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EFFECTIVENESS OF THE FREE HEALTH CARE POLICY FOR DIABETIC PATIENTS IN KABEZI DISTRICT, BURUNDI

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN PEACE, LEADERSHIP AND GOVERNANCE IN THE COLLEGE OF BUSINESS, PEACE, LEADERSHIP AND GOVERNANCE

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Abstract

Burundi is one of the countries that have already started incorporating mechanisms of fighting the prevalence of diabetes. The health situation in Burundi was very shocking with the combined mortality rate being 15 per 1000 (2008 Population Census of Burundi). The Diabetes prevalence in Burundi stands at 2.6% and the government of Burundi has tried to curb diabetic related death through the provision of Free Health care services for diabetes patients under the age of 25. The study used a mixed research methodology. In order to mitigate the limitations of each approach, the qualitative or quantitative approaches created an opportunity for triangulation so as to augment each other in an integrated framework. There are challenges hindering the effectiveness of the free health care policy in the district. Some of these challenges are, transport unavailability, corruption in the public sector, religious beliefs and resistance from the target group. The research shows that the policy of free healthcare is effective, however the government is not capable to offer free healthcare due to resource limitation. From the 86 respondents, 21 people were not pleased with how the health care services are being offered at the health centers. Some indicated that the centers are too small to accommodate many people whilst some indicated that there is not enough medication to support the ever-growing number of diabetic people. The research shows that 17 people have been living with diabetes for a period of 6 to 8 years, 14 people between 4 to 6 years while only 8 people have just been living with it for less than 4 years. There is need to provide strong health system first which the country is yet to do and to decentralize healthcare services. Achieving universal health coverage (UHC) for both individuals and the public at large is necessary. Concentration on development of formulae for determining the necessities for medicines, commodities, essential technologies, and conception of an apparent and accountable procurement system. Fostering on development of an inclusive health financing policy and a strategic plan is also necessary.

Keywords: Policy; Diabetes, Healthcare, Services,

Declaration

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree

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Dedication

This research is dedicated to my wife Tantine Irakoze, and my son Ahijah Jayden Iteka who made it possible for me to go this far.

List of acronyms and abbreviations

AMU	: Assurance Maladie Universelle (Universal Health Insurance)
DESA	: Department of Economic and Social Affairs (United Nations)
FDGs	: Focus Group Discussions
GDP	: Domestic Product
GEGA	: Global Equity Gauge Alliance
IDF	: International Diabetes Federation
OECD	: Organisation for Economic Cooperation and Development
MODY	: Maturity-Onset Diabetes of the Young
NCDs	: Non-Communicable Diseases
NGOs	: Non-Government Organisations
NHS	: National Health System
SDGs	: Sustainable Development Goals
SUS	: *SistemaÚnico de Saúde (*Portuguese)- Unified Health System
SSA	: Sub-Saharan Africa
UHC	: Universal Health overage
USAID	: United States Agency for International Development
WHO	: World Health Organisation

Definition of key terms

Health Care - efforts made to maintain or restore physical, mental, or emotional well-being especially by trained and licensed professionals (Merriam Webster Dictionary)

Diabetes - is a chronic (long-lasting) health condition that affects how your body turns food into energy (Centres for Disease Control and Prevention, 2022)

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CHAPTER 1 INTRODUCTION

1.1 Introduction

The chapter will unpack the narrative which will highlight the background of the study in enunciating the problem statement of the research as well as the research questions and objectives.

1.2 Background of the Study

Across the globe, governments play central role in the provision of health services WHO Regional Office for the Mediterranean (2006). The concept of Free Health Care systems became popular in the last phase of the twentieth century where governments and the global community stepped up efforts and commitments to bring health services to the convenience of the poor, vulnerable and marginalized communities. This global initiative has continued to gain traction although financing and resourcing such initiatives especially in Africa is a challenge. The endemic and perpetual cycles of poverty in Africa and unstable livelihoods due to poor governance and negative climate change imperatives add to epidemics and non-communicable diseases scourge. These dynamics have weakened the capacity of governments to cope in mitigating the negativities that have ensued.

Many conferences have seconded the idea of scrapping user fees for some selected diseases that needs special treatment like malaria, Human Immune Deficiency Virus (HIV), cancers and diabetes among other ailments World Health Organization (WHO) (2015). Koons (2017) recommends that Universal Health Coverage (UHC), comprehensive access to inexpensive and excellent health services, is a key element of the Sustainable Development Goals (SDGs). Erstwhile to formally adopting the goals at the

United Nations in September 2015, several countries began integrating elements of UHC into the domestic policy arena (Koons, 2017).

According to the WHO (2015), projections indicate that by 2030 the death rates from non-communicable diseases (NCDs) such as stroke, ischemic heart diseases, road injuries and diabetes will be greater than in 2015 in the African region while death rates from contagious diseases particularly HIV/AIDS, respiratory infections, diarrhea diseases and malaria will be lesser in 2030 than 2015. This therefore reveals the need for governments to step up efforts in fighting diabetes. Every human being across the world has a fundamental right to good health care provisions, Governments are mandated to provide basic health to its citizenry. In this regard, Africa is not excluded and has been working towards improving the health systems to its people. To achieve this, policy makers are required to look more into policies that contribute towards the provision of well-funded health systems. Such policies will promote equity, efficiency, and effectiveness in curbing the prevalence of such NCDs, furthermore they will ensure that the rights of the most vulnerable are not forgotten.

Globally, advocates of the health finance policies still search for the best ways to provide funds that help in running smoothly health services in different countries especially developing countries. According to WHO (2015), on public finances, the health sector policies should be able to fund vulnerable people equally, effectively, and efficiently. In this regard, active African nations are trying to respond to this need with policies that abolish user fee to a very specific group of patients.

Very important and helpful policies are being taken to ensure that people's health is taken care of, especially for an identified vulnerable group of people. This implies that huge amounts of resources need to be channeled towards achieving the best health care systems in Africa with Burundi included. According to Amon *et.al*, (2015), most poor communities across the globe fail to pay for medication because they simply cannot afford. The most vulnerable groups within societies end up becoming victims of hospital detention because of failure to settle hospital bills. Most sub-Saharan African states such as Nigeria, Kenya, Zimbabwe, and Uganda have practiced detention of patients one way or the other, (Otremba *et.al*, 2015).

Burundi is one of the countries that have already started incorporating mechanisms of fighting the prevalence of diabetes. According to WHO (2015), the health situation in Burundi was very shocking with the combined mortality rate being 15 per 1000 (2008 Population Census of Burundi). The WHO (2015) also reported that the situation was associated mainly with the fragility of the health system due to civil war, heavy burden of communicable diseases, diabetes included.

Thus, reports say Diabetes is still the third cause of mortality and morbidity in Burundi after Malaria and HIV/AIDS (Ministry of Health, November 2018). The impact of diabetes is enormous with most serious health consequences. As asserted estimation by Berenguer and Kupfer (2018: p 7) that in 2014, 20 million people had diabetes and

523,000 died of diabetes and its related complication in Sub Saharan Africa where Burundi is located. And economic consequences estimated to US$3.82 billion in Eastern Africa and US$19.45 billion in Sub-Saharan Africa in 2015 and likely to increase to US$35.33 billion in 2030 in sub-Saharan Africa according to The Lancet Diabetes and Endocrinology Commission (2017) estimation report. Hence, this research is going to assess the extent to which the implementation of free health care policy for U25 diabetic patients is impacting on the beneficiaries.

Diabetes and high blood pressure were responsible for 73.17% of degenerative complications (WHO, 2015) as such the aforementioned is evidently the rationale why the government of Burundi came up with the Free Health Care Policy for the under 25 (U25) diabetes patients. Diabetes disproportionately affects all people but the Free Health Care Policy for diabetes patients targeted the under twenty-five on the pretext that they form the large proportion of those who have limited economic access to health care services.

The Free Health Care Policy for the under 25 diabetes patients was meant to manage Diabetes and the subsequent degenerative complications that follow with such an ailment, furthermore unemployment and challenges in sources of income further exposes those under the age of 25 from accessing medical care. Those that fall within the age threshold have access to Free Health Care on Diabetes related ailments, the worrying challenge is the intractable evidence of diabetes amongst both man and women in Burundi.

The Free Health Care Policy basically envisages to create a Diabetes free Burundi society and as such targeting the below 25 age threshold is a deliberate move to cater for the age demographic group which needs most healthcare support in order to avoid deaths amongst the productive age groups. The fundamental question is to ascertain whether the Policy is achieving the much-desired results in whether it has managed to assist the targeted age group on Diabetes treatment. There is need to ascertain whether the Policy is sufficient in curbing the prevalence of Diabetes amongst those under the age of 25 so as to attain the broader reduction and control of Diabetes amongst the Burundi population.

1.3 Statement of the Problem

According to WHO (2016) the Diabetes prevalence in Burundi stands at 2.6%. The government of Burundi has tried to curb diabetic related death through the provision of Free Health care services for diabetes patients under the age of 25. According to the WHO (2015), projections indicate that by 2030 the death rates from non-communicable diseases (NCDs) such as stroke, ischemic heart diseases, road injuries and diabetes will be greater than in 2015 in the African region and Burundi being no exception. However, since the adoption of the policy in 2015, little is known regarding the efficacy of the policy. Very few systematic academic studies have been done to clarify and provide information on the performance of the policy. There is a significant gap in the existing literature that relates to the establishment of such a policy and its impact. According to Baum *et al*. (2018) literature is full of the epidemiology of the social determinants of health and health inequity is well-established but was lacking on the evaluations of the impact of public policies addressing inequities in health risks and outcomes.

Historically, much of the policy evaluation literature has focused on formative and process evaluations with less emphasis on impact and outcome evaluations (Lee et al. 2018). Many questions are being raised in the health sector regarding the impact of the Free Healthcare Policy on the under 25 diabetic patients. If the problem persists, it will be difficult to understand the performance of the policy and take remedial actions to improve its implementation. This study, therefore, sought to address this gap by exploring the impact of the Free Healthcare Policy on under 25 diabetic patients with a particular focus on Kabezi District.

1.4 Research Objectives

The research will be directed by the following objectives:

1. To examine the purpose and provisions of the Free Health Care Policy for diabetic patients under the age of 25 in Kabezi District.
2. To assess the contribution of the Free Health Care Policy for diabetic patients under the age of 25 in Kabezi District
3. To highlight the factors influencing the performance of the Free Health Care Policy for diabetic patients under the age of 25 in Kabezi District
4. To recommend possible strategies that can be used for the effective implementation of the Free Health Care Policy in Kabezi District and Burundi at large.

1.5 Research Questions

The following questions will be guiding the research

1. What are the provisions and purpose of the Free Health Care Policy in Kabezi District?
2. To what extent has the Free Health Care Policy achieved the intended purpose in Kabezi District?
3. What are the strategies that can be used to improve the implementation of the Free Health Care Policy in Kabezi District and Burundi at large?
4. What strategies can be used for the effective implementation of the Free Health Care Policy in Kabezi District and Burundi at large?

1.6 Significance of the Study

The research provides a broader knowledge to other African countries on how free health services especially to the economically disadvantaged group can impact their wellbeing. The study will be significant in unpacking the Free Health Care Policy as a point of reference for further studies on identified gaps and other related emerging issues which may be presented as findings or outcomes of the study. Coming down to Burundi, the research will give an eye eagle analysis on whether this policy has had any benefit since its implementation and the strategies that can be used to further improve the policy for the betterment of the citizens.

1.7 Delimitations of the Study

The research covered the Kabezi District in Burundi while paying a close look on the beneficiaries who in this case are the diabetes patients below the age of 25. The main thrust being to ascertain the effectiveness of the Free Health Care Policy in the period May 2021 to July 2022.

1.8 Limitations of the Study

The research was impeded by initial reluctance and unwillingness by key informants to participate in the research study. The other impediment was, insufficient sample size as expected to be answering the questions. However, after clearly explaining the purposes of the study there was a change in attitude from the targeted participants and improvement in number of the research participants.

