



**Towards Realizing the Human Right to Health Care for  
Rwandan Rural Communities through Community-Based  
Health Insurance (CBHI): The Case of Gisagara District**

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## **LIST OF ACRONYMS**

CBHI: Community-Based Health Insurance

CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women

CRC: Convention on the Rights of the Child

DDP: District Development Plan

EDPRS: Economic Development and Poverty Reduction Strategy

HRBAs: Human Rights-Based Approaches

ICERD: International Convention on the Elimination of All Forms of Racial Discrimination

ICESCR: International Covenant on Economic, Social and Cultural Rights

ISS: International Institute of Social Studies

MDGs: Millennium Development Goals

MHOs: Mutual Health Organizations

MINECOFIN: Ministry of Finance and Economic Planning

MMI: Military Medical Insurance

NESRI: National Economic and Social Rights Initiative

NGOs: Non-Governmental Organizations

OECD: Organization for Economic Cooperation and Development

PHR: Partnerships for Health Reform

RAMA: *La Rwandaise d'Assurance Maladie*

RSSB: Rwanda Social Security Board

Rwf: Rwandan Francs

UDHR: Universal Declaration of Human Rights

UHC: Universal Health Coverage

UN: United Nations

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WHO: World Health Organization

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May Almighty God Bless You All.

## **DEDICATION**

I dedicate this Research Paper to my family, parents and relatives. A special feeling of gratitude to my loving wife Priscille C. Mugwaneza who supported me throughout the period of my studies by being there for our son Fabrice G. Iranzi.

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## **Abstract**

This study is about the contribution of Community-Based Health Insurance Schemes (CBHI) to realizing the human right to health care in Rwanda. Through the example of Gisagara District, the study explores experiences of rural community households with the CBHI scheme in Rwanda. The study uses a mix of qualitative and quantitative approaches, drawing on interviews with twenty rural households, and a number of interviews with officials and health workers from the District and Ministry of Health. The key findings of this study were that the rate of enrolment is high, and this has helped many rural Rwandans access health care. However the study also found a challenge of sustainability, since around a quarter of rural households were found not to be enrolled, due to their limited financial means. One finding was that the local communities contribute over 65 per cent of all contributions, and donors and government only 35 per cent. For most rural people, although the CBHI system is compulsory, they support it. This includes those who cannot pay because they lack means; this suggests that CBHI seems to be genuinely viewed by those in rural areas as being of importance for their own access to health care. Another finding was that there was a strong political will on the part of government, aimed at improving the existing system. Some modest recommendations at the end of the study seek to improve levels of access in rural communities like Gisagara and elsewhere in Rwanda.

## **Relevance to Development Studies**

Health care is the key of development in the sense of social justice (Declaration of Alma-Ata, 1978). Nevertheless, it is a fact that health care is not free in many countries including Rwanda. This implies that one needs resources to have access to acceptable health care services. Yet, the main challenge for rural communities to realize their right to health care is limited financial means due to the poverty. According to the UN and WHO (2008), poverty and health are closely connected. Therefore, State obligation should be to provide resources to ensure that the right to health care of all individuals especially the poor or vulnerable groups, is fully realised as suggested by General comment 14 (UN, Economic and Social Council. 2000). In view of this, Rwanda initiated CBHI as a key means to achieve the health MDGs and the long-term health objectives of Rwanda's Vision 2020, mainly ensuring an adequate standard of health care which remains important for human development (Rwanda Ministry of Health, CBHI Policy. 2010).

**Keywords:** Right to health care, Community-Based Health Insurance, local community, poor, Rwanda, Gisagara District.

## CHAPTER 1: GENERAL INTRODUCTION

### 1.1 Indication of Research Topic

Community-Based Health Insurance (CBHI) commonly known as *Mutuelle de Santé* in Rwanda is a fundamental and appreciated step towards realization of the right to health care in many developing countries where financial constraints remain a barrier for accessing affordable and equitable health care services. CBHI is understood as an “emerging and promising concept, which addresses health care challenges faced in particular by the rural poor” (Jütting 2004:273). In Rwanda, the CBHI scheme was formally launched in 2005 with the aim of making health care services more accessible to the poor people and has gradually improved (Hartwig et al. 2012:6).

Health care is a human right to the extent that it is recognized in numerous international, regional and local human rights instruments and policies. This right remains essential for dignity, fulfilment and realisation of people’s rights and claims for health protection for everyone. It is pointed out that “at the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, responsive to national and local priorities, and accessible to all” (Hunt and Backman 2008:81). As the right to health care which is part of the right to health (Hunt 2006) appears to be very important to exercise of other rights, the government of Rwanda having observed that there is a great need to remove the financial constraints to health care and increasing access to health care for local communities, has initiated the CBHI scheme as a public policy to help and allow all Rwandans particularly the most vulnerable and poor people to have access to health care such as hospitals, health centers, medicines,... which should be affordable and according to the WHO<sup>1</sup>, must be accessible, available, acceptable and of good quality for every person (WHO. 2014). If health care was free, no insurance would be needed. Therefore, since health care is not free, this implies that without health insurance there is no effective right to health care especially for the poor and hence this policy strengthens the basis for the ‘concept of equity’ in accessing health services delivered by the health system (Rwanda Ministry of Health, CBHI Policy. 2010:5).

In principle, Human Rights-Based Approaches (HRBAs) should enable vulnerable ‘poor’ people, who are trapped by poverty and diseases, to be direct beneficiaries and active participants in implementation of programs that affect them (Yamin 2009:6). In line with this, the study examines the role of CBHI in realizing the right to health care in Rwanda, taking local communities within

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<sup>1</sup> WHO: [http://www.who.int/hhr/news/hrba\\_to\\_health2.pdf](http://www.who.int/hhr/news/hrba_to_health2.pdf), accessed June 03, 2014.

Gisagara District as an example. This is one of the rural areas of Rwanda in which the proportion of poor people is relatively high.

## 1.2 Description of Case Study: Gisagara District

Gisagara District is one of eight Districts composing Southern Province. It is largely a rural area and its economy is based on agriculture and livestock farming. By the year 2012, the population of Gisagara District was estimated at 322,803 of which 53.4% are women and 46.6% are men; the District has 72994 households with the density of 476.1hab/km<sup>2</sup>. Gisagara District *Ubudebe* report 2012 shows that in 2011 the population under poverty line in Gisagara District was 59% of the whole District population. This compared with a national average of 44.9%. The percentage of Gisagara District's population in extreme poverty was 32.1% compared with the national level of 24.1%. Correspondingly, the *Ubudebe* report highlights that 30.58% of the population are in category I and II of *Ubudebe*<sup>2</sup>, which implies that this population lives in extreme poverty (Gisagara District 2013:19&25).

Health is a key sector in the Strategic District Development Plan. Overall, the District's main concern in terms of health is to provide to the population good quality health services. This objective is to be achieved through certain actions and projects including improving health infrastructures such as District Hospitals, Health Centres and Health Posts, and through health insurance schemes. The goals, among others, include: reducing maternal and child mortality rates; increasing the percentage of women who use family planning services; enhancing community health service through building capacities of community health agents; promoting private investment in health services, and combating HIV/AIDS, especially among younger people (Gisagara District 2013:38). These activities aim at eliminating the first seven causes of mortality in the District namely (i) serious paludal bout; (ii) Infection of Inferior Respiratory Tract (IAVRI); (iii) Confirmed simple paludal bout; (iv) Non-bloody Diarrhea; (v) Presumed simple paludal bout; (vi) Physical trauma, and finally (vii) presumed or confirmed HIV/AIDS (Unpublished document provided by staff of Gisagara District, Health Department 2014).

## 1.3 Statement of the Problem

According to Jütting, in many developing countries particularly those of sub-Saharan Africa, states have failed to realize health care needs for their poor people. For instance, decreases in funding health care services, inefficiencies and poor quality of public health services have characterized the health systems in last decades and this 'health care crisis' confirmed the failures of states to meet health care needs of vulnerable people. That is why there has been rise of CBHI schemes in different regions (Jütting 2004:273). In the same way, Hartwig et al. (2012) argue that for many years numerous approaches for financing and

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<sup>2</sup> *Ubudebe*: "a community-based targeting mechanism that categorizes the Rwandan population according to their revenues and vulnerability" (Habiyonizeye 2013:8).

operating a sustainable health care system in Rwanda, were experimented with, but failed to deliver results. For instance during two years after 1994, primary health care was provided for free in most health facilities, financed by donors and the government of Rwanda. Later the country initiated a direct payment system where the population, the majority of whom were still very poor, were supposed to pay for health care services. This made the health care unaffordable for many Rwandans. As a result “health care utilization dropped again” (Hartwig et al. 2012:5). Given these experiences, as Hartwig et al. (2012) discuss, the CBHI policy, generally known as *Mutuelle de Santé*, was experimented within a few districts of Rwanda, from 1999 and then later expanded to all districts of the country in 2005.

Today, Rwanda considers the CBHI as a key means to achieve the long-term health objectives of Rwanda’s Vision 2020, especially ensuring an adequate standard of health care leading to improved human development. Thus, it is important to assess whether the CBHI responds to the requirements of HRBAs to health care and therefore draw the interconnection of the right to health care and human development policy for greater social and economic transformation of the Rwandan society.

#### **1.4 Relevance and Justification of the Research Topic**

Human right to health care is recognized in international treaties, declarations and national laws and policies. It is argued that at the international level, the initial formulation of human right to health which include right to health care, was introduced in 1945 by the United Nations with its special memorandum stating that *Medicine is one of the pillars of peace* and this led to the creation of WHO in 1946 that clearly formulated the right to health (Sepulveda et al. 2004:283). Similarly, I refer to Human Rights Instruments by (van Banning, Theo Robert Geerten et al. 2004), particularly the 1948 Universal Declaration of Human Rights which provides that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and the right to security in the event of...sickness, disability...” (UDHR, article 25). The International Covenant on Economic, Social and Cultural Rights also calls upon the States parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health...and the full realization will include the creation of conditions which would assure to all medical service and medical attention in the event of sickness” (ICESCR, article 12 (1)). Consistently, the preamble of WHO Constitution underlines the “enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being” without discrimination. Again, the Convention on the Elimination of All Forms of Racial Discrimination article 25, the Convention on the Elimination of All Forms of Discrimination Against Women articles 11 and 12, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families article 28; the Convention on the

Rights of the Child article 24(1) and the African Charter on Human and Peoples' Rights article 16, all give emphasis to the right to health and access to adequate health care services for everyone.

At the national level, the right to health care is recognized in many constitutions and other laws. The Constitution of the Republic of Rwanda of 04 June 2003 as amended provides that "All citizens have the rights and duties relating to health. The State shall have the duty of mobilizing the population for activities aimed at promoting good health and to assist in the implementation of these activities" (Article 41 of the Constitution). For this effect, the Community-Based Health Insurance policy was elaborated and the Law n° 62/2007 of 30/12/2007 on mutual health insurance scheme in Rwanda was put in place with the purpose "to increase access to health care and to reduce the burden of catastrophic health spending particularly for the poorer groups" (Hartwig et al. 2012) and therefore recognizing the human right to health care for Rwandans.

