me in the writing of a thesis whose topic is "Addressing the Challenges of Access to Health Care for the Rural Population of the Informal Sector in the Northern Provinces of Burundi".

Questions (original: in French; Translation in English for readers of English)

1. Selon vous, pourquoi LC et UCODE AMR ont introduit le volet des mutuelles de santé communautaires (MUSA) dans leurs programmes ? Et pourquoi en 2010?
In your opinion, why did LC and UCODE introduce the component of community-based health insurances in their development program specifically in 2010?

2. Comment les MUSA ont commencé ? Décrire le contexte et les actions menées par les différentes parties prenantes, les atouts et les contraintes.
How did CBHIs begin? Describe the context and undertaken actions by different stakeholders, favorable conditions and constraints.

a. Contexte d'avant le démarrage et à la phase de démarrage
Context before and at the phase of starting up the CBHIs.

b. Actions menées par LC/UCODE asbl à la phase de démarrage
Actions undertaken by LC and UCODE at the phase of starting up CBHIs.

c. Les atouts de LC/UCODE asbl pour réussir l'action des MUSA et démarrer
Favorable conditions of LC and UCODE for the starting up of CBHIs

d. Les contraintes de LC/UCODE à la phase de démarrage et d'avant le démarrage
Constraints of LC and UCODE before and at the phase of starting up the CBHIs.

3. Quelles sont les preuves tangibles d'appropriation des MUSA par leurs membres enregistrés au cours de leur vie?
What are visible indicators of ownership of CBHIs by their members in the course of their lifespan?

4. Quelle a été la contribution des organisations d'appui (LC/UCODE) dans l'évolution des MUSA (de leur naissance à aujourd'hui) ?
What is the contribution of LC and UCODE in the promotion and growth of CBHIs?

5. Quelle a été la contribution du gouvernement et d'autres intervenants dans l'évolution des MUSA (de leur naissance à aujourd'hui) ?
What is the contribution of the government in the promotion and growth of CBHIs?

Recommandations / *Recommendations*

6. Qu'est-ce que vous recommandez (à qui ?) pour qu'il y ait plus d'appropriation dans les MUSA ?

What do you recommend (to who?) to ensure more ownership of CBHIs by their members?

7. Qu'est-ce que vous recommandez (à qui ?) pour qu'il y ait plus de performance des MUSA ? (N.B. Eléments de performance des MUSA : (1) Sociétariat et collecte des contributions, (2) Mutualisation des fonds (pool) et (3) Paiement des prestations)

What do you recommend (to who?) to ensure more performance of CBHIs? Note: Elements of performance of CBHIs: (1) Membership and collection of contribution, (2) Pooling, and (3) Purchasing

Je vous remercie pour votre temps et votre contribution.

Contact : Félix BANYANKINDAGIYE (Etudiant chercheur, Tél. 79941537, adresse mail : felixbagiye@yahoo.fr***)***

Thank you very much for your contribution!

Contact: Félix BANYANKINDAGIYE (Student & researcher, Phone #: 79941537, e-mail address: felixbagiye@yahoo.fr***)***

IBIBAZO VY'IKIGANIRO C'ABANYWANYI B'ISHIRAHAMWE RYO KUVUZANYA

GUIDE FOR MEMBERS OF COMMUNITY-BASED HEALTH INSURANCES IN FOCUS GROUPS

Ishirahamwe ryo kuvuzanya rya:
Name of the community-based health insurance:

Abitavye ikiganiro: (Abagabo: Abagore: Bose hamwe:)
Informants: (Men: Women: Total:)

Ikibanza:
Location:

Itariki: Abagirisha ikiyago:
Date: *Surveyers:*

Intangamarara: Nitwa Félix BANYANKINDAGIYE, umunyeshuri wo muri Kaminuza. Ndiko nkora ubushakashatsi kuvyerekeye kwivuza kw'imiryango hano mu ntara zo mu buraruko biciye mu mashirahamwe yo kuvuzanya afashwe mu mugongo n'amashirahamwe LC na UCODE. Nabasaba rero mwishure ibibazo bikurikira.
Inyishu mutanga zizomfasha kwandika igitabu gisabwa muri kaminuza ku banyeshuri bahejeje inyigisho.

***Introduction**: I am Félix BANYANKINDAGIYE, a university student. I am doing research on the topic "Access to Health Care for the Rural Population of the Informal Sector in the Northern Provinces of Burundi" thanks to the existence of community-based health insurances initiated by LC and UCODE. I would like to have your answers to the following questions.*
Your answers will help me in the writing of a thesis, which is one of the requirements for students after completion of university studies.

Ibibazo:
Questions (Original: in Kirundi; Translation in English for readers of English)

1. Nimumbwire ivyerekeye iri shirahamwe ryanyu ryo kuvuzanya.
Tell me about your community-based health insurance.

2. Ritaratangura, kwivuza kw'imiryango kwari kwifashe gute?
Describe the situation of access to health care before the creation of your CBHI.

3. Kugira iri shirahamwe ryanyu ritangure hakozwe iki?
What was done which allowed the creation of such a CBHI?

4.Vuga abantu bitanze n'ivyo bakoze kugira ishirahamwe rishike kuri iyi ntambwe rigezeko.
Tell me people who contributed most and what they did in the lifespan of your CBHI up to the stage it is today.

5. Kugira ishirahamwe ryanyu rigume ritera imbere, musaba iki? Mugisaba nde?
For the sake of more performance and ownership of your CBHI, what do you recommend?

MURAKOZE CANE KU KIGANIRO TUGIRIRANIYE !
THANK YOU VERY MUCH FOR YOUR CONTRIBUTION!