CHAPTER 2 REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter explores scholarly views focusing on strategies that can promote and ensure the effectiveness of the free health care policy for diabetic patients in Kabezi district, Burundi. Forms of literature used include dissertations, textbooks, articles, published research papers and various Internet websites. The literature review is divided into subsections basing on the research objectives and questions posed on the research. The chapter starts with the theoretical framework to provide strategies to effective free health care policy for diabetic patients in Kabezi district. The idea behind reviewing related literature is to appreciate what has been covered to try and figure out the existing gaps which were filled by this research.

2.2 Theoretical Framework

The study applied the Health Equity Theory (Goddard and Smith, 2001) which argues that for all people to enjoy healthy lifestyles there is need for policy makers and players in the health sector to have practises and policies that have an equity bias. The Global Equity Gauge Alliance (GEGA) (2003) opined that health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives and all avoidable health inequities, and health disparities must be eliminated. Latts (2008) also defines health equity as a means that everyone should, in practice, and not just in theory, be able to access and use appropriate health services.

The equity theory by Goddard and Smith (2001) asserts that the health services should provide access for all. This therefore implies equitable access and use of health services,

given that some people such as the elderly or the younger people in some instances will need more health care than others or a certain category of people. The theory outlined the factors or challenges that were considered to hinder equity health service delivery; low education, lack of information (awareness), age, sex, low income, price of medicines, and spatial factors. Socio-economic characteristics and discrimination to marginalized groups like the youth may hinder their rights to access health services (Goddard and Smith, 2001 & GEGA, 2003). Therefore, unless the negative impacts of those factors are addressed, it will be difficult for the disadvantaged groups to attain equal access and use of health services equally.

This theory was ideal for the research considering the fact that the free health care policy for diabetic patients in Burundi has targeted only the U25. Thus, the policy is eradicating the divide between the diabetic population and the non-diabetic by trying to maximise the chances of those diabetic to live healthy lifestyles as their counterparts. Equity in general terms implies fairness and impartiality and giving advantage to the disadvantaged so that they can be at the same level or better off just like those living relatively well. Braveman *et.al,* (2017), pronounced health equity as the moral and human rights belief that inspires us to eradicate health differences; health disparities worse health in excluded or disregarded groups are how we measure development toward health equity. However, the theory does not consider other determinant factors that can hinder free access to healthcare for all which could be personal or societal. It also assumed that despite putting in place such a policy the effectiveness of that policy does not only rely on its administration only but other factors for example societal beliefs, attitudes, and institutions.

According to a study of official cost-recovery procedures in 25 sub-Saharan African nations, exclusions for financial hardship or poverty are strikingly rare (World Bank, 1995). Providing safety nets (exemptions, waivers, and credits) in 1989, Uganda guaranteed that everyone, including those with modest financial resources, had fair access to healthcare.

2.3 Relevance of the Theoretical Framework to the study section

The Health Equity theory by stating that the health services should provide access for all, it addresses the study objective to recommend possible strategies that can be used for the effective implementation of the Free Health Care Policy.

This therefore implies equitable access and use of health services, given that some people such as the elderly or the younger people in some instances will need more health care than others or a certain category of people. The theory also outlined the factors or challenges that were considered to hinder equity health service delivery as enlisted in the above paragraph. It therefore addressed the other research objective for this study, to highlight the factors influencing the performance of the Free Health Care Policy for diabetic patients under the age of 25 in Kabezi District.

2.4 Overview of Free Healthcare Policies

It is a known fact that there is high international interest in making healthcare facilities and services accessible for all in an equitable manner. The administration of free healthcare policies normally comes with various challenges but at the same time health

management and coping mechanism for various health situations has been improving since the last decade of the 20th century. According to McIntyre and Ataguba (2015), given the multi-dimensional nature of free healthcare policies, health service access is difficult to measure in an integrated and comprehensive way. It is for this motive that the emphasis in health system valuations is often placed on evaluating exploitation of health services and because access permits use of health services. This was informed by the growing international consensus that user fees at public sector health facilities were not an advisable way of financing health services. As noted by the WHO Director-General Dr Chan in her address to the World Health Assembly in 2014: “User fees punish the poor. User fees discourage people from seeking care until a condition is severe and far more, difficult, and costly to manage. ‘User fees waste resources as well as human lives" (Chain, 2014). The World Bank president, Jim Kim, has also braced this position (McIntyre and Ataguba, 2015).

California Health in All Policies Task Force (2010) presented findings on healthcare spending as a percentage of GDP for seven major developed nations. One outstanding fact is that the United States employs an especially high portion of its GDP on healthcare. Most developed nations spend 9 to 12 percent of GDP on healthcare, while the United States spends more than 17 percent (California Health in All Policies Task Force, 2010). Critics of the U.S. healthcare system use this judgement to claim that the United States is exclusively inefficient. They point out that life expectancy is greater in some countries that pay less for healthcare, such as Canada, France, and Japan. They sometimes recommend that greater dependence on government rather than private health insurance,

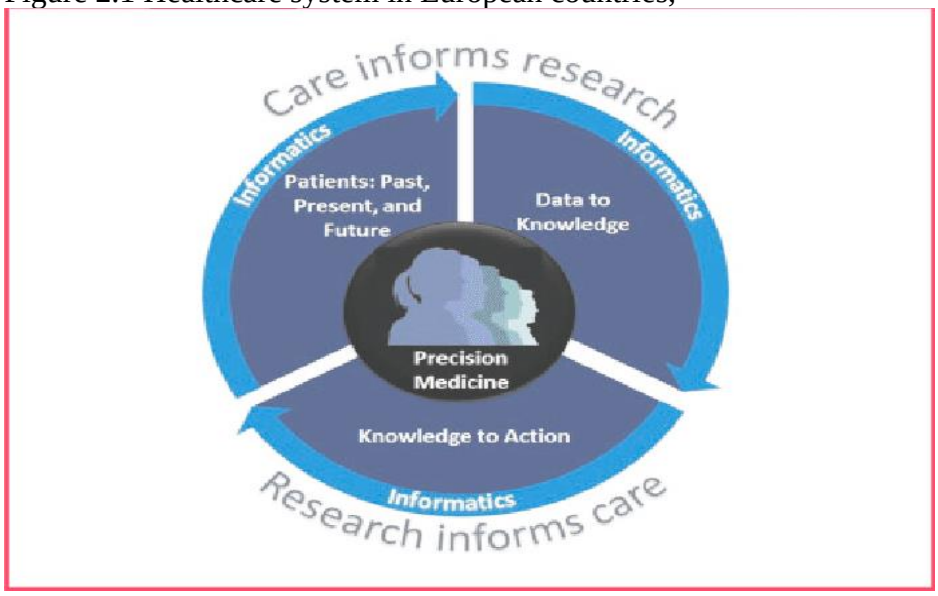
as is the case in most other nations, might lower costs without undesirably affecting health outcomes.

Prior to 1988 in Brazil, the year the Unified Health System (SistemaÚnico de Saúde- SUS) came into being, just 30 million Brazilians had access to health services. Today, coverage is closer to 140 million, roughly three-quarters of the population (WHO, 2013). By improving admittance to primary and emergency care, the SUS has been concomitant with significant developments across a range of health indicators, particularly infant mortality which fell from 46 per 1000 live births in 1990 to 17.3 per 1000 live births in 2010 (WHO, 2013). Life expectancy at birth has also improved, reaching 73 years in 2010 compared to 70 years just a decade earlier (WHO, 2013). The transformations also reduced health disparities with the life expectancy gap between the richer south of the country and poorer north falling from 8 years to 5 years between 1990 and 2007 (WHO, 2013).

2.5 Healthcare systems in European countries

According to Jakubowski (1998), Health care systems come from explicit political, authentic, social and financial customs. Accordingly, the hierarchical plans for medicinal services contrast significantly between Member States, as does the allocation of capital and human resources. The chief types of health care association in the European Union are the expense financed national well-being administration frameworks and those working with social protection in which protection assets might be autonomous of the administration. Thus, in Europe the health sector depends much on research and development in creating a useful system as shown below.

Figure 2.1 Healthcare system in European countries,



Source: Jakubowski, (1998).

Be that as it may, this basic division between the frameworks is debilitating. Nations, for example, the United Kingdom have opened their NHS to interior challenge to differentiate supply and increment buying power. Conversely, in some customary social protection frameworks affliction reserves are being combined and cost control expanded with respect to the focal government. This pattern towards intermingling is an endeavour to hold the general preferences of every framework.

Social insurance in the EU is at cross-roads between challenges and opportunities. The Member States are confronting basic difficulties in conveying equivalent, proficient and excellent well-being administrations at moderate expense in times when the measure of care to be conveyed is beginning to surpass the asset base. The interest for medicinal services in Europe - as somewhere else among industrialized nations - is developing

because of maturing populaces and rising open desires. The combination of demographic changes and mechanical improvements builds the expense of arrangement.

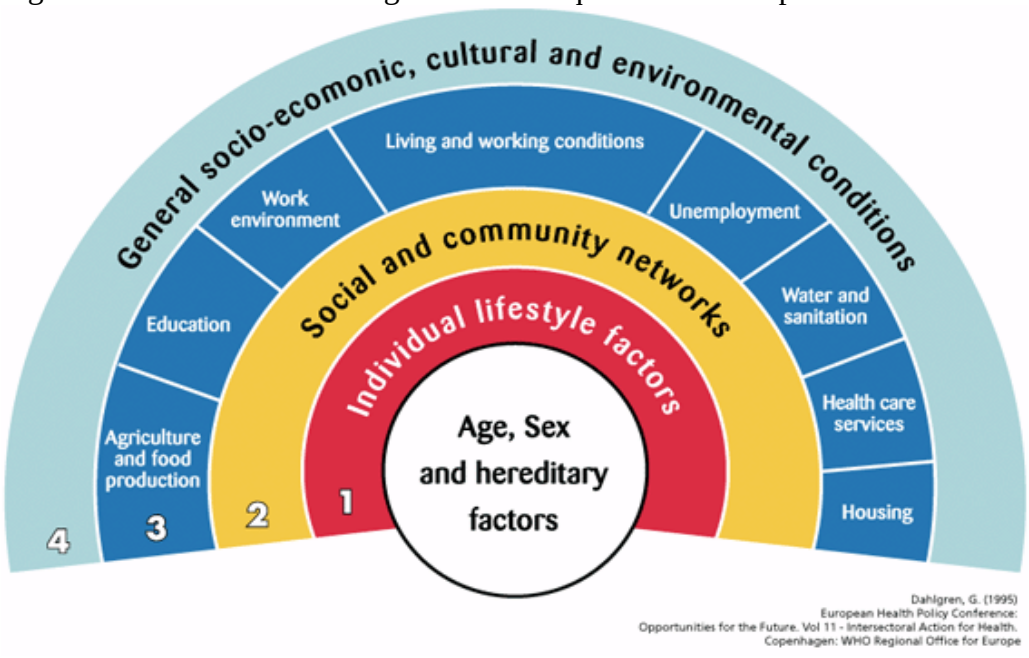
In result, the frameworks face similar issues of apportioning administrations so as to reduce expenses inferable from an expanding request and a diminishing duty base to pay for that request. Simultaneously, it is increasingly difficult to develop widely accepted health policies and maintain public consent. Almost all European nations have a widespread human services framework. In spite of the fact that a few people allude to it as Europe's "free healthcare" framework, in actuality, it's not so much free. While every nation has its own variety, the shared factor is that everybody pays for human services as a public expecting to limit the general cost and spread around the expense and hazard with the goal that an unfortunate few are not bankrupted by therapeutic expenses. This likewise guarantees those living in neediness can get the consideration they may not in any case have the option to bear (Steves, 2016).

2.6 Inequalities in health care provision in Europe

The contrast among need and interest for health care changes between the populace, in the most recent past decade it has been progressively perceived in various EU nations that there are likewise hidden variables of ill-health which come from more extensive financial, social, and ethnic conditions. Disparities in human well-being involve imbalances in well-being status itself and imbalances in finance and conveyance of health services (Jakubowski, 1998). In various European nations, for instance the UK, there is expanding worry about imbalance (lopsided offer) and disparity (shamefulness) in health care services since late perceptions have indicated that distinctions in well-being status (as estimated by future, mortality, and horribleness) are expanding between various social

classes, for the most part oppressing the burdened. Studies embraced into reasons for this well-being partition offer various hypotheses. Nonetheless, it follows from most research embraced that techniques to handle disparities (other than organic varieties) need to concern sectors other than health, for instance money, education, business, and social policies. Perception after some time recommends that the well-being/health status of the occupant populace of the EU has improved generously. This has brought about ageing populaces and has as a result expanded the interest for medicinal services. Simultaneously, with individuals living longer, examples of infection have moved from intense to interminable conditions. These, anyway, are to a huge degree avoidable and along these lines recommend direction towards progressively preventive consideration. There is moreover extensive agreement in the EU that pointless inequalities in health are an expanding challenge.