The justification of this study remains that with the emergence of human rights, it is claimed that health and poverty which is seen as 'social injustice' are interrelated (United Nations. Office of the High Commissioner for Human Rights and World Health Organization 2008) and also it is argued that similar to other human rights, the right to health has a certain concern for vulnerable people and communities including those living in poverty (Backman et al. 2008:2048). Equally, Yamin (2009) points out that health is a matter of rights that should not be understood as a handout and people beneficiaries of health services should not be considered as objects of charity from their own governments or other donors but rather they are key actors who have to participate in implementation programs and policies that affect their well-being (Yamin 2009:6).

### **1.5 Research Objective and Questions**

Generally, this research aims at assessing the role of the Community-Based Health Insurance policy in realizing the right to health care in Rwanda with a focus on rural community of Gisagara District. It was emphasized above that health is a matter of rights and should not be considered as a favor for the people. Therefore, with reference to the 2009 Guidelines for UN Country Teams on Preparing a Common Country Assessment (CCA) United Nations Development Assistance Framework (UNDAF) that provides guidance for carrying out HRBA analysis in relation to health care (WHO. 2014), this study aims to assess what is really happening with the CBHI policy, and to analyze who is most affected by the policy. The study aims to highlight problems, causes and possible gaps in CBHI policy implementation that may lead to poor access to health care services for local people. It does this by considering one local context, in Gisagara District. The study also aims to identify the key 'duty-bearers' and the capacities needed so that people can become 'rights-holders' in

fulfilling the human right to health care for local communities through the CBHI scheme.

**Main question:**

To what extent does the Community Based-Health Insurance (CBHI) policy contribute to the realization of the right to health care for Rwandans, particularly for those in rural communities?

**Sub-questions:**

1. How is the human right to health care understood, framed and realized?
2. How does the CBHI scheme known as *Mutuelle de Santé* operate in practice? Has the arrival of CHBI meant that healthcare is seen as more of a 'human right' in Rwanda?
3. What are the views and experiences of the local community in Gisagara District on CBHI? Do they feel that CBHI is enabling them to access health care, as a right?
4. What are the views and opinions of officials responsible for the CBHI scheme?
5. How do different actors participate and what kind of intervention is needed for the efficient implementation of the CBHI policy?
6. What are the possible gaps in ensuring adequate health care through the CBHI policy?

**1.6 Working Hypothesis and Analytical Framework**

The CBHI policy represents a contribution to equity and social justice in accessing health care services. It is a participatory and inclusive process that defines 'duty-holders' and 'rights-holders' with the effect to increase the level of understanding and see health care as a human right rather than a favor to the citizens. Therefore, the working hypothesis is that being in a *Mutuelle de Santé* and paying health insurance, or having health insurance paid, tends to lead people to feel more entitled to healthcare i.e. to have 'the right to healthcare' and encourages them to be more active in claiming such a right. It is assumed that the gaps in the CBHI policy implementation will generally be due to failures to meet obligations not only on the part of Government, but also by other partners and the local population as key actors.

The realization of right to health care is a participatory and inclusive process (United Nations. Office of the High Commissioner for Human Rights and World Health Organization 2008). It requires combination of efforts from different actors who in this study are the Government of Rwanda, Rwanda Social Security Board (RSSB), districts, hospitals and health centres, health workers, NGOs, other development partners and people beneficiaries of healthcare services. Thus, analytical framework of this research does not only look at the role of different actors in implementing the CBHI policy but also evaluates the contribution of *Mutuelle de Santé* in achieving affordability and

accessibility to health care services. Therefore, HRBAs helps to deal with participatory, inclusive and accountable analysis, interventions and outcomes of the CBHI policy in Gisagara District.

### 1.7 Research Methodology

This research applied primary and secondary data sources. Primary data is qualitative and quantitative that was collected through interviews with key informants and other information like rate of enrolment to the CBHI scheme and numbers provided by relevant institutions. Secondary data sources contributed in reviewing the literature and exploring useful concepts. Applying both methods contributed to enrich the results of this study and to enhance its authenticity. The use of qualitative and quantitative methods also helped me to answer a number of research questions that were formulated basing on my assumptions.

#### 1.7.1 Data Collection and Techniques

Primary data collected in Gisagara District is a result of the field work carried out in four rural Administrative Sectors and four Health Centres where households, Health workers and district officials were interviewed in order to get information from grassroots level on the functioning of CBHI and challenges encountered. The visited Health Centres are under Kibilizi Hospital that covers a large number of the population in Gisagara. Health workers were selected purposively because their contacts (telephone numbers) were available at Health Centres. Therefore, those living near Health Centre were contacted and met easily which helped me to save time. The table below shows Sectors, Health Centres and the number of health workers and households visited.

**Table 1: Sectors, Health Centres, Health Workers and Total Households Visited**

N <sup>o</sup>	Sector	Health Centre	Number of health workers	Number of households visited
1	Ndora	Ndora	1	5
2	Kansi	Kansi	1	5
3	Kigembe	Kigembe	1	5
4	Kibirizi	Kibirizi	1	5

The interview method which enables the researcher to interact with interviewees (Ritchie et al. 2013:140), and to find relatively open, unrestricted answers to the research questions (O'Leary 2005:113), is the method selected for this study. Semi-structured interviews, with some open-ended questions alongside some 'factual' yes/no type questions, have helped me to gather opinions as well as data from members of local communities in Gisagara District, and to better understand how they experience the CBHI scheme.

After setting initial questions to guide interaction, a total of twenty households was selected for face-to-face interviews, each household represented by parents or other responsible persons. It is to be underlined that in a household of two parents, a husband was usually more active than a woman mainly because of hegemonic power of men as the ones most likely to be involved in paid work, giving them an income with which to pay the family's CBHI contributions. Furthermore, households headed by single parents who were widows, or by orphan, were generally supported by the government, in the payment of CBHI contribution.

In point of fact, households members of the CBHI scheme were randomly selected because the random sampling is considered as fair and gives equal chance of inclusion to all designed respondents and therefore enables generalization of findings (O'Leary 2004:106-107). I had a list of households and then picked households at random, without any guidance from intermediaries. As expected, the semi-structured interview method allowed for more flexibility, enabling the rural citizens who composed the interviewees, to express their views more freely than had a formal survey been conducted. Table 2 below indicates the number of selected respondents.

**Table 2: Interviewed Households and number of family members**

Household Number	Number of household members	Household responsible person
1	6	Woman/widow
2	7	Two parents
3	2	Woman/single
4	8	Two parents
5	5	Woman (widow)
6	5	Two parents
7	4	Two parents
8	3	Woman/single
9	7	Two parents
10	4	Two parents
11	4	Two parents
12	2	Orphan
13	2	Woman/widow
14	2	Two parents
15	3	Two parents
16	6	Two parents
17	4	Two parents
18	3	Woman/single
19	8	Two parents
20	7	Two parents



The CBHI operates from below to the national level. Thus, other relevant institutions have been visited in order to collect numerical data and get their views on the implementation of CBHI. These are Kibilizi Hospital, Direction of *Mutuelle de Santé* at Gisagara District, Rwanda Social Security Board (RSSB) and the Ministry of Health through its Unit of Health Financing in charge of monitoring and evaluation of the system.

Furthermore, secondary data helped in literature review of the CBHI schemes and in theoretical framework of the key concepts such as the right to health care and HRBAs to healthcare. It is noted that working with literature inspires the researcher to generate new ideas that helps to formulate relevant research questions (O'Leary 2004:66). Similarly, working with texts has been helpful in analysing reports on the CBHI policy, its implementation and other related documents on health care outcomes in Rwanda.

### **1.7.2 Ethical Consideration and Limitations**

Moreover, ethical considerations were very important in this study because of the sensitivity of the subject matter and the people interacted with. For instance, information about households' source of revenues and their category under *Ubudehe* system was not easy to provide. In addition, many respondents did not accept to be recorded and/or being taken pictures. Therefore, as a researcher I ensured confidentiality and no harm to the respondents in collecting primary data. Importantly, the letter received from the International Institute of Social Studies (ISS) was useful to prove the objective of the study and introduced me to different institutions and officials who authorized me to interact with respondents.

Obviously, there are challenges that would have negatively affected the results of this research. Firstly, it was not easy for the respondents to provide information relating to the CBHI scheme and interact with someone they are not familiar with. Thus, I had to be in contact with local authorities who introduced me to the respondents. Secondly, time allocated to the field research, thirty one days, was not enough since during the period of July to the end of August was a very busy period in Rwanda for government employees and officials who were dealing with reports of the financial year 2013/2014. However, as an Ombudsman staff who previously worked with local communities and different local leaders, my experience helped to overcome the main challenges and hence achieve the objectives of the study.

### **1.7.3 Researcher's Personal Position**

Examining the realization of human right to health care was guided by the idea of seeing healthcare as a basic human right and the conviction that the State has an obligation to ensure the realization of that right. I intended to investigate whether the implementation of the CBHI scheme responds to the requisites of HRBAs to healthcare as it is conceptualized by the General

Comment 14 on the right to the highest attainable standard of health and the Universal Health Coverage (UHC) that provide for interconnected aspects of availability, accessibility, acceptability and quality of healthcare services as prerequisites to move towards realizing human right to health care. Therefore, data collected was mainly related to the experience of local communities in accessing healthcare, as a right, through the CBHI scheme. In this view, after gathering preliminary information about the CBHI policy, its legal framework, operational aspect and recent national rate of enrollment, the respondents were interviewed about the importance of CBHI, capacity to pay contribution, people' opinions about categorization system (*Ubudehe*), quality of health care services provided to the members of the CBHI scheme by health facilities and lastly, awareness of the population about their right to health care.

### **1.8 Structure of Research Paper**

This Research Paper is divided into seven chapters. The first chapter has introduced the link between the CBHI scheme and human right to health care. It also stated the problem of realising human right to health care and highlighted questions being answered and how. The chapter two handles the details of the two key concepts such as the right to health care and HRBAs to health care while the third chapter deals with the review of literature on the CBHI schemes. In the fourth chapter, it is presented the findings on CBHI in Rwanda and the fifth stresses on CBHI at community level with emphasis on Gisagara District as a case study. The chapter six reflects on the analytical findings of previous chapters and leads to the conclusion and recommendations in chapter seven.

## **CHAPTER 2: KEY CONCEPTS: HUMAN RIGHT TO HEALTH CARE AND HRBA**

The research is based on Rights-Based Approach to health care. Therefore, this chapter presents the theoretical framework on the right to health care and the HRBAs to healthcare.

### **2.1 Right to Health Care**

Industrial revolution in 19<sup>th</sup> century led to unhealthy working and living conditions with health problems requiring states interventions in terms of public health measures. Accordingly, health as human right was initiated at the international level by the United Nations in 1945. In its special memorandum, medicine was declared as one of the key for sustainable peace (Sepuldeva et al. 2004:283). With subsequent creation of WHO in 1946, the right to health was explicitly formulated as defined in the Preamble of WHO constitution. In addition to health for all and primary health care, the right to health entails first; Access to maternal and child health care, immunisation against the major infectious diseases, appropriate treatment of common diseases and injuries, essential drugs, adequate supply of safe water and basic sanitation, and freedom from serious environmental health threats; Secondly, it involves “availability of health services, financial and cultural accessibility of health services, quality of health services and equality in access to available health services” (Sepuldeva et al. 2004:283). This, is exactly where the right to health care finds its meaning.

It is pointed out that in relevant international human rights instruments the right to health care is seen as an integral part of the right to health (Smith 2005:1315-1316). Equally, Da Lomba argues that the right to health care is a core component of the right to health and it is enshrined in numerous international human rights instruments mainly International Covenant on Economic, Social and Cultural Rights (ICESCR) article 12(1) which recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The normative content of this article that focuses on aspects relating to the right to health care was interpreted by General Comment 14 of the Committee on Economic, Social and Cultural Rights (Da Lomba 2011:360).

NESRI is the National Economic and Social Rights Initiative which in partnership with communities, works to build a broad movement for economic and social rights, including health, housing, education and work with dignity<sup>3</sup>. It is debated that the right to health care, as a core constituent of the right to health means that health care facilities namely hospitals, medical services and drugs must equitably be available, accessible, acceptable, and of good quality for every

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<sup>3</sup> <http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care>, Accessed July 25, 2014.

person in all places and any time they are needed by people. Thus, every health care system is supposed to be steered by those fundamental human rights principles without discrimination taking into consideration transparency, accountability and citizen' participation (NESRI. 2014). These fundamental human rights standards as discussed by Da Lomba (2011), are essential to the realization of the right to health care. Respectively, the General Comment 14 suggests that availability entails among others, right to adequate functioning of public healthcare facilities, goods and services. It considers a non-discrimination principle as essential to exercise and enjoy the rights acknowledged in the ICESCR and therefore, this remains crucial to the realization of the right to health care for all, especially the most vulnerable groups, poor people (Da Lomba 2011:360-361). Two other principles participation and accountability which are also very important in this research, have been defined by NESRI as follows:

“Participation entails that individuals and communities must be able to take an active role in decisions that affect their health, including in the organization and implementation of health care services.... while accountability implies that private companies and public agencies must be held accountable for protecting the right to health care through enforceable standards, regulations, and independent compliance monitoring”(NESRI. 2014).

By these human right standards, it is understood that the realization of the right to health care requires inclusive and participatory development of health care system.

Besides the international human rights law to recognize the right to health care and highly commending for its realization by the States, there are other efforts to acknowledge the significance of this right and through which it was expressed the need for urgent action to protect and promote right to health care. For instance, the famous Declaration of Alma-Ata 1978 on Primary Health Care reaffirmed that “health care is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (Declaration of Alma-Ata 1978). Under paragraph VI of this Declaration, it is stated that:

“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made 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. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing

health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (‘Declaration of Alma-Ata’1978:Para. VI).

Again, this Declaration highlights the inclusive and participatory development of health care system which must provide quality health services that should be available, accessible and affordable for every one and everywhere. It urges the governments, international organisations like WHO, UNICEF and other funding agencies to co-operate and increase financial and technical support, particularly to developing countries, to realising the right to health care.

The mentioned General Comment 14 furthermore refers to article 12 of the ICESCR and recalls that the right to health which encompasses the right to health care, like other human rights, imposes on States parties three levels of obligations such as the obligation to respect, protect and fulfil. Consecutively, the obligation to fulfil comprises obligations to facilitate, provide and promote health care related services. It also requires States to adopt appropriate measures towards the complete realization of the right to health care, being legislative, budgetary, administrative, judicial etc. Under the obligation to respect, States must refrain from denying or limiting equal access for all persons including vulnerable groups to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy. Generally, States must refrain from direct or indirect interference with the enjoyment of the right to health care. The obligation to protect furthermore includes among other duties of the States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services (UN, Economic and Social Council. 2000).

## **2.2 Rights-Based Approaches to Health Care**

Human Rights-Based Approaches (HRBAs) have been discussed and defined in different ways. On one hand, they are:

“standards aiming at supporting better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development problems. Under HRBAs, development efforts are anchored in a system of rights and corresponding State obligations established by international law. Civil, cultural, economic, political and social rights provide a guiding framework for development plans, policies and processes” (WHO. 2014)<sup>4</sup>.

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<sup>4</sup> [http://www.who.int/hhr/news/hrba\\_to\\_health2.pdf](http://www.who.int/hhr/news/hrba_to_health2.pdf), Accessed July 24, 2014.

On the other hand, HRBAs are seen as “principles that justify demands against privileged actors, made by the poor or those speaking on their behalf, for using national and international resources and rules to protect the crucial human interests of the globally or locally disadvantaged” (Gauri and Gloppen 2012:486). These two definitions have some common points, mainly that each includes unjust power relations between rich and poor, the use of international human rights law to address such inequalities, and protecting the human rights of vulnerable people as a matter of priority.

Most definitions of HRBAs have been subject to critique. Besides the usual semantic disagreements about what human rights mean in practice, HRBAs are criticized because they do not differentiate between positive rights (economic, social, and cultural) and negative rights (civil and political), but instead simply affirm that both are essential. Conversely, HRBAs do not limit responsibility for meeting human rights claims to states, but leave open the possibility or idea that individual persons and other non-state actors may also be duty-bearers. Lastly, HRBAs are seen as excluding the rights of the rich and focusing only on rights violations connected with poverty and vulnerability (Gauri and Gloppen 2012:486-487). For the purposes of this research, however, the definitions seem appropriate, since our concern is with locally disadvantaged people, especially the poor households who may struggle to enjoy their economic and social rights. In view of this, it can be recalled that a government tends to be judged by how it treats the most vulnerable persons, not by how it treats those who are powerful and better-off. Therefore, if the right to health care is to be realized, international human rights law needs to be integrated into the health sector system, and one means for doing this is through HRBAs. In view of this, the Special Rapporteur on the right to health, Paul Hunt, discusses that generally:

“A Human Rights-Based Approach requires that special attention be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these and other features of a Human Rights-Based Approach is to empower disadvantaged individuals and communities” (United Nations E/CN.4/2006/48 2006).

In fact, Paul Hunt insists that governments under their international commitments and obligation to protect, respect and promote human rights to health, they should ensure that disadvantaged people ‘poor’ participate at the levels of decision making and implementation process of health-related policies.

It was discussed in previous section that health care is a universal and fundamental human right which remains essential to exercise of other rights. The most international human right instrument referred to is the International

Covenant on Economic, Social and Cultural Rights (ICESCR), article 12. This human rights instrument guarantees the right of everyone to health care and the realization of this right requires four core dimensions: accessibility, availability, financial accessibility and acceptability. However, it is argued that “the existence of such a right is not necessarily a proof of their actual enjoyment by those who are entitled to them” (Chuene and Mtapuri 2014:520). It suggests that some people are not actually realizing their human right to health care and therefore something should be done. This would be explained in the sense that there is a shared responsibility among different actors, ‘duty-holders’ and ‘rights-holders’ to realizing human right to health care for all. Accordingly, the 2003 Constitution of the Republic of Rwanda clearly states that people have the rights and duties relating to health and the State remains the duty-holder for mobilizing the population for activities related to promotion of good health and to help in implementing these activities (Article 41 of the Constitution).

There is a close relationship between HRBAs to health care and Universal Health Coverage (UHC) which is also a matter of international concern. According to WHO, UHC is defined as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (WHO. 2014). This explanation about UHC expresses three linked objectives which are: “equity in access to health services meaning that those who are in need of health services should get them, not only those who can pay for them; that the quality of health services is good enough to improve the health of those receiving services; and financial risk protection to ensuring that the cost of using care does not put people at risk of financial hardship”(WHO. 2014).

In that sense, it is argued that UHC represents a clear approach towards a better health and protection from poverty for a big number of communities mainly those in the most vulnerable conditions ‘poor’. In effect, UHC is definitely based on the 1948 WHO Constitution declaring health as a fundamental human right and on the agenda of health for all established by the Declaration of Alma-Ata 1978 ratified by many countries including Rwanda. Therefore, it is expected that the realization of health MDGs and the subsequent trend of targets looking beyond 2015 will essentially depend on how states progress in achieving the Universal Health Coverage (WHO. 2014). Nyandekwe M et al. discuss that UHC in health care, as determined solely by financing mechanisms and access to healthcare services has been achieved in 27 member States of the OECD. Encouraging progress has also been made in some low and middle-income countries, including Thailand, Sri Lanka, Rwanda, Cuba, Colombia and Chile (Nyandekwe et al. 2014).

According to Curtice and Exworthy, it follows that HRBAs to healthcare is centered on the idea that disregarding people’s human rights has negative

consequences on their health and the use of this approach can deliver enhanced quality of ‘person-centred’ healthcare and generally increase health outcomes (Curtice and Exworthy 2010:151). Thus, among other key aims of HRBAs to health care, “putting human rights principles and standards at the heart of policy and planning is very crucial just as empowering staff and patients with knowledge, skills and organizational leadership and commitment to achieve HRBA” (Curtice and Exworthy 2010:151). Equally, it is prominent that enabling active participation of the main actors including vulnerable groups in policy making and implementation as well as to ensure accountability would be very important to achieve HRBA to health care. This argument helps further to understand the interplay between a country’s international commitment and health care related policy and plans in moving towards health care as a human right.

To sum up, Human Rights-Based Approaches to health care and to Universal Health Coverage (UHC) rest on some basic principles; accessibility, availability, financial accessibility and quality of health services. In the next chapters, these criteria of RBHAs will be used to assess the contribution of the CBHI scheme, towards realizing the human right to health care of Rwandans.



## **CHAPTER 3: COMMUNITY-BASED HEALTH INSURANCE (CBHI)**

This chapter is mainly a literature review, which defines the CBHI concept, presents briefly an overview and synthesis of earlier studies that can explain the background to this concept and its key goals.

### **3.1 Background**

Many decades after several international commitments had been put in place to improve health care for the disadvantaged people, many individuals mostly in developing countries still suffer and lack access to primary health care. Due to the entrenched poverty, they are exposed to a variety of illnesses and health risks such as malaria, HIV/AIDS, diarrhea and epidemic diseases. Although it was unanimously affirmed that access to basic health services is a fundamental human right and hence “governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures....and primary health care is the key of development in the spirit of social justice” (Declaration of Alma-Ata, 1978).

However, until now the majority of the population are pushed into poverty to pay for health care and several States in developing countries have failed to realize health care necessities of their poor people. As a matter of fact, the real public sector per capita spending in health sector has been diminishing in Africa since the late 1970s. The budget support for health care services has been gradually reduced, public health provision inefficiencies and low quality of public health services have been increased, and due to the imposition of direct payment for health care services, States were unable to fulfill their duties towards their vulnerable people ‘poor’ (Jütting 2004:273). Equally, Ekman (2004) discusses that, the WHO (2001) reported the assessment of national health care expenses which shows that in the period of 1997-1999, a group of least-developed countries on average spent US\$11 per person per year, low-income countries spent US\$23 per person, the group of lower middle-income countries US\$93 per person, and US\$1907 per person in high-income countries. Yet, when it comes to the question as to how much a country should spend in financing health care, there is no certain answer in terms of share of gross income (Ekman 2004:249). Therefore, Jütting (2004) argues that the health care crisis in diverse regions of developing countries led to arrival of the CBHI schemes.