Figure 2.2 Factors contributing to health Inequalities in Europe.



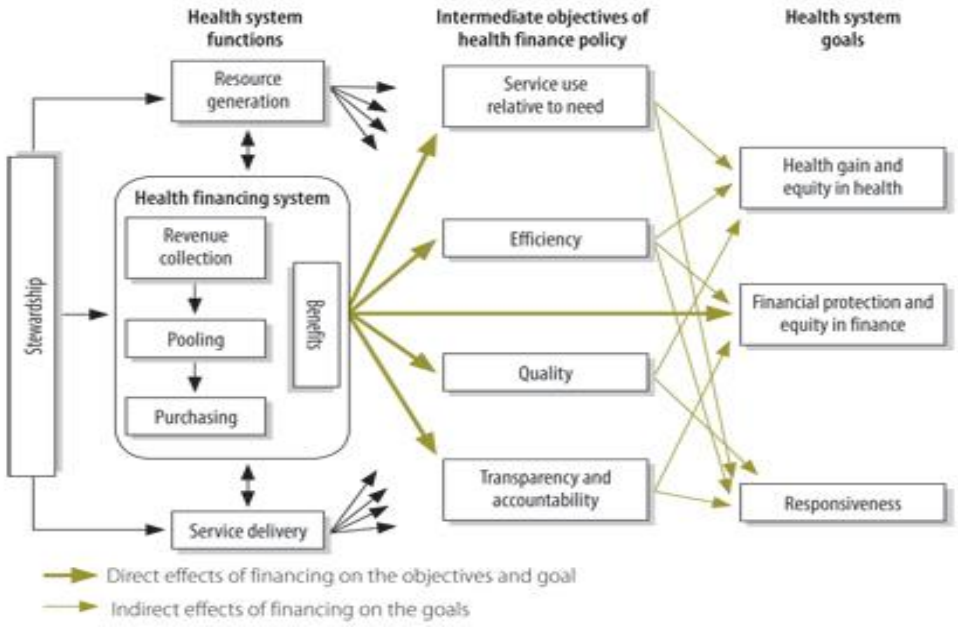
Source: Jakubowski, (1998).

2.7 Finance and organization of Health Care in Europe

Pavolini & Guillén (2013) postulated that in spite of the fact that EU nations have each built up their own subsidizing instruments, comparative targets and regular authentic improvements have brought about frameworks which share a lot of practically speaking. All frameworks depend on a blend of subsidizing sources, yet most of assets are state controlled, regardless of whether straightforwardly or by implication. Just a little extent originates from direct fee-for-services. State guideline in the Member States accommodates general medical coverage or administration inclusion for human services through necessary plans. In Ireland, general inclusion for essential health care just applies to lowly paid people. In the Netherlands, necessary medical coverage covers just 60% of the populace. The remainder of the populace are typically secured by deliberate private or open insurance. Social insurance in the EU frameworks is either financed through general tax collection or by commitments to medical coverage insurance.

There are three overwhelming frameworks of social insurance account in the European Union. The first is open account by general tax assessment (frequently alluded to as the Beveridge model). Secondly, there is open money/ public finance dependent on necessary social protection (the Bismarck model). The diagram below shows how the health care system is financed.

Figure 2.3 Finance & Organization of Health Care in Europe.



Source: Pavolini & Guillén (2013)

Thirdly, there is private money/ private finance dependent on deliberate protection/ voluntary insurance, which covers just a little minority of EU resident's altogether; however, which likewise works over social protection as an advantageous type of subsidizing human services.

Table 2.1 Methods of Financing Healthcare in member States of EU

Table 5: Methods of Financing Health Care in the Member States of the EU		
Countries	Predominant system of finance	Main supplementary system of finance
Finland, Greece, Ireland, Italy, Sweden, Spain, United Kingdom	public: taxation	private voluntary insurance, direct payments
Denmark, Portugal	public: taxation	direct payments
Austria, Belgium, France, Germany, Luxembourg	public: compulsory social insurance	private voluntary insurance, direct payments, public taxation
Netherlands	mixed compulsory social insurance and private voluntary insurance	public taxation, direct payments

2.8 History of free health care in Africa

During the colonial era in Africa, native citizens were discriminated against many benefits such as the health services. A lot of them survived through the use of raw herbs from the forest. The death rates to native Africans during those years were very high due to inaccessibility to health services. Then came the era of independence and a lot had to change. In Burundi like most other African nations, many sectors saw a lot of changes from the management to the provision of services. Those who were marginalized saw an improvement in service delivery. That is when free health care was deemed a prerequisite for every African country as many if not all the citizens wanted immediate health care as millions of diseases were emanating every day.

As indicated by the World Health Organization (WHO) (2017), Africa conveys 25% of the world's ailment trouble/ diseases burden yet its expenditure uses in relation to the worldwide expenditure in the health sector is under 1%. Worse-still, it produces just a portion under 2% of the medicines expended on the landmass. A greater part of Africans, for the most part poor people and those in the middle-income bracket, depend on under-financed general healthcare facilities while a little minority approaches well-supported, quality private medicinal services. In 2001, African nations consented to dispense in any event 15% of their spending limits to medicinal services. However, after 15 years, just six nations (Botswana, Burkina Faso, Malawi, Niger, Rwanda, and Zambia) have met this responsibility. Indeed, even in these nations, general access to good human services is yet hidden. It takes a ton of resourcefulness to turn the ship around. For instance, Rwanda has figured out how to arrange a national health insurance scheme which presently covers 91% everything being equal (WHO, 2003).

This is in sharp complexity to other African nations where medicinal protection plans spread, by and large, under 8% of the population, as indicated by WHO. There are a couple of splendid spots in battling a few sicknesses. Africa is at last making progress in the battle against intestinal sickness/ malaria, the main source of mortality in the local. WHO reported a year ago that the worldwide rate of intestinal sickness had at last been eased back, to a great extent because of a gigantic roll-out of mosquito nets, hostile to jungle fever prescriptions and utilization of bug sprays?

Over the previous decade, on account of uplifted accentuation on avoidance, treatment what's more, care, the pace of new HIV diseases is easing back down as progressively infected individuals are accepting anti-retroviral drugs. Africa's key test, nonetheless, is facing what despite everything should be finished. Governments should focus on giving access to essential social insurance and reasonable medications, preparing greater network health labourers, and expanding medicinal protection inclusion through innovative organizations with the private sector (World Health Organization, 1999).

2.9 The origin of free/ Affordable Health Care in detail

Palmer (1999) orally reproduced an 1800 paper which was pointing out the curse to affordable health services the United States was about to take those day. She lamented that the battle for some type of widespread government-subsidized human services has extended for about a century in the US on a few events, advocates accepted they were nearly achievement; yet each time they confronted rout. The advancement of these endeavors and the explanations behind their disappointment make for a charming exercise in American history, belief system, and character. Other developed nations have had some

type of social protection for about if the US has been attempting to get it. Some European nations began with mandatory infection protection, one of the main frameworks, for laborers starting in Germany in 1883; different nations including Austria, Hungary, Norway, Britain, Russia, and the Netherlands finished as far as possible 1912. Other European nations, such as Sweden for 1891, Denmark in 1892, France in 1910, and Switzerland in 1912, financed the shared advantage social orders that laborers framed among themselves. So, for quite a while, different nations have had some type of all-inclusive social insurance or if nothing else its beginnings.

The essential purpose behind the rise of these projects in Europe was salary adjustment and assurance against the compensation loss of sickness instead of instalment for restorative costs, which came later. Projects were not widespread to begin with and were initially imagined as methods for keeping up livelihoods and purchasing political devotion of the laborers. In a seeming paradox, the British and German frameworks were created by the more moderate governments in power, explicitly as a resistance to counter development of the communist and work parties. They utilized protection against the expense of infection as a method for "going generosity to control".

2.10 Discussing Diabetes in a Universal Perspective

The complete number of individuals with diabetes is anticipated to rise from 171 million out of 2000 to 366 million of every 2030. The occurrence of diabetes is higher in men than ladies, yet there are a bigger number of ladies with diabetes than men. The urban populace in developing nations is anticipated to two-fold somewhere in the range of 2000 and 2030. The most significant segment change to diabetes predominance over the world has all the

earmarks of being the expansion in the extent of individuals 65 years old (Wild *et.al,* 2004).

According to Wild *et.al,* (2004) the quantity of individuals with diabetes is expanding because of populace development, maturing, urbanization, and physical inactivity. Measuring the predominance of diabetes and the quantity of individuals influenced by diabetes, presently and later, is essential to permit normal arranging and designation of assets. Evaluations of present and future diabetes commonness have been distributed beforehand (1–3). Since these reports showed up, further epidemiological information has gotten accessible for a few nations in Africa and the Middle East and for India. Ramachandran *et.al,* (2001) postulated that in developing nations, most of individuals with diabetes are in the range of 45-to 64-years of age. Interestingly, the larger part of individuals with diabetes in developed nations is 64 years old. By 2030, it is evaluated that the quantity of individuals with diabetes will be the 64 years old reaching to 82 million in developing nations and 48 million in created nations.

The quantity of cases of diabetes worldwide in 2000 among grown-ups which is around 20 years old is assessed to be 171 million. This figure is 11% higher than the past gauge of 154 million. Evaluations of all out-population size and extent of individuals 64 years old in 2000 utilized in the past report were higher than those utilized right now, in this way segment changes can't represent the inconsistency. The higher commonness is bound to be clarified by a blend of the incorporation of overviews revealing higher predominance of diabetes than was accepted already and various information hotspots for certain nations. The IDF Diabetes Atlas 2000 utilized unique and less stringent criteria for the

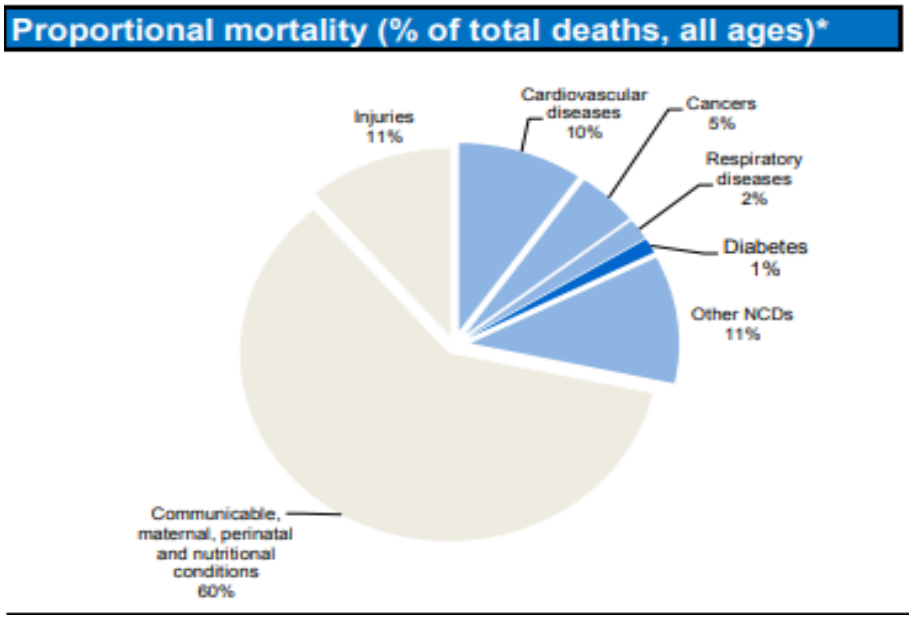
incorporation of concentrates to gauge pervasiveness of diabetes for 20-to 79- years-elderly people in the 172 IDF part nations.