### **3.2 Definition and description of the CBHI Schemes**

The CBHI is one of the main modalities of community-based health care financing which has developed into an umbrella term that covers a wide range of health financing instruments. The CBHI refers to a non-profit health financing system providing health services to people within the informal sector in which the beneficiaries take part in both its management as well as cost

sharing with the purpose of reducing health risks (Musau 1999 cited by Jakab and Krishnan 2001:10). In Rwanda, the CBHI scheme is identified as *Mutuelle de Santé* and the Law on mutual health insurance scheme (2007) defines it as “solidarity system in which persons mutually come together with their families and pay contributions for the purpose of protection and receiving medical care in case of sickness” (Article 5, 1<sup>o</sup>). Other modalities of the community-based health care financing as defined below, include Mutual Health Organizations (MHOs) and Mutual Insurance Schemes, Community Financing and Micro-insurance (Jakab and Krishnan 2001:9).

On one hand, the MHOs are community and employment-based groupings that have increasingly grown in West and Central Africa in recent years. They are defined as insurance schemes for non-profit in which the members voluntarily join with the purpose of overcoming health risks. The main objective of the members is to improve access to good quality of health care services and actively take part in identifying health risks, resource mobilization and pooling as well as effective management of the scheme on the basis of solidarity and other democratic principles (Atim 1998 cited by Jacab and Krishnan 2001:10). This explanation articulates both the developing character and the wide-ranging schemes of mutual. The MHOs have similarities with Mutual Insurance Schemes which are associations of people based on voluntary basis and solidarity. However since members share a purpose that bound them together, they may in this case, be obliged to meet some obligations such as payment of certain premiums among others. Sometimes these associations are laid on the foundation of traditional beliefs and be guided by a formal system (Ziemek and Jutting 2000 cited by Jacab and Krishnan 2001:10).

On the other hand, Hsiao says that community financing is identified as scheme that has three features: “community control, voluntary membership, and prepayment for health care by the community members” (Hsiao 2001 cited by Jacab and Krishnan 2001:10). This explanation would ignore financing health systems such as community-managed direct payment program and compulsory social insurance scheme (Jakab and Krishnan 2001:10). Another modality of community-based health care financing is Micro-insurance schemes which are discussed as groups of individuals who organize themselves to mutually help each other in order to prevent and protect their health from various health risks. It is argued that the aim behind micro-insurance is that the populations left out have not been protected by the existing health insurance schemes due to two simultaneous reasons. Firstly, apart from important differences between private and social schemes, the insured members have not shown efforts to consider the excluded population. Secondly, excluded people are not empowered enough within community and therefore declined to claim access (Dror and Jacquier 1999 cited by Jacab and Krishnan 2001:10).

According to the above definitions, the community-based health care financing systems have common features. The central feature is that all of them indicate the significant role of community in mobilizing, pooling, allocating and managing health care resources. Secondly, these systems commonly describe the group of beneficiaries as those with no sufficient means, no access to financial protection or access to other health care financial arrangement. The third feature is the social values and principles encompassing voluntary participation, solidarity mechanisms and reciprocity (Jakab and Krishnan 2001:9-11). Consequently, I realize that all these systems are meant to be part of a wider answer to various health care financing problems in a number of countries largely those with low-income.

### **3.3 Goals of the CBHI Schemes**

Carrin (2003) argue that the WHO has considered final objectives of health system: “health status and health equality, responsiveness of health systems to people’s non-medical expectations and fairness in financial contribution” (Carrin 2003:5). Accordingly, it is claimed that financial contributions for health care are fair when health expenditures of households are distributed according to capacity to pay rather than to real expenses incurred as a result of sickness. Nevertheless, the analysis proved that it is not yet achievable to value the performance of community health insurances with reference to the above mentioned objectives. Therefore, besides retaining the goal of fairness, additional intermediate goals such as equity in utilization and sustainability are considered because of availability of their prevailing information (Carrin 2003:5). Therefore, I correspondingly argue that CBHI as one of the health financing systems that can not be looked at in isolation, requires also to be linked to the final objectives of the entire health system in order to realize health care needs for citizens.

There is a claim that previous studies showed that the lack of health insurance coverage appears to be at the center of the problem of accessing health care services particularly for the poorer groups and therefore contributes to the promotion of inequity in service use. Thus, CBHI serves the main objectives of health insurance specifically to increase access to health care services and to minimize the burden of disastrous health spending (Hartwig et al. 2012:3).

The CBHI is also seen as social protection and social risk management instrument. On one hand, the majority of the population especially in Africa are involved in informal sector and obviously most of them have no social protection. Therefore, it is discussed that social protection has been developed to expand ordinary social security protective measures for employees within the formal structure of employment, to include those persons in poverty, operating outside of that formal structure (Habiyonizeye 2013:13). On the other hand, researches show that the poor are the most vulnerable in society as they are exposed to natural and manmade shocks. As a result, they are likely to face dramatic

and threatening welfare consequences. Regarding health risks (illness), the poor in informal sector do not have access to structural provided income support and market-based instruments like insurance. Similar to this, they have not enough means to deal with the above mentioned risks. Thus, it is remarked that access to social risk management instrument helps the poor getting out of health challenges and hence give them an opportunity to progressively move out of poverty (Holzmann 2003; Holzmann and Jorgensen 2001 cited by Habiyonizeye 2013:13). This argument 'social protection and social risk management' remains crucial in this study ever since the CBHI scheme as one of social protection means, plays a significant role in protecting poor people against routine health risks.

However, the related empirical literature on CBHI still illustrates the gaps in implementing community-based health financing systems. For instance, Preker et al. (2001) in a synthesis report on 'role of communities in resource mobilization and risk sharing', argued that the main weaknesses of community financing systems consist of ineffective mechanisms in revenues collection from rural poor people, non-participants, who do not join because they are not able to afford the premiums, inadequacies of pooling risk, challenges of capacity to manage the schemes by those in rural areas and restricted access to the available comprehensive benefits like formal health financing schemes and other private health providers (Preker et al. 2001:22). Nevertheless, the analyzed literature evidenced that CBHI has a promising impact on health financing in developing countries.

## **CHAPTER 4: COMMUNITY-BASED HEALTH INSURANCE IN RWANDA: AN OVERVIEW**

This chapter presents the findings on CBHI in Rwanda. It deals with the development of CBHI, its organization and operational aspect. Toward the end of the chapter, the medical services covered by the CBHI Scheme and its sources of funding will be briefly discussed.

### **4.1 Contextual background**

Rwanda is a developing country that for the last ten years has made a tremendous progress in terms of socio-economic development (MINECOFIN 2013:1). Different policies have been put in place in order to achieve objectives of EDPRS and the MDGs. The Vision 2020 is the main guideline towards realization of those long-term objectives of the Rwandan Government. In health sector, the Government of Rwanda has gradually increased the budget allocated to this sector. The budget has been increased from 8.2% to 9.1% in 2005 to 2008 respectively. The rate has been also increased to 10.2% in 2009/2010, 11.5% in 2010/2011. It is reported that the allocation rate of all the budgets allocated to health in the public institutions was 16.05% in 2011-2012 and 15.5% in 2012-2013 (Rwanda Ministry of Health 2013:56).

It is emphasized that since health and poverty are closely related, the government' ambitions would be impossible to be achieved if there is no effective national health policy to improve the financial accessibility to health services. For that reason, "the CBHI was identified as a privileged channel for the evolution of financial accessibility to health services in both rural settings and in the informal sector" (Rwanda Ministry of Health, CBHI Policy. 2010:5).

### **4.2 Emergence of CBHI in Rwanda**

In Rwanda, before 1994 genocide that destroyed health infrastructure and disrupted other health care initiatives, the Rwandan vision for health care was reinforced by the Bamako Initiative of 1988 which was adopted by many Sub-Saharan countries with the aim of stimulating health care strategies and strengthening equity in access to health care through decentralization to the local levels (Habiyonizeye 2013:3-4).

After 1994, the government of Rwanda in partnership with various donors decided to deliver public health care services for free to all patients. However, two years later the Ministry of Health reestablished the old system of user charges or direct payment. During the period of 1994-1999, the country was threatened by the consequences of genocide, problems of poverty, worrisome HIV prevalence among the population groups and poor health outcome indicators, which factors influenced a fast drop of primary health care services. This situation of poor health system motivated the government of Rwanda to develop the CBHI policy in order to make accessible health care

services to the majority poor from informal sector. In collaboration with the population and USAID-funded Partnerships for Health Reform Project (PHR), in January 1999 the Rwandan Ministry of Health started the process to pilot test fifty four prepayment schemes in three former districts of Kabutare, Byumba and Kabgayi. At the end of first year of operation, the results of pilot programme were promising to the extent that the fifty four schemes involved more than eighty eight thousand members (Schneider and Diop 2004:251-252).

Following the encouraging results of the pilot programme in improving the access to health care services and reducing financial risks, efforts to launch more CBHI schemes, known as *Mutuelle de Santé*, increased progressively from 2000, and by 2005, when the *Mutuelle de Santé* scheme in its current form was formally launched, the CBHI had reached every part of Rwanda, including Gisagara District. Subsequently, enrolment into *Mutuelles* increased nationally (Hartwig et al. 2012:4). Presently, the legal framework of CBHI is provided by the Law N° 62/2007 of 30/12/2007 establishing and determining the organization, functioning and management of mutual health insurance schemes. This law stipulates that health insurance is compulsory for every person residing in Rwanda (Article 33). It is argued that this provision seems to have contributed to the remarkable increase in the rate of enrollment between 2007 and 2010 (Hartwig et al. 2012:5). However, there seems to be a challenge of sustainability, judging from the data, with evidence that those attracted to enroll in CBHI may not be able to maintain their enrolment over time. Table 3 below shows the rate of enrollment in *Mutuelle de Santé* from 2007 to 2013/2014:

**Table 3: Rate of enrollment in CBHI at national level**

Year	2007	2008	2009	2010	2011/12	2012/13	2013/14
Rate of enrollment (%)	75	85	86	91	90.7	80.7	73

*Source: Rwanda Ministry of Health, 2014.*

The table above shows that the rate of enrollment increased significantly from 75 per cent in 2007 to 91 per cent in 2010. But from 2011/12, the rate of enrollment decreased considerably from 90.7% to 73% in 2013/2014. On one hand, the Ministry of Health through its Health Financing Unit declared that:

*“While it remains ambiguous as to why enrolment in Mutuelle de Santé has dropped, the decline of subscription to CBHI can be analyzed in two hypothetic causes: Firstly, in 2006 the contribution was 1000 Rwf per member of the household per year and in 2010 the Government of Rwanda adopted a new CBHI contribution scheme based on social economic stratification (categories of Ubudehe) which increased household contributions; The second hypothesis is that from 2006, the Ministry of Health has been using non-updated population census and statistical*

*mistakes could have been made in earlier data about the CBHI coverage rate*” (Interview with Director of Health Financing Unit, Ministry of Health on 01<sup>st</sup> September 2014).

On the other hand, RSSB argues that after implementing the new policy on CBHI in 2011, the CBHI scheme has confronted various challenges particularly in terms of coverage and financial gaps. It is noted that even though there is considerable evidence indicating the positive impact of CBHI, the main challenge that is currently on top is the problem of its sustainability. For these reasons, the Cabinet meeting of April 28<sup>th</sup> 2014 tasked the Ministry of Finance and Economic Planning, Ministry of Local Government and Ministry of Health to conduct a study related to CBHI poor performance. Therefore, from July 2014 the research intended to come up with root causes of CBHI deficit and aiming at providing clear strategies to ensure its sustainability was launched and nowadays being carried out by RSSB which took over the responsibilities of managing the CBHI (Rwanda Social Security Board 2014). In view of this, the research being conducted in 2014 will be expected to meet the following objectives:

“evaluate whether the CBHI’s current contribution mechanism based on *Ubudehe* categorization is appropriate, identify root causes for non-adherence to the CBHI scheme by some Rwandans, assess the CBHI’s sensitization system, assess insurance related risks (fraud, cost escalation, moral hazard, etc.), assess the level of satisfaction of CBHI members on service provided by the scheme, analyze the benefit package provided to CBHI members and its level of availability at all the health care pyramid, assess appropriateness of the copayment structure and finally design the strategies and recommendations to ensure the CBHI financial sustainability as well as institutional and organizational arrangements” (Rwanda Social Security Board 2014).

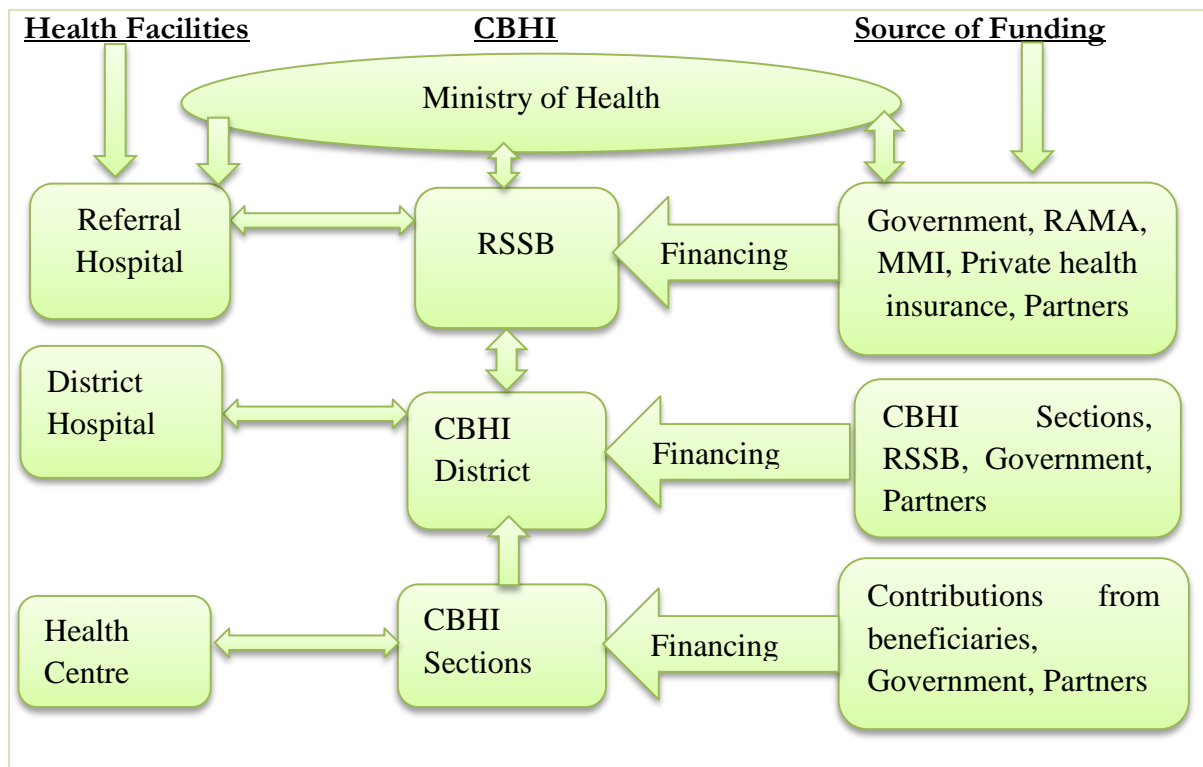
### **4.3 Organisation and operational aspect of CBHI**

The organisation and functioning of the CBHI schemes in Rwanda are provided by the law on mutual health insurance<sup>5</sup>. According to this law, mutual health insurance schemes are autonomous organisations operating in each district and coordinated at the Fund “*Fonds de Mutuelle de Santé*” which has its headquarters at the level of the district and managed by a director appointed by Order of the Minister of Health. The overall structure is shown in Figure 1:

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<sup>5</sup> Law N° 62/2007 of 30/12/2007 establishing and determining the organization, functioning and management of the mutual health insurance scheme.

Figure 1: Organizational structure of CBHI



Source: Author's own figure, based on information from Ministry of Health, 2014.

As Figure 1 highlights, within the overall organizational structure of CBHI, the Ministry of Health is the supervising authority and provides support to the CBHI schemes. Thus, the National Pooling Risk mainly funded by the Government and other existing insurance schemes, was established and this fund was used for paying services offered by referral hospitals (Hartwig et al. 2012:5). However, on 28 March 2014, the Government of Rwanda through its Cabinet meeting<sup>6</sup> approved the transfer of the management of CBHI to the RSSB. This decision resulted from reported failures of the National Pooling Risk of the Ministry of Health.

According to the formal policy, CBHI is mainly intended to serve local communities, with the focus being on those outside the public sector. The CBHI schemes coordinated at the district level are decentralized to the grass-roots. At the sector level, there is at least a health centre that provides primary medical services and a *Mutuelle* section managed by an administrator. The section collects contributions and sensitizes the population around the need for enrollment,

<sup>6</sup> Statement on Cabinet Decisions of 28/03/2014 is available at [http://www.primature.gov.rw/publications/pointer/0.html?tx\\_mmdamfilelist\\_pi1%5BgetSubFolders%5D=fileadmin%2Fuser\\_upload%2Fdocuments%2FCabinet%20Decisions%2F2014%20Cabinet%20Decisions%2FEnglish%2F&tx\\_mmdamfilelist\\_pi1%5Bgetsubfolders%5D=fileadmin%2Fuser\\_upload%2Fdocuments%2FCabinet%20Decisions%2F&cHash=43141484457e7f2a321449470c0225a5](http://www.primature.gov.rw/publications/pointer/0.html?tx_mmdamfilelist_pi1%5BgetSubFolders%5D=fileadmin%2Fuser_upload%2Fdocuments%2FCabinet%20Decisions%2F2014%20Cabinet%20Decisions%2FEnglish%2F&tx_mmdamfilelist_pi1%5Bgetsubfolders%5D=fileadmin%2Fuser_upload%2Fdocuments%2FCabinet%20Decisions%2F&cHash=43141484457e7f2a321449470c0225a5), Accessed July 20, 2014.



within cells and villages. In every village, cell and sector, members of the CBHI schemes are empowered to participate in management of *Mutuelle* sections through their mobilization committees for the CBHI activities. Each committee is composed of members elected by the population for a two year renewable mandate (Rwanda Ministry of Health, CBHI Policy. 2010:7). This point is to be appreciated because it shows that the population who are the ‘right-holders’ and key actors participate actively in implementation of the CBHI policy that affect their daily life.

The members of CBHI contribute annually according to the six categories based on *Ubudebe* system that categorizes the population on the basis of their financial means. The contribution is individual even though the whole household is enrolled to circumvent the risk of divergent selection. This system considers the low purchasing power of the great majority of the Rwandan population through grants provided by the government and its development partners (Rwanda Ministry of Health, CBHI Policy. 2010:7). For the CBHI contributions, the first group pays an annual premium of 2,000 Rwf<sup>7</sup> equivalent to approximately \$ 3. This group includes the most vulnerable and poor whose contributions are paid by the Government or development partners. The second group pays 3,000 Rwf; and the third group pays 7,000 Rwf for every person (Rwanda Ministry of Health, CBHI Policy. 2010:11). The categories of *Ubudebe* and CBHI are presented in Table 4.

**Table 4: CBHI population categories and corresponding fees**

Ubudehe Categories	CBHI Categories	Amount per capita (Rwf)
1 & 2	One	2000
3& 4	Two	3000
5 & 6	Three	7000

**Source: Ministry of Health, Annual Report: Community Based Health Insurance, 2012.**

The 2012 CBHI annual report highlights that in the year 2011/2012, 24.8% of the Rwandan population were placed into the CBHI category One, 65.9% into category Two and only 0.04% of the population was placed into categories Three of *Ubudebe* (Rwanda Ministry of Health 2012:12). Comparing with households surveyed in this study, only category One and Two are more involved into CBHI schemes, being largely the population in rural areas. According to the CBHI policy, this stratification process helps to improve the long term financial sustainability of the CBHI scheme and the fairness in contributions because before the new system of categorizing people according to the household wealth, the poor and rich were contributing the same amount.

<sup>7</sup> According to the National Bank of Rwanda, the exchange rate of 1 USD is 696.38 Rwf as per November 2014.

In addition to the household contribution, a co-payment (*ticket modérateur*) is requested from those enrolled at the time of health service utilization (Rwanda Ministry of Health, CBHI Policy. 2010:8). Actually, this co-payment is two hundred Rwandan francs as pointed out by many of respondents in Gisagara District.

#### **4.4 Medical services covered by the CBHI Scheme and sources of funding**

The CBHI scheme covers medical services at all three levels of health service provision. These are Health Centre, District Hospital and Referral Hospital (Rwanda Ministry of Health 2010:8). At the health centres, the medical services package provided by CBHI comprises vaccination, consultation with doctors, maternity care, nursing care, medication, physiotherapy, dental care minor surgery, laboratory analyses, radiology and scanning and transportation to the hospital (Law on mutual health insurance scheme, article 30). Though, for other complex hospital treatment, insured patients can be given a package of additional services and pay a contribution of 10 per cent of the total cost of the service delivered. The CBHI covers all drugs in health centres and hospitals. Occasionally, when the drugs are not available in public health facilities, the members of CBHI scheme will be obliged to buy them from private pharmacies, costs not covered by CBHI sections (Sebatware 2011:20).

Although CBHI delivers a complete benefit package, there are still challenges at different levels. According to the Rwanda National Health Insurance Policy, CBHI system relies on the contributions of households who are relatively poor. Also, the availability and comprehensiveness of products, commodities, and services for treatment at hospitals and health centres needs to be enhanced. “It is common practice for drug prescriptions for insured patients to be filled in private pharmacies without reimbursement. And, there is a claim that co-payments at the district and referral hospitals remain a burden for poor, enrolled patients” (Rwanda Ministry of Health 2010:10). According to the new system of the CBHI management under the RSSB, there is promising steps showing that some of the above challenges will be overcome.

Regarding sources of CBHI funding, the Law on the mutual health insurance scheme provides for sources and composition of the property of mutual health insurance fund. That property is composed of movable and immovable assets including contributions from members, grants from the District, Government subsidies, grants from National Guarantee Fund of the CBHI which has been replaced by the RSSB, grants from donors, interests from CBHI bank deposits, donations and other source that may be approved by the CBHI Board of Directors (Article 37). Reference to the 2012/2013 annual report of the Ministry of Health, CBHI system depends mainly on its members simply because 66% of the total CBHI funding is from the contributions of the members while the government and other actors contribute only 34% (Rwanda Ministry of Health 2013:61). In my point of view, this is relatively regarded as

strength of the CBHI system in Rwanda because the system is basically owned by the population, beneficiaries.