2.11 Overview of the Health system and diabetes in Burundi

In Burundi, the health system is organized as a pyramid structure, with three levels: the central level, the intermediate level, and the peripheral level (WHO, 2015). Decision making is still centralized with the central level in charge primarily with formulating sector policy, strategic planning, coordination, mobilization, and allocation of resources as well as oversight-evaluation (WHO, 2015). Since most of the population is poor in Burundi, living with diabetes can be very difficult for most of the population in terms of getting medicines and equipment plus suitable diet. As a way to overcome the problem the government of Burundi has come up with a provision of free insulin to people under the age of 25 (Harargirimana, 2018).

According to Lim *et.al*, (2017) the diabetes has a proportional mortality of 1% of total deaths in all ages amongst other causes such as cancers 5%, injuries 11%, and communicable, maternal, prenatal, and nutritional conditions 60%. The treatment of these diseases remains a major problem, due to the fact that the medications are very expensive and should be taken daily. The chart below illustrates the description above.

Figure 2.5 Overview of Health System and Diabetes in Burundi.



Source: WHO, 2015

Burundi is one of the 32 nations of the IDF African locale. Some individuals have diabetes on the planet and more than 16 million individuals in the Africa Region, by 2045 it will be around 41 million (WHO, 2015). There were 132.900 instances of diabetes in Burundi in 2017 (International Diabetes Federation). The International Diabetes Federation (IDF) is an umbrella association of more than 230 national diabetes associations in 170 nations and regions. It speaks to the interests of the developing number of individuals with diabetes and those in danger. The Federation has been driving the worldwide diabetes network since 1950. A lot has been done according to many sources in trying to do away with diabetes. Below are the attempts indicated in table 2 .2

Table 2.2 National Response to Diabetes.

National response to diabetes	
Policies, guidelines and monitoring	
Operational policy/strategy/action plan for diabetes	*Yes*
Operational policy/strategy/action plan to reduce overweight and obesity	*No*
Operational policy/strategy/action plan to reduce physical inactivity	*Yes*
Evidence-based national diabetes guidelines/protocols/standards	*Available and fully implemented*
Standard criteria for referral of patients from primary care to higher level of care	*Available and fully implemented*
Diabetes registry	*No*
Recent national risk factor survey in which blood glucose was measured	*No*

Source: WHO, 2015

Figure 2.6 Causes of Diabetes to young & elderly.

Source: Morrish et.al, (2001)

Advocates for user fees policy argue that the demand for health care is relatively inelastic with respect to price (McPake, 1993) citing cases where the poor bypassed cheap public

health centres in preference for private ones. Regarding this, the research sought to find out how the poor diabetic patients have been considered in Burundi.

Toli (2014) proposed a model of a typical health care system which is discussed below. This also resonated with Hatting, Dreyer, and Roos' model (2006:64). They said a health service should possess the following characteristics: it should be accessible, affordable, acceptable, equal, effective, efficient, sustainable, caring, comprehensive, comfortable, considerate, scientifically advanced, and careful with the patient's safety. Each one of the characteristics will be briefly explained below.

OECD nations is committed to patients who are inside two years of death. Prosperity can empower unfortunate propensities and posture dangers to wellbeing, not least by means of reactions on the environment. A few gatherings in OECD nations, for example the jobless and poor people, will in general be rejected from the general wellbeing propels appreciated by the dominant part or do not profit to a similar degree.

2.12 Challenges in the provision of free health care

There have been so many constrains affecting the provision of effective health care systems in the developing countries. The user fees policy had not received universal acceptance due to its potentially negative impacts on equity (McPake, 1993; Creese, 1991; Gertler and van der Gaag, 1990) and the fact that the prospective for revenue generation seems to have been overstated (McPake, 1993; Creese, 1991; Gilson *et.al*, 2000). It has also been stressed that credit constraints may limit the ability to access fee-based services even when there is a clear willingness to pay (Hausman-Muela *et.al,* 2000). Thus, the researcher sought as well to find out some of the challenges on the provision of free health care in Burundi. Factors causing underutilisation of health care interventions.

There are several factors that are responsible for the underutilization of effective health care interventions in many countries especially the developing world. Despite the fact that governments are making efforts to raise income to cater for health care, it seems the resources are still insufficient for full implementation. Another challenge is that the available resources are not allocated to the most effective interventions, are geographically concentrated in large cities, and do not reach the poor. It therefore, means that full implementation of the services is hindered. Other factors include inappropriate allocation of resources and inadequate quality of services, which act as impediments to the delivery of effective health care that reaches the poor and the vulnerable.

One essential challenge for improvement endeavors is that of persuading healthcare laborers that there is a genuine issue to be tended to. Clinicians and others may contend that the issue being directed by an improvement intercession is not generally an issue; that it is anything but an issue 'around here'; or that there are unquestionably progressively significant issues to be tended to before this one. Trying to persuade clinical groups who think they are now doing admirably to change is probably going to be purposeless except if they can be indicated that activity is truly required. Those structuring and arranging mediations ought to be cautious to target issues that are probably going to be acknowledged as genuine. Potential techniques for building up the issue as an issue incorporate hard information to show its reality, persistent stories to make sure about passionate engagement, connect with the clinicians in characterizing what they might want to improve in their administration and show that there is a 'relative advantage' in executing the mediation.

2.12.1 Convincing people that the Solution Chosen is the right one

Improvement mediations are frequently 'basically challenged': everybody may concur on the requirement for good quality yet not on what characterizes great quality or how it ought to be accomplished. Clinicians and others may stand up to change on grounds that intercessions need adequate proof or are incongruent with favoured methods for rehearsing that as of now seem to convey great outcomes. Guaranteeing that there is acceptable quality logical proof to support intercessions, and that implementers are well informed and equipped for dealing with challenge, is along these lines basic.

One methodology for guaranteeing agreeableness of intercessions includes utilizing very much encouraged gatherings to examine and banter the proof and open it to challenge, instead of trusting that the proof will 'talk for itself'. It may likewise help if improvement activities are supported by a reasonable and express 'program theory' than record of the exercises to be attempted, however, the causal connections between these exercises and the results sought. Among different things, a program hypothesis makes unequivocal why a mediation is probably going to work and explains centre and key bearing. Extensive exertion should be put resources into the underlying program hypothesis, yet it ought not to be viewed as fixed and unchanging; it might create after some time as those occupied with the program gain from their encounters of execution.

The other challenge that is faced in trying to set up strong health systems in a country is the leadership in the health sector. Leading development efforts is challenging and tormenting, requiring a combination of technical skills, enablement skills and personal qualities. It needs to happen at various levels and needs to guarantee alignment with staff

priorities, and active work amongst staff to foster cooperation and engagement with enhancement aims. Respected personalities can play a vital role in heartening colleagues across different professions. Key to achievement may be ‘quieter’ management, less about pompous announcements and more about working to facilitate teamwork.

2.12.2 Human Resource crisis in the health sector in African countries

The human asset emergency is brought about by numerous variables, for example, insufficient generation in some nations, failure to enlist in others, mind channel, poor inspiration, irreconcilable circumstance, defilement, what's more, abuse of assets including time in many African nations. In numerous nations, a larger part of health laborers is amassed in a couple of urban zones. All categories, predominantly doctors and nurses, are in diminutive supply compared to the standards of population ratios for nurses and other health workers.

2.12.3 Specialist Shortage

The number, quality, and capacity of medicinal services laborers across nations as a proportion to the populace are low. Globally, there is a severe lack of human resources for health (HRH), and low-income nations, particularly those in sub-Saharan Africa and some regions of Asia, bear the brunt of this shortfall. The achievement of health-related development goals has been severely hampered by this scarcity, which has also slowed down the rapid move toward universal health care (UHC). According to the MOH Training Needs Assessment report (2015), there is a serious shortage of healthcare

workers in about 57 nations, the bulk of which are in Africa and Asia. According to the World Health Organization (WHO), to close the current gap, at least 2 360 000 health providers and 1 890 000 management support personnel are needed.

There are significant disparities in the distribution of healthcare personnel between industrialized and developing nations, with the latter suffering the most. The greatest difficulty is faced by Sub-Saharan Africa, which has 11% of the world's population, 24% of the world's illness burden, and only 3% of the world's health workers (WHO, 2006).

2.12.4 Corruption in the Public Sector

Corruption defilement diverts genuinely necessary assets from social insurance conveyance and decreases patients' access to basic services. For instances therapeutic staff for public hospitals that sell sedates/drugs that ought to be free, and robbery or preoccupation of medications and supplies at government stockpiling and circulation focuses. Moreover, bribery to gain up endorsement for drug registration or to pass tranquilizes quality assessments are bringing about phony medications "honestly" entering markets.

2.12.5 Counterfeit Drugs

A darker result of the rise of innovation is that it empowers forgers to run much progressively advanced tasks and make fake medications that are more diligently to identify. Therefore, fake medications currently present themselves as bona fide medications.

2.12.6 Changing Medical Needs for the Population

A great part of the present focal point of social insurance conveyance in Africa is on customary and noticeable elements like HIV and intestinal sickness. Notwithstanding, changes in way of life and a developing white-collar class are making non-communicable sicknesses like cardiovascular ailment, disease, and diabetes huge issues among populaces. Fast urbanization and expanded Westernization of ways of life among the white-collar classes is causing an expansion in the hazard factors that cause non-communicable diseases. Individuals devour more inexpensive food and bundled nourishment, which will in general have significant levels of sodium; they take part in less physical action, sitting in their autos and transports on their approach to work; and they are bound to expend liquor in their relaxation time. Another hazard factor is an expansion in smoking rates across populaces.

2.13 Factors Rendering Free Healthcare Policies futile

Other than financing and resourcing factors there are some other factors that research found as having a countervailing effect on the implementation of free health care policies. McIntyre and Ataguba (2015) found out that in some instances there were lack of utilisation of the free health care services due to dissatisfaction among users. The major source of dissatisfaction that they identified relates to the length of waiting time before receiving care (38% in the case of public sector outpatient services and 18% in the private sector). The next most important sources of dissatisfaction were not being treated with respect and dignity (20% in public and 10% in private sectors respectively); perceptions of lack of effectiveness of drugs received (18% in public and 9% in private sector); lack of privacy in consultations (14% and 8%); and lack of confidentiality (10% and 7%). Lack

of respectful treatment, privacy in consultations and confidentiality were seen as more problematic in inpatient than outpatient services in public sector facilities. More so, stigma and judgmental behavior of health care providers, which pose acceptability barriers to health service access, are particularly a problem in relation to certain services such as HIV, tuberculosis, and other non-communicable diseases.

Many of the 'acceptability' barriers within public health facilities are seen as relating to low staff morale or motivation. There are many factors that have contributed to this situation, including: a sense of exclusion and disempowerment among front-line health workers due to top-down implementation of policy on which they are not consulted or well-informed although they bear the consequences of these decisions. While some of these factors relate to national level policies and their implementation, institutional factors that can be addressed by improved management and leadership at the facility level are equally important. However, management improvements must be enabled by public sector health facility managers having the authority to make decisions that will allow them to create a conducive working environment (McIntyre and Ataguba, 2015).

2.14 Reasons why Health Care must be free

The vital point of universal health coverage is to guarantee that everybody can utilize the health services they need without danger of money related ruin or impoverishment, regardless of what their financial circumstance. The over-arching concept of global health coverage takes a broader view of the services that are required for good health and well-being (Chetty, 2012). These services extend from clinical consideration for singular patients to the public administrations that ensure the health services of entire populaces.

They incorporate administrations that originate from both inside and past the health sector. Money related hazard assurance is one component in the bundle of measures that gives generally social insurance, just as the security against serious monetary troubles in case of sickness gives the significant serenity that is a fundamental piece of prosperity.

Fundamentally, to help the objective of widespread health coverage is likewise to communicate worry for value and for regarding everybody's entitlement to health services universally. These are close to home and good decisions with respect to the sort of society that individuals wish to live in, taking all universal coverage past the details of health financing, general well-being, and clinical consideration. With a more noteworthy comprehension of the extent of all universal health coverage, numerous national governments around the globe presently see progress towards that objective as a core value for the improvement of health frameworks, and for human advancement for the most part.