Furthermore, it is to be underlined that the CBHI scheme complements other existing social insurance systems in Rwanda, such as *La Rwandaise d'Assurance Maladie* (RAMA) which is a civil servant health insurance in Rwanda and Military Medical Insurance (MMI) which covers servicemen and their dependents, and other private insurance schemes targeting employees from the formal economy and private sector. These schemes also constitute other funding sources of the CBHI at the national level (Rwanda Ministry of Health, CBHI Policy. 2010:5).

## **CHAPTER 5: CBHI AT COMMUNITY LEVEL: *UBUDEHE* AND BEYOND**

Some results of this research were already presented in the previous chapter, which outlined the CBHI system as it operates in Rwanda, in general. In this chapter, the focus is on community-level implementation in Gisagara District. It considers the health care system and the role of different actors in implementation of CBHI to improving health care services in the Gisagara District.

### **5.1 Health Care system in Gisagara District**

Health sector as one of areas of priority in Gisagara District needs actions and efforts from different actors. According to the District Development Plan, improving health infrastructures and health insurance system, enhancing community health service through building capacities of community health agents are the main actions to ensure qualitative health care services (Gisagara District 2013:38).

The District of Gisagara has two district hospitals namely Kibilizi Hospital serving a total population of 191,764 people, and Gakoma Hospital serving a population of 145,870. Kibilizi Hospital is actually serviced by 9 Medical Doctors while there are 6 in Gakoma Hospital. Under these hospitals, there are 14 Health Centres operating in 13 Sectors composing the District. This means that at the level of each Sector there is at least one Health Centre. Kibilizi Hospital covers 10 Health Centres and 4 others are under Gakoma Hospital. To facilitate access to health care services, a number of 4 Health Posts have been set up in some sectors where the access to health care facilities would be complicated due to the long distance between households and health Centres (Unpublished document provided by staff of Gisagara District, Health Department 2014).

Community Health Service is another important aspect supporting different levels of health sector. It is organized from the District, Sector, Cell to the Village (*Umudugudu*) level. At the district and sector levels (Health Centre), there are staff who are civil servants in charge of health; they coordinate other community health workers operating as volunteers at the levels of sector, cell and village. In Rwanda, community health workers are considered as key in health sector mainly to improve maternal and child health. They work in collaboration with Hospitals, Health Centres and Posts (Unpublished document provided by staff of Gisagara District, Health Department 2014). One of the interviewed community workers in Gisagara District highlighted that their main duties include sensitizing families of their different areas about basic health needs, maternal and newborn care, family planning and subscription to the CBHI scheme (Interview with Health Worker, 21<sup>st</sup> August 2014).

From 2007, health care system in Gisagara District is also supported by different NGO's assisting in various aspects of health care. These are for instance CARE International/COMBAR and CONCERN supporting people infected with HIV/AIDS, women and children's health and nutrition; ARBEF and *Croix Rouge Rwandaise*, assisting children heading households by paying insurance scheme (*Mutuelle de Santé*) contributions for them, family planning and voluntary HIV/AIDS test; Health Unlimited (*Irirwa* and *Urunana*) assisting in raising people's awareness in general through training; and GIZ/Santé that provides basic health services (Unpublished document provided by staff of Gisagara District, Health Department 2014).

## 5.2 CBHI in Gisagara District

CBHI in Gisagara District is organized and implemented according to the law on mutual health insurance. Like in other areas of the country, citizens are encouraged to join the Mutual Health Insurance scheme in order to access health services easily and less costly. Some measures have been agreed upon to promote insurance scheme, *Mutuelle de Santé*. These include for example organizing regular meetings and trainings for local leaders, *Mutuelle de Santé* committees, community health workers, and the population with the aim of motivating them to join *Mutuelle de Santé* associations. *Ibimina* (tontines) as a mechanism of collecting premiums have been formed and this proved to be very helpful for individuals with limited financial resources (Nyandekwe et al. 2014).

In collaboration with the Central Government and donors, the poorest households are assisted to paying contributions. By the year 2013/14, a number of 98,103 population equivalent to 31% of the total population of Gisagara District were under category 1 and 2 of *Ubudebe*, which means that they are supported by the government and partners in as far as *Mutuelle de Santé* is concerned (Unpublished document provided by staff of Gisagara District, Direction of *Mutuelle de Santé* 2014). Although some challenges remain to this end, the highlighted initiatives have helped to improve the level of public participation in *Mutuelle de Santé*. The table below shows the rate of participation by the population of Gisagara District in *Mutuelle de Santé* from 2010 to the financial year 2013/2014:

**Table 5: Participation by the population of Gisagara District in *Mutuelle de Santé***

Year	2010	2011/12	2012/13	2013/14
Rate of participation (%)	66	72.9	80.8	77

*Source: Gisagara District, Direction of Mutuelle de Santé 2014.*

The Table 5 presents that the rate of enrollment is high but this has declined from 80.8% in 2012/2013 to 77% in 2013/14. At the time of the field

work in August 2014, two months after the beginning of financial year 2014/15, the overall rate of enrollment in Gisagara District was less than 50% of expected members. This indicates the tendency to drop off again. There are different reasons for non-participation by some households according to qualitative data as presented in the following section.

### 5.3 Population's experience and causes of non-participation

Like in other districts, the rate of participation in Gisagara District has dropped for the same reasons mainly, increasing contribution of one household member from 1000 Rwf to 3000 and 7000 Rwf basing one categories of *Ubudebe*. On the side of officials, the Director of *Mutuelle de Santé* puts forward that:

*“The increase of the CBHI contribution per year may have affected the progress of the programme but we cannot ignore that there are some people whose mindset should change. They think that the government must pay the health insurance for all communities. Others do not understand the importance of CBHI until they get experience from sickness.”* (Interview with Director of *Mutuelle de Santé*, Gisagara District on 18<sup>th</sup> August 2014).

Equally, in their interview with Rwandan media<sup>8</sup>, officials said that:

*“It's all about people's mindset. Changes are naturally difficult for people to accept but some have already understood that the new premium will help improve the healthcare services they receive and have created measures to save money for Mutuelle. It will require new energy and new strategies before everyone can understand why the Mutuelle fee was increased and we are working on it”* (The Mayor of Rulindo District in interview with The New times Newspaper, 31<sup>st</sup> July 2014).

Similarly, the Minister of State for Community Development and Social Affairs, argued that:

*“the increase of contribution into Mutuelle since 2012, from 1000 Rwf to 3000 Rwf may have dragged down subscriptions as some Rwandans may have found the charges too high or are still pondering on whether to pay that much or not”* (The Minister in interview with The New times Newspaper, 31<sup>st</sup> July 2014).

The above statements by officials at district and national levels put forward the increase of CBHI individual contribution to be the cause of the CBHI decline. This suggests that households' financial means seem to be limited to afford the cost of insurance. The hospitals expressed their worries about the possible negative impact of the CBHI deficit because the majority of their patients are those enrolled into *Mutuelle de Santé*. It was stated that:

*“There has been much sensitization about the importance of the health insurance but, the number of people registered is so far low...we risk running short of drugs because people don't pay for what they take. When restocking of medicine fails, we shall only be doing examination and send patients to*

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<sup>8</sup> <http://www.newtimes.co.rw/section/article/2014-07-31/176/>, Accessed August 18, 2014.

*buy prescribed medicine outside*” One Medical Doctor said in interview with The New Times Newspaper, 31<sup>st</sup> July 2014.

On the side of the population, interviewed households acknowledged the role of *Mutuelle de Santé* for having helped them to access health care services. As our respondents were twenty households sample, the tables 6 and 7 below present the results of interviews.

**Table 6: Results of household interviews**

Household Number	Category of <i>Ubudehe</i>	Source of household income	Insured (Yes/No)
1	3	Agriculture	No
2	2	Agriculture	Yes
3	3	Agriculture	Yes
4	3	Agriculture	No
5	3	Agriculture	No
6	3	Agriculture	No
7	3	Agriculture	Yes
8	2	Agriculture	Yes
9	3	Agriculture	Yes
10	3	Agriculture	Yes
11	3	Agriculture	No
12	2	Agriculture	Yes
13	3	Agriculture	Yes
14	3	Agriculture	Yes
15	3	Agriculture	Yes
16	3	Agriculture and Informal trading	Yes
17	3	Agriculture	Yes
18	2	Agriculture	Yes
19	3	Agriculture and construction	Yes
20	3	Agriculture	No

The Table 6 shows that four respondents are under category Two of *Ubudebe* and as discussed earlier, this category is supported by the government. Sixteen respondents are under category Three and are supposed to pay health insurance by themselves. Among them, six equivalent to 30% of the respondents were not yet insured at the time of the field research. The main cause pointed out by non-participants is financial constraints. Table 7 below refers to the information in Table 1 and 6, and summarizes the level of understanding, views about *Mutuelle de Santé* and challenges faced by its members and non-participants:

**Table 7: The views of the population in relation to the CBHI functioning in Gisagara District**

Views of the rural community	Frequency (out of 20)	Rate	Comments
We are aware that <i>Mutuelle</i> helps to access health care services at the lowest cost.	19	95 %	Due to the mobilization program and experience, people understand the benefits of the CBHI scheme.
We do not agree with the system of category of <i>Ubudebe</i> (unfair, not transparent).	8	40 %	Failure to pay contributions into <i>Mutuelle</i> leads to claim for revising the categories of <i>Ubudebe</i> under which households are registered.
We are not able to pay health insurance ( <i>Mutuelle</i> ) because individual contribution has excessively increased.	6	30 %	The majority of those who fail to pay the CBHI contributions are the households having between six and eight members (see Table 2 and 6). This gives the impression that the cost of household CBHI contribution becomes unaffordable for households with large number of family members.
We are given poor health care service comparing to those with other insurance schemes (RAMA, MMI, etc.).	4	20 %	The raised problem is related to the time spent at the Hospital or Health Centre and also the fact that CBHI does not work with private pharmacies. Although, some medical services like drugs may not sometimes be available at public health facilities.
We are aware that we can claim for our right in case of poor health care service by health facilities.	2	10 %	In general, people do not claim in case of poor service or when some concerns are not solved by health providers. The right to health care seems to be a new concept in rural communities.

According to the Table 7, the population even those who are not enrolled in *Mutuelle de Santé*, have a positive understanding on the importance of the CBHI scheme. For illustration, one parent responding to the question of importance of *Mutuelle de Santé* reacted:



*“Mutuelle is good because any time one of the members of my family falls sick, I can go to the nearest Health Centre and get medical services for only 200 Rwf. Reason why paying CBHI household contribution is a priority of the family”* (Interview with Household 9, 20<sup>th</sup> August 2014).

Another woman of 79 years old responded: *“If I exist today, it is because of Mutuelle and God. Before buying clothes, I initially have to make sure that I paid for Mutuelle”* (Interview with Household 13, 21<sup>st</sup> August 2014).

Above all, people who got experience from illness are the ones who understand more about the role of *Mutuelle de Santé*:

*“In 2012, my son got sick and we had no health insurance. The only solution was to sell off our cow so that we managed to pay for medical services. Today, I can’t live without Mutuelle for my family”* (Interview with Household 16, 22<sup>nd</sup> August 2014).

However, some of the households pointed out the challenge of limited financial means to afford the cost of *Mutuelle*:

*“As you can see, this is a large family of 8 persons, I have no monthly income and I always struggle for feeding children and pay for their school fees. We have been put in category 3 of Ubudebe, it is really unfair, I can’t afford getting twenty four thousand Rwandan francs for Mutuelle because it is a lot of money for a poor household like this”* (Interview with Household 4, 19<sup>th</sup> August 2014).

Another household representative said that:

*“I know Mutuelle is good, you get medical services easily and you feel comfortable once you have paid. However, I have no means to pay fifteen thousand Rwandan francs since they do not even allow us to pay contribution for two of us”* (Interview with Household 6, 20<sup>th</sup> August 2014).

Equally, it was pointed out that the system of *Ubudebe* is unfair and not transparent for some respondents:

*“We are six persons in this family and now we are no longer subscribed in Mutuelle. Before we were under category 2 but in 2012, we have been removed from the list of the poorest and they do not tell us why. Indeed that system is unfair and not transparent”* (Interview with Household 1, 19<sup>th</sup> August 2014).

This opinion of was supported by other respondents including those who are able to pay CBHI contribution. According to the Table 7, 40% of the respondents do not necessarily appreciate the functioning of *Ubudebe* system.

It was found out that in rural communities for a household of six members or more, it is a big challenge for them as peasants<sup>9</sup> without means to

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<sup>9</sup> They live through agricultural activities and largely on a subsistence level as it is highlighted in the Table 6.

pay the amount of three thousand for every family member. Most of interviewed health workers highlighted that the main challenge for people to subscribe for *Mutuelle de Santé* remains that of limited income:

*“Some of households cannot afford the cost of insurance. We hope that categories of Ubudebe will change and correspondingly include those poor families in category 2 where they will be able to be supported by the Government”* (Interview with Health Worker, 25<sup>th</sup> August 2014).

Officials interviewed about the mentioned problem, agreed that some errors might have been made in categories of *Ubudebe* but they argue that the process for correction has already started. Generally, officials are aware of challenges in implementation of CBHI and measures have been taken to address them. On the other hand, the population beneficiaries of the scheme appreciate the importance of *Mutuelle de Santé* and understand their role for the success of the CBHI program. However, people’s awareness about their right to health care remains questionable since the majority of the respondents (90%) have no idea of what that right entails in general and can’t claim it. Consistently, previous research about the UHC in Rwanda proved that the right to necessary health care is a new concept in sense that many patients ignore their rights when they are given poor service by health care providers (Nyandekwe et al. 2014).

The main impact of CBHI decline consists of weakened access to health care services. Kibilizi Hospital shows that the frequency by the population to health care services at this hospital increased until 2012 for two reasons as declared the Director of Kibilizi Hospital in interview on 26 August 2014; *“There has been improvement of awareness of the population to use health care services and also the arrival of health insurances mainly Mutuelle de Santé”*. However, in two consecutive periods the rate of frequency has gradually dropped as highlighted in Table 8 below:

**Table 8: Frequency by the population to health care service at Kibilizi Hospital**

Period	Population	New cases - Out Patient Diseases	Insured- <i>Mutuelle de Santé</i> or other insurance members	Insured (%)	Frequency (%)
2012	182644	7037	3970	56.4%	3.9
2013	195314	7034	6521	92.7%	3.8
2014	195314	4590	3979	86.7%	2.4

*Source: Kibilizi Hospital, 2014.*

The Table 8 shows that the frequency by the population to use health care services decreases from 3.9%, 3.8% to 2.4 in 2012, 2013 and 2014 respectively. Even if at the time of collecting data (August 2014), the year was not yet ended but the tendency is that the frequency will also decrease at the end

of the year 2014. According to the Hospital, at least 85% of their insured patients are members of the CBHI scheme (Interview with Data Manager of Kibilizi Hospital, 26 August 2014). I therefore argue that the decline of frequency in health care utilization by the population would equally reside in the CBHI enrollment shortage in the District as the rate of subscription to the scheme also declines countrywide.

In summary, this chapter explored experiences of rural households in Gisagara District. CBHI scheme is genuinely supported by the population and as major finding, the rate of enrollment is relatively good and this fact helped communities access to health care. However, it highlights the challenge of sustainability of CBHI system since 23 percent are non-participants due to the limited financial means. This challenge is linked to the decline of CBHI system with the impact of decreasing access to health care services.

## **CHAPTER 6: CBHI AND THE REQUISITES OF HRBAs TO HEALTHCARE**

This chapter reviews and reflects on the analytical findings of the previous two chapters, and asks whether CBHI is an adequate means of ensuring the human right to health care for rural Rwandans. The chapter extends the analysis by considering the role of Government and of citizen participation in making CBHI more effective as a means to access health care rights for rural Rwandans. This chapter emphasizes the contribution of CBHI in achieving accessibility and affordability of health care services, fundamental pre-requisites for moving towards improved realization of the human right to health care. The chapter also returns to the question of how to overcome barriers to participation among the poorest citizens in rural Rwanda in relation to CBHI enrollment.

### **6.1 Progressive realisation of health-related rights**

Rwanda as member of WHO has signed and ratified a number of international human rights instruments concerning the right to health<sup>10</sup>. These include the UDHR, ICESCR, CEDAW, CRC, ICERD, Declaration of Alma Ata 1978 and the African Charter on Human and Peoples' Rights. The Constitution of the Republic of Rwanda also recognizes the right to health. Following this tremendous international commitment on the right to health in general, it is reminded that under the obligation to respect, any State must refrain from denying or limiting equal access for all persons including vulnerable groups to preventive, curative and palliative health services. The obligation to protect includes among other duties of the States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that health care services and health facilities of good quality are available, accessible and acceptable for all especially the poor (General Comment 14). To fulfil the stated commitments, the Government of Rwanda adopted several health related policies including Rwanda Health Financing Policy (2009), Rwanda National Health Insurance Policy (2010), and the CBHI policy (2010) which is implemented countrywide (Rwanda Ministry of Health, 2014).

The HRBAs recommend that in realizing human right to health care, a special attention should be given to the individuals, poor communities whose active participation in health related policies that affect their lives is considered as an essential condition. It also requires effective, transparent and accessible monitoring and accountability mechanisms on behalf of the government.

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<sup>10</sup>See <http://www1.umn.edu/humanrts/research/ratification-rwanda.html>, Accessed September 18, 2014.

## **6.2 CBHI and Role of the Government of Rwanda**

This section mainly presents steps undertaken towards realizing the right to health care by the Government of Rwanda through the CBHI. It considers the findings of the research with particular emphasis on Gisagara District as a case study.

### **6.2.1 Strengthening and supporting CBHI implementation**

In addition to the decentralized health facilities, a number of strategic interventions have been put in place by the government in order to strengthen CBHI implementation at different levels. To start with the legal framework of CBHI which is taken as first step appreciated for the reason that the Law N° 62/2007 of 30/12/2007 on mutual health insurance scheme enlightens how CBHI is organized and managed, provides the package of services, rules of membership and the mechanisms of financing the CBHI scheme.

Secondly, the CBHI system is intended to ensure equity and solidarity among the members who contribute according to their capacities. This research showed that equity and fairness principles in paying CBHI contributions were achieved through introducing the system of stratification that categorizes CBHI members in three categories (See Table 4) which consequently led to the households' contribution based on the financial means to afford the cost of health insurance. In order to sustain the system financially, the government and partners provide subsidies to covering the costs of health care for CBHI members particularly the poor communities.

The study shows that the Government of Rwanda pays CBHI contributions for 98,103 poor people equivalent to 31% of the total population of Gisagara District. However, the analysis of this research shows the gaps still persist in the *Ubudebe* classification system, which defines who is poorest, and involves the government in paying CBHI contributions for the households defined as unable to pay due to poverty. It was highlighted that 40% of the respondents did not agree with the *Ubudebe* system, because of concerns with fairness and transparency. One can conclude that those who fail to pay contributions for whatever reasons, may be the same people who will tend to accuse the system of being unfair. However, according to the findings of this study 30% of respondents were not insured at the time of the field research. This means that even some insured respondents were not necessarily fully satisfied with the functioning of *Ubudebe* system (40 per cent of the total in the small sample of households). From this perspective, it does seem that there are a number of (non-insured) people who feel they are being left out and are not fully realizing the right to health care.

### **6.2.2 Reinforcing the management of CBHI**

The CBHI system in Rwanda is decentralized in order to serve the local communities who are mostly targeted. The new organizational chart (Figure 1)

shows that from Sector level to the District, a number of *Mutuelle* sections working with health facilities have been set up. At the national level, the management of CBHI is assigned to the RSSB which replaced the former National Pooling Risk because of its earlier failures. It is expected that the RSSB as a government institution that generally deals with social security needs of all Rwandans, will put in place strong strategies to ensure the financial sustainability of CBHI as well as its organizational and institutional arrangements (Rwanda Social Security Board 2014).

The Ministry of Health points out that to reinforce the management of the CBHI schemes, the government's role is extended to the institutionalization of internal and external audit systems for strengthening financial and administrative management of CBHI at all levels (Rwanda Ministry of Health, CBHI Policy. 2010:11). I equally discuss that these initiatives and other actions to improve the functioning of CBHI in Rwanda are in line with the State's commitments to promote access to health care under article 41 of the Constitution of Rwanda and article 12(1) of the International Covenant on Economic, Social and Cultural Rights.

### **6.3 Key Finding: the role of public participation in CBHI implementation**

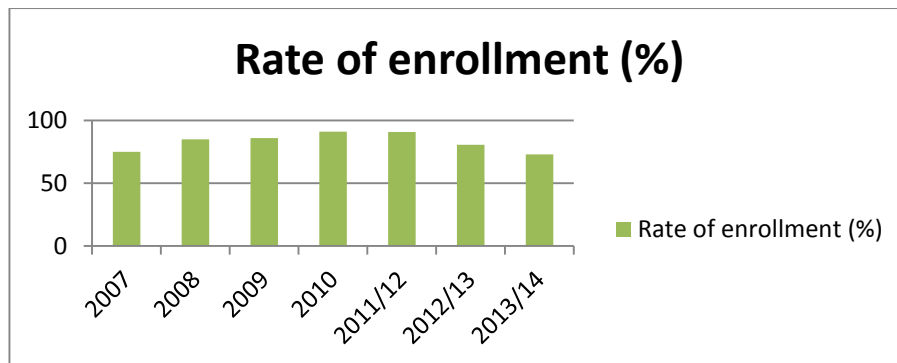
Arising from the HRBA perspective adopted in this study, one finding is that community participation does seem to play an important role in the sustainable implementation of CBHI within Gisagara. Perhaps this applies more widely in Rwanda, and can help to ensure that CBHI is kept more effective and responsive to the health care needs of the poorest sectors of the local community. It is said that to support the CBHI members to actively participate as key actors and right holders, tools like internal regulations, statutes and community participation modules have been given to the CBHI sections in Rwanda (Rwanda Ministry of Health, CBHI Policy. 2010:12). Accordingly, this research found that the local community in Gisagara District mostly agreed that CBHI was important and contributed to their social well-being and the realization of their right to health care.