In each nation, there are individuals who can't pay straightforwardly, out-of-pocket, for the services they need, or who might be truly impeded thusly. At the point when individuals on low livelihoods with no money related hazard security become sick, they face a difficulty. At last, if a nearby health service exists, they can choose to utilize the service and languish further impoverishment in paying over it, or they can choose not to utilize the administration, stay sick and hazard being not able to work (Hjortsberg, 2003). What's more, preventive and therapeutic services secure health and ensure salaries. Solid youngsters are better ready to learn, and sound grown-ups are better ready to contribute socially and monetarily. The way to all universal health coverage has likewise been named "the third global health transition", after the segment and epidemiological changes.

2.15 Sustainable Health Care

In Europe the health systems managed to flourish even though they were not merely free due to a number of reasons. The first one amongst the long list of the reasons is because of the governments working in conjunction with major stakeholders in the health sector internationally which many African countries have not been doing. For example, when the HIV/AIDS epidemic hit Burundi for the first time, the nation was so isolated in the World and couldn't be able to seek help else up until the World Health Organization, International Monetary Fund, USAID and more intervened. In Europe and other developed countries these organs have always been there to help even soon after World War 2 when many of these countries were desperate to end war as well as abuse of human rights and health problems.

Critical to partnership is the call for partners to be familiar with the skills and contributions of each other as equivalent in worth to set up relationships of reciprocal trust and confidence. This is probable only if the offerings and actions required of each associate are based on each partner's capacities and areas of their own influence; not on areas of apprehension or need. It is in the areas of authority where any effort or time investment would harvest maximum proceeds. This is a way of ensuring that each partner also benefits or reaps results from their contribution. Partners may benefit in areas of need because of the joint venture but, partnership building should not be based on needs.

2.16 Summary

To conclude, this chapter managed to clearly explain the components of free health care system from a wider point of view and wrapping Burundi's case inside. The chapter also managed to pinpoint the theories that are very linked to the topic of health care systems.

The next chapter will explain the methodology that the researcher used in getting the information for the purpose of this study.

CHAPTER 3 METHODOLOGY

3.1 Introduction

The previous chapter explored literature on free healthcare systems in general and specifically in Africa and Burundi in particular. The literature search was to form the basis for the empirical study that ensued. In this chapter, the researcher presents the methodology utilized for the study including the research design, research philosophy, sampling, data collection techniques and tools, data analysis and research limitations.

3.2 Research Design

Howard and Sharp (1983), described a research design as an intended plan. It refers to the issues involved in planning and executing a research project from identifying the problem through to reporting and publication of results (Kumar, 2005). It tries to find the purpose of the study and methods used.

The study used a mixed research methodology. To mitigate the limitations of each approach, both the qualitative and quantitative approaches created an opportunity for triangulation so as to augment each other in an integrated framework. Creswell (2003) defines mixed research method as the process of collecting and analyzing data, combining the findings, and reaching conclusions using both qualitative and quantitative approaches in a single study. This preference was largely influenced by the fact that, the researcher sought to maximize the gains of both qualitative and quantitative research methods and thus create a much-balanced study that guaranteed capturing more detail in understanding empirical realities as presented by the research findings.

3.2.1 Qualitative Study

Qualitative research provides a wealthy and well-grounded descriptions and explanations as well as unanticipated issues. The role of the researcher in qualitative study relates to compassionately thoughtful, personal participation and partiality. Qualitative phenomenological study places more importance on participants' lived experiences and the meanings they give to certain situations, processes, or events (Finlay, 2011). Creswell (1998) noted that qualitative research offers a rich source of data resulting in the formation of theories, patterns and or policies that help to illuminate the phenomenon under research. In this case, qualitative research provided more detailed narrations that look at what people think and feel i.e., about the effectiveness of the free health policy.

The case study design unlocks a way of giving a voice to the invisible, incapable, or ostracised by letting them speak for themselves (Maree, 2007) and this study aims to give voice to the diabetic patients and other respondents to speak on their own experiences of the free health policy and also analyzing the policy delivery patterns. The study wanted to ascertain the effectiveness of the free healthcare policy, and this could be aptly done through interaction using related qualitative techniques as narratives from key informants will give empathy and expressions that may not be captured quantitatively.

3.2.1 Quantitative Study

Bryman (2012:35) defines quantitative methodology as a research strategy that emphasizes quantification of responses of the participants in the collection and analysis of data. Quantitative data is often generated by instruments such as questionnaires. The quantitative research is involved in objective depiction, detachment, and impartiality. Quantitative research is more objective where the researcher coins a proposition and then

tests it through prearranged means. Instead of exploring or unfolding a phenomenon, quantitative methods deal with facts and statistics. It is imperative that the statistical data was to be gathered to ascertain reflections and realities that may not be established through quantitative means. Furthermore, the research is fundamental in informing a policy and thus availing such is important in advocacy for the necessary and appropriate action going forward.

3.3 Population and Sampling

3.3.1 Population

As defined by White (2010:9), a population is the throng of respondents who had pertinent information to the study from which outcomes are to be accomplished. In fact, it is theoretical initiative hefty group commencing the data which the researcher draws a design to which the result from the test will be comprehensive. In this research, the study population were the residents of Kabezi District, the Ministry of Health staff, the Ministry of finance staff, the Ministry of Labour staff, the Ministry of rural development staff, and staff at health centres in the district. The total population of Kabezi District is 198 000 Burundi Ministry of Health (2011). This formed the basis of a balanced research population that guided the researcher in getting results that were essential to this research.

3.3.2 Population Size

According to Tabachnik and Fidell (2001), a sample is that part of a large population that gives a representation of the entire population. The sample has properties that make it representative of the whole. Generalizations of populations from data collected using any probability samples are guided by probability laws and assumptions. Sampling has been defined by Gay (1985), as the technique of selecting a set of subjects for research skilfully

in such a manner that the individuals are representative of the larger group from which they were handpicked. For feasibility, the study used a sample size of 115 respondents from Kabezi district.

3.3.3 Sampling

It is a process of selecting a few from a bigger group (population) to become the basis for estimating or predicting a fact, situation or outcome regarding a bigger group (MaPhail, 2001). In simple terms it is a representative of the population being studied or investigated. Since the researcher carried out research on a large population, sampling reduced costs and save time so that the researcher meets the tight deadlines. Through collecting data from fewer cases, the researcher will collect more detailed information.

3.3.4 Sampling Methods

To cite quality data, a sample must be representative of the population and must allow accurate collection of data and all population units should stand a fair chance of being selected. The research used both purposive and convenience sampling. The researcher selected these sampling methods as the combination would ensure that varied information would be gathered as the respondents was chosen from the affected group to obtain varied information. Sampling saved time, money and get faster results as not every person in the population will be interviewed.

3.3.4.1 Non-probability Sampling Techniques

In non-probability sampling, the probability of any subject of the population being chosen is unknown (Mitchell 2003:70). The technique relies mainly on personal judgment hence the selection of the sample is quite arbitrary. This was used to sample residents from the 3 locations in Kgabezi District.

3.3.4.2 Purposive Sampling

Purposive sampling is about the selection of people based on the researcher's judgement that relevant information can be sought from the chosen people (Neville, 2005). Key informants for the study were selected using purposive sampling. It is to be used to gather important information for the research from government officials, health workers in the Ministry of Health in Burundi.

3.3.4.3 Convenience Sampling

To draw a convenience sample, a researcher merely collects data from those people or other pertinent rudiments to which he or she has most convenient entrée. This method, also occasionally denoted to as haphazard sampling, is most useful in exploratory research. It is also often used by those who need quick and easy access to people from their population of interest. Since convenience sampling is fast and easy, researchers can summarily gather their data and begin to infer theories from the data. This form of sampling allows for a faster analysis, permitting researchers to focus on the more important aspects of their experiment instead of scheming the best way to get a population sample. Because this type of data gathering is factually done at the expediency of the researcher, it is faultless for quick studies, and is often used in initial surveys to prove a need for a better thoughtful of the research material.

Table 3.1 Location & Number of Respondents of FGDs

Target Group	Location	Participants	No of FDGs	Percentage (%)

Diabetic Patients	Urban	20	2	10
Diabetic Patients	Peri Urban	20	2	10
Diabetic Patients	Rural	20	2	10
TOTAL		60	6	10

Source: Researcher

Table 3.2 Number of Participants on Interviews

Targeted Group	Number Of Participants
Ministry of Health Officials	5
Nurses in Charge at Health centres	7
Other government officials	5
TOTAL	17

Source: Researcher

3.4 Data Collection Instruments

3.4.1 Research Instruments

Collecting data is a procedure of formulating and gathering information from dissimilar sources which might be primary or secondary sources. As Kumar (2011:138) noted primary sources occur when data is composed using the first approach and that data is gathered purposively and precisely for the study at hand. Whereas secondary data obtained

for the use of the study but not originally intended for the research at hand. Understanding this will lead the data compilation of this study to involve textual exploration throughout an examination of various sources.

Research instruments can be well-defined as apparatuses that are used in data collection of the research. The researcher used such instruments basing on their suitability to the study situation. Interviews, questionnaires, document analysis and focus group discussions were used as tools for data collection in carrying out this study. According to Frankle (1993), a research instrument is a device for systematically collecting data. Research tools are unavoidably indispensable in research for the study to come up with disclosures it seeks to bring to light.

3.4.2 Focus Group Discussions (FGDs)

Focus group discussions involve interviewing several people discussing and commenting on, personal experiences about the subject of the research (Bryman 2004:346). The focus group discussions enabled the researcher to examine people's different perspectives as they operated within a social network" argued Seale (2004:181). Focus groups typically bring together a small group of people to participate in a carefully planned discussion on a defined topic (Morgan, 1998). In this case the impact of free health policy for U25 diabetic patients, focus group discussions was done on diabetic patients. These people were mobilised with the help of health practitioners at health facilities who have the contact details of their patients, and the sessions was conducted at an agreed place with them.

3.4.3 Questionnaires

A questionnaire is a research instrument comprising of a set of questions specifically designed to collect data from respondents. In this study, the researcher used the survey questionnaires with both structured and unstructured questions. Schwandt (2007) defined a survey questionnaire as an effective data collection tool used in the study of a social phenomenon in which participants may give their honest opinions in both structured and unstructured manner on the subject under study. The researcher used the questionnaire because it is easy to administer and that it is used to collect information from a large sample simultaneously and therefore saves time in data collection process. Questionnaires were effective in allowing respondents to express their views in an independent way free from fear because of anonymity. Forty questionnaires were administered to diabetic patients, and fifteen questionnaires were given to key informants (Ministry of Health Officials and Nurses in Kabezi District). These were given to each participant at their homes, in their offices for key informants and left to be completed before the researcher follows up for collection.

3.5 Pilot Study

A pre-test refers to a trial management of an instrument to recognize any flaws. When a questionnaire is used as a data assembly tool it is necessary to determine whether questions and directions are clear to respondents and whether they understand what is required of them (Polit and Hungler 1995:711). The questionnaire was pre-tested with 4 respondents to check whether the questions are clear, but the responses are not from part of the study results. Suggestions made for improvement, were incorporated in the final questionnaire which was administered to the sample population.

3.6 Analysis and Organization of Data

It is of supreme importance to note that Blanks (2007:22) classify data presentation and examination as a way of making sense out of large amounts of raw statistics. The FGDs and interviews were recorded using a voice recorder. Transcriptions from the audio recordings was the empirical basis for the content analysis. This was presented in narrative form with charts and tables. This is a process that encompasses the reduction of accumulated data to a manageable size, developing abstracts, observing patterns, and then applying techniques which allow the interpretation of results in accordance with the research objectives (Cooper &Schindler, 2003). After data collection the researcher subjected the data to coding, editing and then processing which forms an integral part of data analysis. The data was presented in themes as they emerge from the responses. The researcher also sought the help of experts in translating responses to English where native language was used.

Data from the questionnaires was manually captured onto an excel spread sheet. Without a good data analysis technique, it is impossible to come up with meaningful findings. The data analysis was performed using a Statistical Epi Info package. The analysis involved the following:

A database was formed entering all the Liker items

Data from the questionnaire was apprehended into the database and disemboweled.

The Epi info was run to perform various statistical tests, frequency, test for normality, reliability of data, cross tabulation, correlation, and regression.

Data was then interpreted to answer the research question and to prove or disprove the hypotheses. The statistical package has comprehensive data manipulation tools.

3.7 Ethical Considerations

Ethics can be defined as the standards of behaviour that differentiate between the acceptable and unacceptable. Cooper and Schlinder (2008), says ethics are defined as the norms or standards of behaviour that guide moral choices about one's behaviour and relationships with others. The researcher highlighted the objectives of the study on the consent forms and sought permission from the respective authorities. This is in support with Sekaran (2010) and Robson's (2002) suggestion that a researcher should not attempt to exert any pressure on prospective participants to be granted access.

Besides signing the consent letter, the researcher gave a brief description of the purpose and benefit of the research to the participants in order to put them at ease and all participation was on a voluntary basis. The participants were also told that they have the right to opt out and withdraw their consent at any time if he or she is not comfortable or if their emotional state is affected or feel harmed physically, legally, or otherwise during the research, hence the need to discontinue. They were also informed that their withdrawal from the study will not affect their relationship with their jobs and employers, nor will it have any consequences on them.

In order to avoid compensation or reimbursement, the researcher upheld the rights of the respondents to privacy so as to protect the participants and also for retention of validity of

the research (Cooper & Schindler, 2003). Confidentiality was ensured during and after the research. In fact, names, addresses and respondents' area of origins were not used. He also assured the interviewers that names were not mentioned since the research is for academic purposes only. The researcher promised ethical behavior, claimed to be honest and conducted the research decently through abiding by specific ethical codes, standards and procedures that are compulsory when dealing with human subjects. He also selected participants based on their official age through their birth certificates, national identity cards, passports or any other documents which can provide genuine participants' age to the researcher and judged official by the government of Burundi.

The researcher looked up at all the information with a lock and key in a cupboard and it will not be discussed with those out of the research. He finally also sought permission to carry out the research from AUREC, then responsible authorities from Kabezi District, that is the local government authorities, health officials and the police as soon as he arrives on the field in Kabezi, Burundi and before he started any activities related to this study. At the end of the research, the researcher shared the findings with the participants and other respondents as well as the key informants by availing copies of the results sent to participants, other copies will be available at the college and in the library.

3.8 Summary

The chapter looked at the study methodology including the design, philosophy, sampling techniques, selection of survey instrument, data collection and synthesis and data analysis and interpretation.

CHAPTER 4 DATA PRESENTATION, ANALYSIS & INTERPRETATION

4.1 Introduction

The chapter presents the results of data collected from the research in a logical manner in order to have easy interpretation with the major aim of drawing up a correct conclusion. The chapter presents the results of the whether the free healthcare policy for diabetes patients in Kabezi district is really impacting the beneficiaries or not. During data collection, respondents were deemed to have knowledge in the subject. For data analysis, the SPSS software and Excel were used.

4.2 Data Presentation and Analysis

The Burundi government through its ministry of health embarked on a door-to-door campaign to reduce the deaths attributed to diabetes. The government also openly said that everyone is aware that there is a free healthcare policy for years, for people living with diabetes. There are obstacles however which are still dragging them back in ensuring the effectiveness of the free healthcare policy for diabetic patients. Addressing the first research objective of pointing out the provisions and purpose of the Free Health Care Policy in Kabezi District, the purpose of the policy is to promote equal access to health regardless of one's financial status. There is therefore a need for policy makers and players in the health sector to have practices and policies that have an equity bias.

The Health equity theory ascertained on literature review section in chapter 2 states that the health services should provide access for all.

This therefore implies equitable access and use of health services, given that some people such as the elderly or the younger people in some instances will need more health care than others or a certain category of people. It outlines challenges that hinder equal health

service delivery. Low education, lack of information (awareness), age, sex, low income, price of medicines, and spatial factors are some of the challenges the theory highlights. The stated challenges are the same challenges hindering the effectiveness and implementation of the free health care policy for diabetic patients in Kabezi district, Burundi. The policy is eradicating the divide between the diabetic population and the non-diabetic, hence the theory was relevant for this research.

4.2.1 The Sample and its Characteristics

This section of the questionnaire covered the respondents' age, gender, type of work, marital status, level of education and the number of their children. Although not essential to the study, the personal data helped contextualize the findings and the formulation of appropriate recommendations.

4.2.1.1 Respondents by Age

Table 4.1 Age of Respondents

Ages	Frequency	Percentage
18-25	40	46.5%
25-35	10	11.6%
35-45	10	11.6%
45-55	15	17.4%
55-65	11	12.8%
TOTAL	86	100%

4.2.1.2 Respondents by Gender

Table 4.2 Gender of Respondents

Gender	Frequency	Percentage
Male	35	40.7%
Female	51	59.3%
TOTAL	86	100%

4.2.1.3 Respondents by Marital status

Table 4.3 Marital Status of Respondents

Status	Frequency	Percentage
Single	30	34.9%
Married	41	47.7%
Widow	15	17.4%
Total	86	100%

The table above showed that the majority of the patients were married individuals below 25 years of age, 15 widows and 30 single respondents.

4.2.1.4 Respondents by Level of Education

Table 4.4 Education level respondents rate

Level	Frequency	Percentage
Form 4	40	46.5%
Form 6	25	29.01%

Diploma/ degree	21	24.4%
Total	86	100%

This table above showed that in many of the respondents have only attained O level certificates (40), while 25 respondents have reached A level, and a few have made it to university or colleges (21).

4.3 Questionnaire response rate

Table 4.5 response rate to the questionnaire

Occupation	Questionnaire send	Questionnaire received	Percentage
Diabetes Patients	40	30	70%
Nurses	10	5	5.8%
Min/Health Officials	5	3	9.3%
Total	55	38	85.1%

The data above showed that a total of 85.1 percent of the respondents managed to bring back their questionnaires after answering them and a percentage of 14 failed to submit back their feedbacks. The researcher finalised that maybe those who failed to bring back their feedbacks was because of being unable to read and write. Some might have failed as well due to suspicion as they thought answering would bring their identities to risk. Most of those who did not answer were the patients.

1. What are the provisions and purpose of the Free Health Care Policy in Kabezi District?

2. To what extent has the Free Health Care Policy achieved the intended purpose in Kabezi District?

3. What are the strategies that can be used to improve the implementation of the Free Health Care Policy in Kabezi District and Burundi at large?

4. What strategies can be used for the effective implementation of the Free Health Care Policy in Kabezi District and Burundi at large?

4.4 The response by nurses on effectiveness of the free healthcare policy

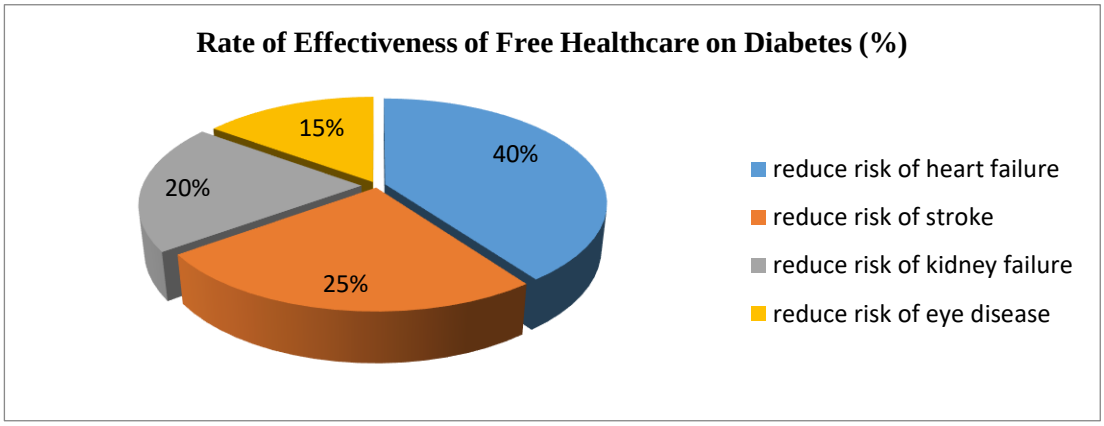


Figure 4.4 Nurses' Response on the Effectiveness of free Healthcare Policy

The above information was obtained from the Ministry of Health officials (nurses). Regular treatment of the diabetes patients is very important as it reduce the risk of the patients from being affected by heart failure. Thus, if treated regularly the patients will be 40% safe from risk of heart failure, while 25% safe from risk of being paralyzed, 20% safe from kidney failure while as well 15 % safe from eyes problems. This shows how important treating the patients regularly for diabetes is.

4.5 Responses from the nurses on the effects of the free healthcare policy

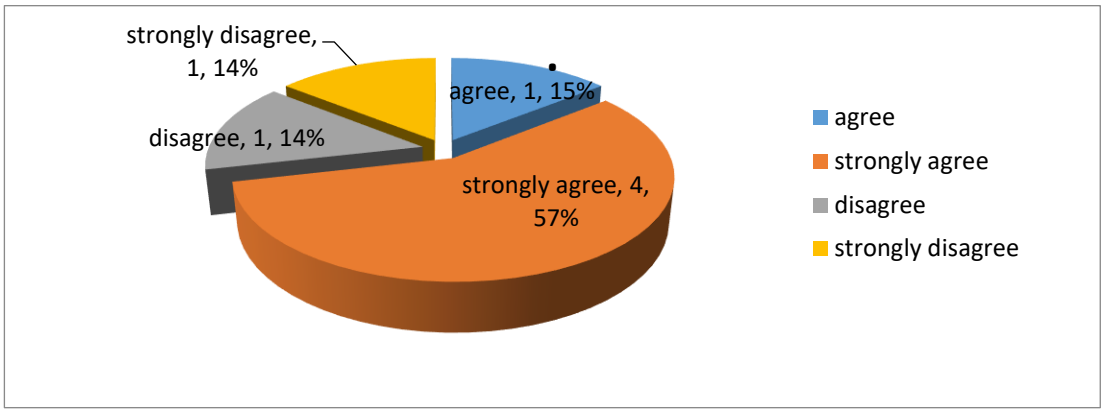


Figure 4.5 Nurses' Response on the Effects of the Free Healthcare Policy

From the information gathered above, many nurses saw the policy of free healthcare as very effective in dealing with this disease of diabetes in the country. They indicated that free healthcare to the under 25 is very important as they don't have the capacity to pay for their medical expenses. 4 out of 7 nurses endorsed the policy as very imperative in the society. However, one of them just agreed that the policy is good, while one of them disagreed followed by another who as well strongly disagreed as he pointed out that the government does not have the capacity to free do the services to the country at large. The information shows that there are still some issues that have to be dealt with to ensure that everyone become confident to the effectiveness of the system. As long as, some people are still not confident it means that there are gaps to the policy

4.6 Growth Rate of Patients treated at Kabezi District Hospital since 2017

Table 4.6 Rate of Patients treated at Kabezi District Hospital Since 2017

Year	Growth rate %
2017	14%

2018	27%
2019	39%

Source: Kabezi District Hospital Database

The results above showed there are many people who are suffering from diabetes who are below the age of 25. However, in 2017 many people were not aware confident to the reliability of the policy which is the reason why a few turned up to the call by the government to visit the nearest hospital for free treatment. By the end of 2019 a rate of 39 % was recorded from 14% of 2017 meaning people were now beginning to appreciate the policy and confident to the effectiveness of the services that are being offered in Kabezi District Health facilities.

4.7 Understanding of Diabetes by Respondents

From the focus groups that were done as well as a few interviews that were conducted by the researcher, the results showed that at first many people were not aware of this disease of diabetes. Many people died as a result until the time the government introduced the policy as well as campaigns to encourage people to seek treatment as quick as possible. Lack of education was the other factor which contributed the rate of the deaths that were recorded. Campaigns according to the respondents made things a bit better and reduced the rates of deaths as people were now aware.