CBHI members are involved in the management of the CBHI schemes, in sensitization of others within their local communities about its importance, and also they monitor and evaluate the system through committees at sector level. However, the capacities of the CBHI committees to carry out their duties are questionable since the majority of CBHI members are poor people with low levels of literacy, who may not be accustomed with the idea that they have a right to health care. Thus, for local committees to be able to monitor the quality of health care services delivered to the CBHI members, may require some capacity building among committee members. Nevertheless, it is claimed that the continuous role of the population has significantly contributed in progressive increase of enrollment until 2010. On the other hand, this increase

is associated to the provision of the law on CBHI that makes the health insurance compulsory in Rwanda (Hartwig et al. 2012:6).

The results of this research showed that at the national level the rate of enrollment to the CBHI dropped off dramatically from 91% in 2010 to 73% to 2013/14, as underlined in the following graph.

**Figure 2: CBHI situation at the national level**



*Source: Ministry of Health, 2014 (Author's own figure)*

In Gisagara District, the decline of CBHI adhesion started in 2012/13 where the rate dropped from 80.7% in 2012/13 to 77% in 2013/2014. Consequently, this controversial shortage affected the use of health care services by the population. The case of Kibilizi Hospital has revealed that the decrease of frequency in accessing health care service by the patients is due to the drop of CBHI enrollment although 85% of insured patients are members of *Mutuelle de Santé*.

Therefore, one may confirm that CBHI is actually helping local communities to access affordable health care service, as a right. This conclusion is basically drawn from the current rate of enrollment 73% at the national level and 77% in Gisagara District particularly. But still, the sustainability of CBHI will require more to be done, in the near future. Therefore, it will be crucial for government to intervene with strategies for overcoming the challenge of stagnant levels of enrollment. On the positive side, this study has revealed that most local people are very well aware and appreciate the benefits of being in a *Mutuelle de Santé*. The study has also suggested that non-participants of around one quarter of the population, who fail to enroll for the CBHI, is mainly due to limited financial means, which can result in dissatisfaction with the health care system among those unable to pay.

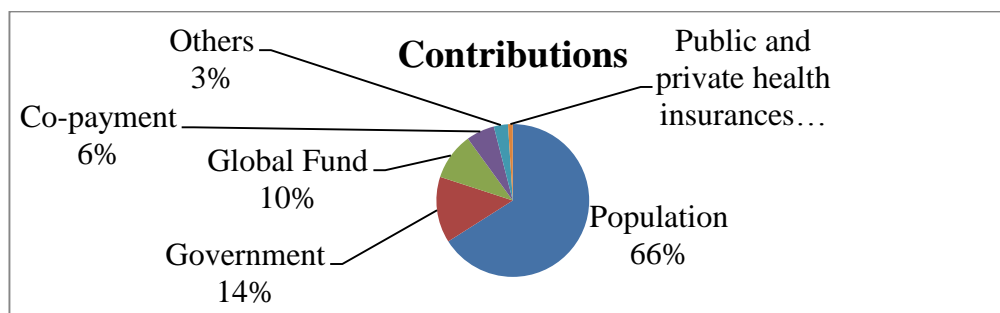
#### **6.4 The potential contribution of actors' participation to CBHI funding**

This research presented that the main actors in CBHI policy implementation are the government of Rwanda, RSSB, private health insurances, development partners and the population beneficiaries. These actors are divided in two categories which are Duty-bearers and Rights-holders. The

effectiveness of CBHI depends on inclusive and participatory role of each actor. To assess the financial contribution of the actors, I referred to the annual report of the Ministry of Health 2012/2013 that highlights the achievements of CBHI in terms of financial revenues and expenditures.

The report shows that on one hand, the district revenues increased from 10.501.714.022 Rwf in 2011/2012 to 14.586.998.668 Rwf in 2012/2013. But the expenditures exceed the revenues as the deficit registered was 887.108.401 Rwf in the financial year 2012/2013. On the other hand, the revenues of National Pooling Risk increased from 3.441.011.364 Rwf in 2012/2013 to 4.417.223.275 Rwf in 2012/2013. At this level, revenues exceed the expenditures as the surplus of 84,904,050 Rwf was registered at the end of 2012/2014 (Rwanda Ministry of Health 2013:61). The figure below presents the CBHI sources of funding as per the financial year 2012/2013:

**Figure 3: CBHI sources of funding**



*Source: Ministry of Health Annual Report, 2012-2013 (Author's own figure)*

The figure 3 illustrates that the contributions from the population are higher than the contributions from other five actors. It is also observed that the CBHI funding mainly depends on internal resources. These facts indicate to what extent the CBHI scheme is the ownership of the population which gives an optimistic impression about the success of CBHI in Rwanda. Together with other mentioned qualitative data, this point also influences our conclusion that the main reason behind the decline of CBHI in the country remains the financial constraint to afford health insurance by non-participant households having large number of family members.

In a nutshell, this chapter is a reflection on the overall findings. While considering the role of government and of community participation, it was revealed that the CBHI scheme is helping local communities accessing health care as a right. There are challenges related to the sustainability of CBHI and the *Ubuganda* system. At the same time, a number of promising strengths and opportunities mean that CBHI is potentially coming under the ownership of the population, assuming the political will of the government of Rwanda to further improve health care for all Rwandans in future.



## CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

### 7.1 Conclusion

This study assessed the contribution of the Community-Based Health Insurance (CBHI) scheme in realizing the human right to health care of Rwandans in local communities, and particularly of the poor, taking the case of Gisagara District. To achieve the objectives of the study, a Human Rights-Based Approach was adopted. The main research questions were discussed in relation to realization of the right to health care. As the right to health care is composed of four fundamental principles: availability, accessibility, acceptability and quality of health care services, these were referred to as pre-requisites for realizing the human right to health care. Reference was made to General Comment 14 on the right to the highest attainable standard of health in accordance with article 12 of ICESCR, and the aim of Universal Health Coverage (UHC) which remain matters of international concern.

This study highlighted that to ensure the realization of the right to health care with special attention to the rural communities, the government of Rwanda adopted the CBHI policy in 2004. Many scholars, including Hartwig et al. (2012), Habiyonizeye (2013), Schneider & Diop (2004) and Sebatware (2011) have shown that the CBHI scheme has improved affordability of health care services for the Rwandans. Therefore, one of the major findings of this research is that the CBHI policy is among the most successful policies within the health care system in Rwanda today. Compared to the previous system of direct user payments, therefore, CBHI allowed a big number of people in informal sector to have access to health care at all levels of the health facilities in Rwanda. Yet there are questions of sustainability in relation to adherence rates. Together with qualitative data, it was affirmed that without health insurance for poor people, it would be very difficult for the Government of Rwanda to achieve the current much improved and widely commented on, levels of health care access for Rwandan citizens.

The CBHI as with other community-based policies involves a range of different actors, including the government, the private sector and NGOs, donors and the population, at the heart of health policies. Accordingly, the realization of the right to health care requires combining efforts between duty-bearers who are accountable and empowered rights-holders, especially the poorest among the population. In this research, the role of State is clear through its interventions and actions towards realizing human right to health care. The role of government should be complemented by a significant role for CBHI members themselves, so that they can prove to be taking on meaningful ownership of the CBHI system at community-level.

The analysis in this study has highlighted different strengths and opportunities in implementation of CBHI. There are both weaknesses and

threats, and the weaknesses need to be addressed before it is possible to move forward faster towards realizing the human right to health care for all Rwandans, especially those in rural communities.

In terms of the role of the State, it is to be underlined that the political will of the Government of Rwanda to improve health care services and to cut financial barriers to access, has helped many people to have more equal and equitable access to the health care services delivered by decentralized health facilities. Equally, together with the continuous support to those people who can least afford the cost of health insurance, these government actions and interventions constitute a very significant step towards meeting what are known as the *core minimum obligations of the State* to realize the human right to health care under the International Covenant on Economic, Social and Cultural Rights (United Nations. High Commissioner for Human Rights and World Health Organization 2010:25).

However, the study also revealed a few more surprising findings. The first is that *Ubudebe* remains an imperfect mechanism for selecting beneficiaries of health insurance schemes who need government support. A significant percentage of the population were found not to appreciate the way the CBHI functioned, presumably because some of them felt excluded from its benefits. According to some respondents, the fairness and transparency of the *Ubudebe* system need to be enhanced.

Secondly, the study found that community participation in management and monitoring of the CBHI scheme can be seen as the key to effective functioning of the system. This can be illustrated (see Figure 3 in Chapter 6) by the two-thirds financial contribution of the population, whose contributions are well above any other sources of funding. The establishment of CBHI committees all over the country may in future enable local communities to more directly benefit and to more actively participate in implementation of health care related policies that affect them. As was noted earlier in this study, quantitative data collected from relevant institutions highlighted that whilst the rate of adherence to the CBHI scheme was 91 percent in 2010, and 90.7 percent in 2011/2012, this fell to 80.7 percent in 2012/13 and was 73 percent by 2013/14. The sustainability of the CBHI system thus remains a challenge, as this statistical data indicates, and CBHI enrollment rates will need to increase again in future.

Last but not least, the study left no room for doubt that Rwandans in rural areas highly appreciate the importance of the *Mutuelle de Santé*. It follows that CBHI members' expectations are directed towards better quality health care services supplied by health facilities. This research found that generally CBHI members appreciated health care services delivered to them. However it was also found that some weaknesses remain in the CBHI scheme, such as when sometimes public health facilities do not stock all needed medical services,

including drugs. This can mean that local people are obliged to pay additional costs to find medicines at a private pharmacy, costs not covered by CBHI provisions. It was also noticed that the level of understanding of health care as a human right, was not widespread among the local people in this particular rural community.

## 7.2 Recommendations

The results of this study show that the population (40% of the respondents) in Gisagara District do not necessarily agree with the system of *Ubudebe* for various reasons mainly not being fair and transparent on the economic situation of the households although, this system is intended to ensure equity and solidarity among the CBHI members. Thus, the Government of Rwanda is recommended to carefully follow up and enhance the functioning of the *Ubudebe* system at grassroots level. The government could also make some arrangements for clearer monitoring and evaluation mechanisms, so as to avoid possible injustices resulting from inappropriate categorisations that might negatively affect the poorest households in particular. Such steps might improve enrolment rates, and could help ensure that the poorest households could benefit from the positive impacts of the CBHI scheme, as much as those who can afford to pay their contributions.

Though the local people are aware of the importance of the CBHI scheme, the research revealed that larger households, with six to eight members, are those which most often fail to pay contributions to the *Mutuelle de Santé* because of their limited financial resources. Therefore, the Government of Rwanda could either put more efforts into sensitizing rural Rwandans about family planning, or provide additional support to larger households.

It was noted that the right to health care is an unfamiliar concept to most local community members, and that the great majority do not consider themselves to be 'entitled' to health care as a human right (90% of respondents). This means that relatively few rural Rwandans, at least in Gisagara (10% of respondents), are aware of their rights to health care from the local health facilities. Therefore, for the population to get more involved in the implementation of CBHI, the Ministry of Health in collaboration with other development partners could start a campaign to sensitize people about their rights to adequate, accessible, affordable and good quality health care.

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## **INTERVIEWS**

Interview with rural households, Gisagara District, August 2014 (Table 2 and 6).

Interview with health workers, Gisagara District, August 2014 (Table 1).

Interview with Director of *Mutuelle de Santé*, Gisagara District on 18<sup>th</sup> August 2014.

Interview with Director of Kibilizi Hospital, on 26<sup>th</sup> August 2014.

Interview with Data Manager of Kibilizi Hospital, on 26<sup>th</sup> August 2014.

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