4.8 Challenges Faced by Patients

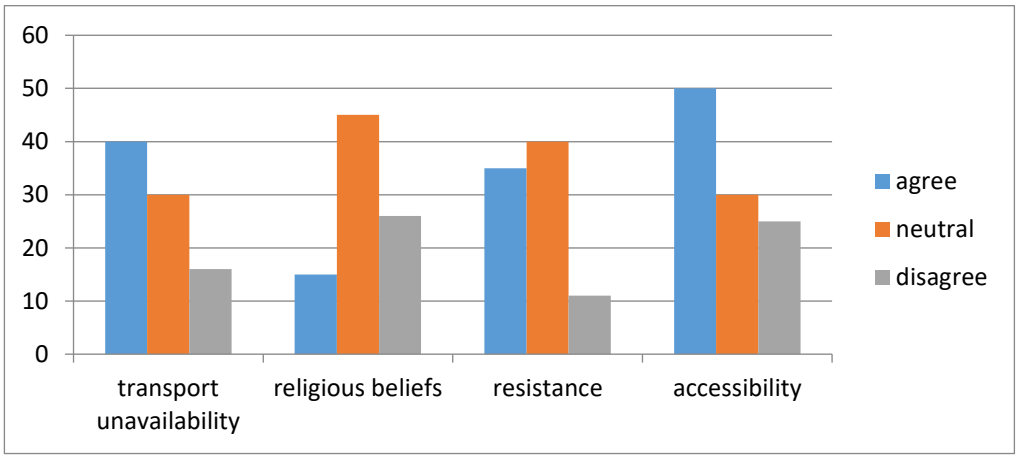


Figure 4.6 Challenges faced by Diabetes Patients

The results above showed that most of the respondents agreed that transport in many areas especially the rural areas is scarce which is the challenge many patients are facing as they are not able to walk on foot for very long distances to get the services. A few people pointed on the issue of religious beliefs as having effects to the probability of people who are diagnosed with diabetes to visit the hospital for treatment. The respondents also indicated that some people are simply resistant to go for treatment which is usually due to lack of education and strong awareness on the need to seek treatment. Lastly, some pinpointed that there might be transport but at times especially during the rainy season the services are not accessible due to degradation of land and other hazards associated with the rainy season.

4.9 Level of Wages

The researcher perceived that some of the people who are between 18 and 25 of age are formally or informally employed in the country and the sad and surprising part was these

folks were also complaining that at times they do not go for medical treatment simply because they cannot afford the transport fees being charged. The researcher then went on to examine how much an average Burundian in the Kabezi district is getting as salaries and or wages. The researcher interviewed 42 people who are under 25 years randomly to get enlightened. The results are shown below.

4.10 Minimum Wage Level

Table 4.7 Minimum wage level of Diabetes Patients

Minimum Wage	Frequency	Percent (%)
Between 19000Bif (10 US) and 114000Bif (US 60)	15	35.7
Between 114000Bif (60 US) and 161500Bif (85 US)	10	23.8
Between 161500Bif (85 US) and 228000Bif (120 US)	7	16.7
Between 228000Bif (120 US) and 285000Bif (150 US)	3	7.1
Between 285000Bif (US150) and 342000Bif (180 US)	2	4.8
Between 342000Bif (180 US) and 399000Bif (210 US)	3	7.1
Between 399000Bif (210 US) and 456000Bif (240 US)	1	2.4
Above	1	2.4
Total	42	100.0

The results above showed that the majority of the respondents are earning an amount which is 85 USD. Many of these people have a lot of demands especially from their

families and self-demands as well. Which means their earning will never be sufficient to carter for every need they have. Many of them at times end up not getting basic needs like visiting the hospital for medications. To add more, there is also a bunch of unemployment youths of the same age who are also diabetic and are finding it hard to access the hospital especially those who stay in the marginal areas of Kabezi district.

4.11 Benefits of free Healthcare according to the Ministry of Health agents

The researcher managed to compile the list of the benefits of free healthcare as they were being said by the ministry of health agents during the interview. They include:

- The system provides healthcare to the people who can't afford the services they need.
- Saves Money to the guardians of these young folks as they are no longer worried about getting money to pay for treatment of their children.
- Free healthcare to the diabetes patients in Burundi also eliminates the competition from other private hospitals that seeks to make profits.
- Benefits of the Marginalized Community who are poor to afford the treatment
- The Ministry of Health agents lastly underlined that this policy is very important as it boost the economy. As more young energetic people are treated it means they will be able to work in industries and contribute to the national gross domestic product.

4.12 Falsification tests

The researcher also carried out a falsification test to see whether or not the government statistics and records are reliable. The government through its ministry of health said that they have embarked on a door-to-door campaign to reduce the deaths attributed to diabetes. The government also openly said that everyone is aware that there is a free healthcare policy for people under the age of 25 years who have diabetes. The hospital is welcoming everyone between the aforementioned range of years to come for regular check-ups and medication. It was however unsure to whether or not these allegations were true. Thus, the researcher went on to interview 40 people in different areas within Kabezi District to see if this was true. The results are shown below.

4.13 Responses on whether or not the government has informed them on the free healthcare policy

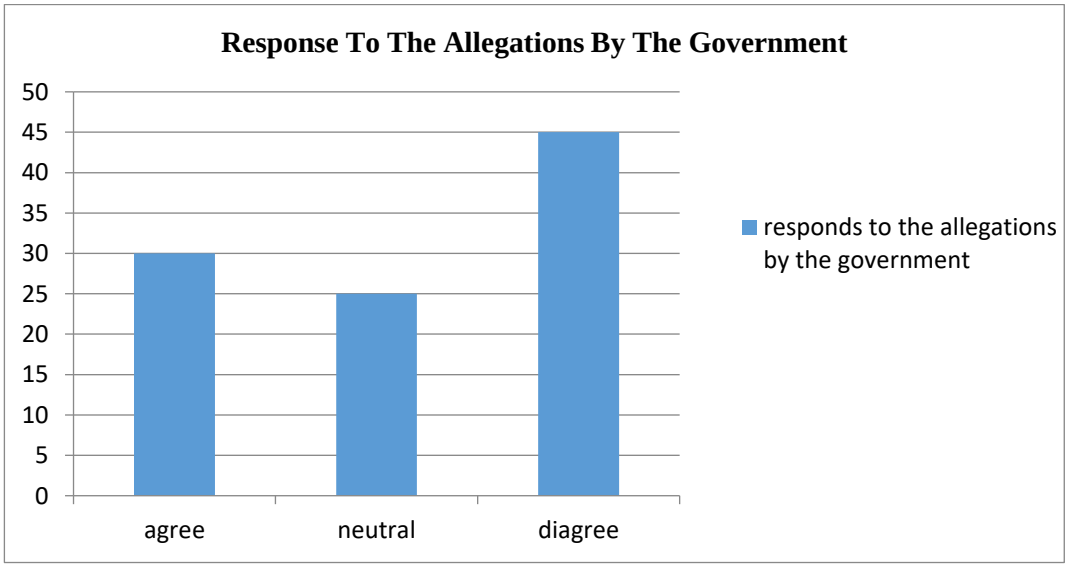


Figure 4.7 Response to the allegations by the Government

The results were a bit complicated and way different from the government's allegations. Out of 40 people, 45% of the number denied that there were no campaigns that were done in their community on such matter. These people are however poor enough to even own radios that would have helped them to get the news. What would have been the only solution were door to door campaigns and unfortunately the government never reached these areas may be due to inaccessibility and remoteness of some of the areas. 25% of the respondents were not sure whether or not they have heard of the news and only 30% were very sure that there is such a policy in the country which allows everyone affected by the disease under the age of 25 years to seek free medication at the nearest health centre.

These results did not surprise the researcher as many African countries have such a mentality of propaganda. A lot of people are suffering in the continent yet if the governments are asked it may seem as if the problems are under control. Up to now some are still struggling for shelter and food, yet the government officials have the guts to publicly say everyone is secure and living large in the area now. Thus, in Burundi the government has also been doing the same to prove too smart in the eyes of the international partners.

4.14 Level of satisfaction

From the over 86 respondents and an investigation was done to see whether or not they are satisfied with the services that are being offered at Kabezi District hospital. There were different answers from the respondents and the results are illustrated below.

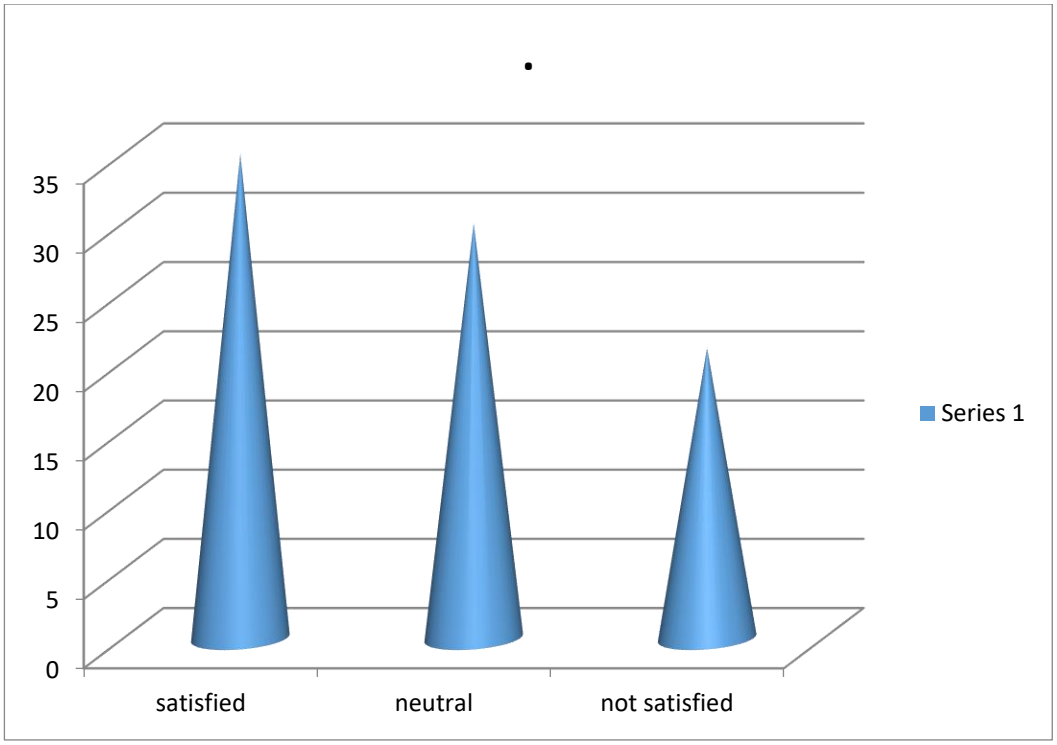


Figure 4.8 Level of satisfaction

From the 86 respondents of this whole study a total of 21 people were not pleased with how the services are being offered at the health centres. Some indicated that the centres are too small to accommodate many people whilst some indicated that there is not enough medication to support the ever-growing number of diabetic people. 21 people were not satisfied while 35 people were very satisfied. At least the majority pledged trust to the health centers which is something to smile about.

4.15 Discussion and Interpretation

There are more benefits than costs on the provision of free healthcare for diabetes patients, as outlined in the findings. The system provides healthcare to the people who can't afford the services they need. It saves money to the guardians of these young folks as they are no longer worried about getting money to pay for treatment of their children. Free

healthcare to diabetes patients in Burundi also eliminates the competition from other private hospitals that seeks to make profits. The Ministry of Health agents lastly underlined that this policy is very important as it boost the economy, because as more young energetic people are treated it means they will be able to work in industries and contribute to the national gross domestic product. However, obstacles are there in hindering effectiveness of the free health care policy for diabetic patients in Kabezi. Transport unavailability, corruption in the public sector, religious beliefs and resistance from the target group remain eminent.

There have been so many constrains affecting the provision of effective health care systems in the developing countries. It has also been stressed that credit constraints may limit the ability to access fee-based services even when there is a clear willingness to pay.

There are several factors that are responsible for the underutilization of effective health care interventions in many countries especially the developing world. Despite the fact that governments are making efforts to raise income to cater for health care, it seems the resources are still insufficient for full implementation. Another challenge is that the available resources are not allocated to the most effective interventions, are geographically concentrated in large cities, and do not reach the poor. It therefore, means that full implementation of the services is hindered. Other factors include inappropriate allocation of resources and inadequate quality of services, which act as impediments to the delivery of effective health care that reaches the poor and the vulnerable.

One essential challenge for improvement endeavors is that of persuading healthcare laborers that there is a genuine issue to be tended to. Clinicians and others may contend that the issue being directed by an improvement intercession is not generally an issue; that

it is anything but an issue 'around here'; or that there are unquestionably progressively significant issues to be tended to before this one. Trying to persuade clinical groups who think they are now doing admirably to change is probably going to be purposeless except if they can be indicated that activity is truly required. Those structuring and arranging mediations ought to be cautious to target issues that are probably going to be acknowledged as genuine. Potential techniques for building up the issue as an issue incorporate hard information to show its reality, persistent stories to make sure about passionate engagement, connect with the clinicians in characterizing what they might want to improve in their administration and show that improvement mediations are frequently 'basically challenged': everybody may concur on the requirement for good quality yet not on what characterizes great quality or how it ought to be accomplished. Clinicians and others may stand up to change on grounds that intercessions need adequate proof or are incongruent with favored methods for rehearsing that as of now seem to convey great outcomes. Guaranteeing that there is acceptable quality logical proof to support intercessions, and that implementers are well informed and equipped for dealing with challenge, is along these lines basic.

One methodology for guaranteeing agreeableness of intercessions includes utilizing very much encouraged gatherings to examine and banter the proof and open it to challenge, instead of trusting that the proof will 'talk for itself'. It may likewise help if improvement activities are supported by a reasonable and express 'program theory' than record of the exercises to be attempted, however, the causal connections between these exercises and the results sought. Among different things, a program hypothesis makes unequivocal why a mediation is probably going to work and explains center and key bearing. Extensive

exertion should be put resources into the underlying program hypothesis, yet it ought not to be viewed as fixed and unchanging; it might create after some time as those occupied with the program gain from their encounters of execution.

The other challenge that is faced in trying to set up strong health systems in a country is the leadership in the health sector. Leading development efforts is challenging and tormenting, requiring a combination of technical skills, enablement skills and personal qualities. It needs to happen at various levels and needs to guarantee alignment with staff priorities, and active work amongst staff to foster cooperation and engagement with enhancement aims. Respected personalities can play a vital role in heartening colleagues across different professions. Key to achievement may be ‘quieter’ management, less about pompous announcements and more about working to facilitate teamwork.

The human asset emergency is brought about by numerous variables, for example, insufficient generation in some nations, failure to enlist in others, mind channel, poor inspiration, irreconcilable circumstance, defilement, what's more, abuse of assets including time in many African nations. In numerous nations, a larger part of health laborers is amassed in a couple of urban zones. All categories, predominantly doctors and nurses, are in diminutive supply compared to the standards of population ratios for nurses and other health workers.

The number, quality, and capacity of medicinal services laborers across nations as a proportion to the populace are low. Globally, there is a severe lack of human resources for health (HRH), and low-income nations, particularly those in sub-Saharan Africa and some regions of Asia, bear the brunt of this shortfall. The achievement of health-related development goals has been severely hampered by this scarcity, which has also slowed

down the rapid move toward universal health care (UHC). According to the MOH Training Needs Assessment report. (2015), there is a serious shortage of healthcare workers in about 57 nations, the bulk of which are in Africa and Asia.

There are significant disparities in the distribution of healthcare personnel between industrialized and developing nations, with the latter suffering the most. The greatest difficulty is faced by Sub-Saharan Africa, which has 11% of the world's population, 24% of the world's illness burden, and only 3% of the world's health workers World Health Organization. (2006)

Corruption defilement diverts genuinely necessary assets from social insurance conveyance and decreases patients' access to basic services. For instances therapeutic staff for public hospitals that sell sedates/drugs that ought to be free, and robbery or preoccupation of medications and supplies at government stockpiling and circulation focuses. Moreover, bribery to gain up endorsement for drug registration or to pass tranquilizes quality assessments are bringing about phony medications "honestly" entering markets.

A darker result of the rise of innovation is that it empowers forgers to run much progressively advanced tasks and make fake medications that are more diligently to identify. Therefore, fake medications currently present themselves as bona fide medications.

A great part of the present focal point of social insurance conveyance in Africa is on customary and noticeable elements like HIV and intestinal sickness. Notwithstanding, changes in way of life and a developing white-collar class are making non-communicable

sicknesses like cardiovascular ailment, disease, and diabetes huge issues among populaces. Fast urbanization and expanded Westernization of ways of life among the white-collar classes is causing an expansion in the hazard factors that cause non-communicable diseases. Individuals devour more inexpensive food and bundled nourishment, which will in general have significant levels of sodium; they take part in less physical action, sitting in their autos and transports on their approach to work; and they are bound to expend liquor in their relaxation time. Another hazard factor is an expansion in smoking rates across populaces.

4.16 Factors Rendering Free Healthcare Policies futile

Other than financing and resourcing factors there are some other factors that research found as having a countervailing effect on the implementation of free health care policies. McIntyre, D., & Ataguba, J. (2015) found out that in some instances there were lack of utilisation of the free health care services due to dissatisfaction among users. The major source of dissatisfaction that they identified relates to the length of waiting time before receiving care (38% in the case of public sector outpatient services and 18% in the private sector). The next most important sources of dissatisfaction were not being treated with respect and dignity (20% in public and 10% in private sectors respectively); perceptions of lack of effectiveness of drugs received (18% in public and 9% in private sector); lack of privacy in consultations (14% and 8%); and lack of confidentiality (10% and 7%). Lack of respectful treatment, privacy in consultations and confidentiality were seen as more problematic in inpatient than outpatient services in public sector facilities. More so, stigma and judgmental behavior of health care providers, which pose acceptability barriers to

health service access, are particularly a problem in relation to certain services such as HIV, tuberculosis, and other non-communicable diseases.

Many of the 'acceptability' barriers within public health facilities are seen as relating to low staff morale or motivation. There are many factors that have contributed to this situation, including: a sense of exclusion and disempowerment among front-line health workers due to top-down implementation of policy on which they are not consulted or well-informed although they bear the consequences of these decisions. While some of these factors relate to national level policies and their implementation, institutional factors that can be addressed by improved management and leadership at the facility level are equally important. However, management improvements must be enabled by public sector health facility managers having the authority to make decisions that will allow them to create a conducive working environment McIntyre, D., & Ataguba, J. (2015)

The vital point of universal health coverage is to guarantee that everybody can utilize the health services they need without danger of money related ruin or impoverishment, regardless of what their financial circumstance. The over-arching concept of global health coverage takes a broader view of the services that are required for good health and well-being (Chetty, 2012). These services extend from clinical consideration for singular patients to the public administrations that ensure the health services of entire populaces. They incorporate administrations that originate from both inside and past the health sector. Money related hazard assurance is one component in the bundle of measures that gives generally social insurance, just as the security against serious monetary troubles in case of sickness gives the significant serenity that is a fundamental piece of prosperity.

Fundamentally, to help the objective of widespread health coverage is likewise to communicate worry for value and for regarding everybody's entitlement to health services universally. These are close to home and good decisions with respect to the sort of society that individuals wish to live in, taking all universal coverage past the details of health financing, general well-being, and clinical consideration. With a more noteworthy comprehension of the extent of all universal health coverage, numerous national governments around the globe presently see progress towards that objective as a core value for the improvement of health frameworks, and for human advancement for the most part.

In each nation, there are individuals who can't pay straightforwardly, out-of-pocket, for the services they need, or who might be truly impeded thusly. At the point when individuals on low livelihoods with no money related hazard security become sick, they face a difficulty. At last, if a nearby health service exists, they can choose to utilize the service and languish further impoverishment in paying over it, or they can choose not to utilize the administration, stay sick and hazard being not able to work (Hjortsberg, 2003). What's more, preventive and therapeutic services secure health and ensure salaries.

4.17 Summary

Chapter 4 presented the outcome (qualitative and quantitative data) obtained from the research carried out, on assessing the effectiveness of the free health care policy for diabetic patients in Kabezi district, Burundi. The next and last chapter presents the summary, conclusion, and recommendations for the research.

CHAPTER 5 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter lays out the summary, conclusion, and recommendations for the effectiveness of the free healthcare policy in Kabezi district. Implications of the study and recommendations for further research are also clarified.

5.2 Discussion

The research sought to establish how effective the implementation of the free healthcare policy for diabetes patients in Kabezi district, Burundi. The first Chapter of the research highlighted the background of the study looking at the reality and impact of the new policy introduced in various communities across the country, to identify some of the implementation gaps. The statement of the problem justified the focus of the research, which was to assess the effectiveness of the free healthcare policy for diabetic patients. The research objectives were also laid out together with, the significance, limitation and delimitation on the study.

Chapter 2 reviewed the literature on the results and reaction of beneficiaries, after the free healthcare policy for diabetic patients was introduced. With a good number of nurses who saw the policy of free healthcare as less effective in dealing with this disease of diabetes in the country. The government however has fairly lived to its promises in providing basic services for diabetes patients below the age of 25. The provision of free healthcare in Kabezi District is not being fully utilized as some patients are resistant while some are hindered by religious beliefs.

The services are also not up to standard. Many patients are not able to reach the services due to inaccessibility. Awareness campaigns for the healthcare policy were not done quite well and effectively and relatively, some patients are not satisfied with the services they are getting daily. The falsification tests show that the government is exaggerating its statistics on the number of people receiving free healthcare.

The research methodology for the study is delineated in Chapter 3. Presentation of findings is laid out in Chapter 4 clearly linking the results to the objectives of the study.

Chapter 5 discusses the results, provides conclusions, implications suggesting a set of recommendations for adoption by stakeholders, interest groups and communities implementing the free healthcare policy for diabetes and even other chronic diseases. Areas for further study are also highlighted.

5.3 Conclusions

The community members and the stakeholders in Kabezi district confirmed that the healthcare services in Africa and Burundi in particular are well below standard. The health workers are not doing their best because of being lowly paid which is the reason why they don’t have confidence in every policy Burundi comes up with. There is a lot the government needs to do to upgrade its services especially on provision of health workers and medicine. Burundi has not received much help from the outside because of propaganda. It is not going to receive outside help if it continues to provide misleading information in their databases.

The death of diabetes patients is escalating in Africa and Burundi despite their free healthcare policy. There is need to provide strong healthcare system first, which the

country is yet to do. The implementation has not ripe fruitful results because of poor campaigning by the government. Lack of effective strategies has been a problem because the policy has no ripe fruits.

5.4 Implications

The overall aim of this study was to assess how effective the implementation of the free healthcare policy for diabetes patients was in Kabezi district of Burundi. The findings imply that diabetic patients in Kabezi District are affected by factors that are economic, religious, political, also, shortage of resources and lack of prioritisation in implementing the free healthcare policy. Free healthcare services are always difficult to provide even in developed countries. The most important thing that the government of Burundi must ask is who is going to pay for the services. If that is well answered, then they can strategize on how to do it. Otherwise, this is the reason why the services provided are not well up to standard.

In other words, the study reveals that without the requisite resources, technical skills, maximum participation of community members among others, implementation of Community Based policies is negatively affected and in turn. Highlighting these variables will go a long way in ensuring the effective implementation of the free healthcare policy for diabetic patients.

5.5 Recommendations

- There is need to decentralize- decentralization of healthcare services has not been done because the country is poor and cannot meet the escalating number of people in need of the services.

- The government must stop using propaganda on things that matters. They must clearly explain where they are not getting it right so that outside forces can provide help rather than providing exaggerated and cooked information in their databases.

- Education is key not only because it makes someone wealth, but it also gives someone the knowledge to prioritize. Some people in the rural areas of Kabezi District are ignorant on the severity of diabetes which is why they tend to resist and pay no attention to the free healthcare policy. The government and other civil society groups must start educating the masses, so they are aware of the brutality of this disease and take medication.

- Having different religious affiliations is not a problem, the problem comes when other religions hinder their followers from getting medication. This high level of stupidity has made Africa poor and unable to move.

- No one doubts the influence of achieving universal health coverage (UHC) for both individuals and the public at large. Many countries in sub-Saharan Africa (SSA) are presently struggling for exactly the better access to care, dignified standard of treatment and better-quality health outcomes that UHC could bring. But current limited budgets from both governments and international donors combined with challenges in implementation capacity mean this cannot be attained without the private sector. This means Burundi must do its best to attract the private sector take part in the provision of healthcare to diabetes patients and all other patients diagnosed with different diseases at large.

All services involved in disease diagnosis and treatment, or in promoting, maintaining, and restoring health, including both personal and non-personal health services, are considered to be part of the field of health care (WHO, 2016). While provision describes the way resources like money, staff, equipment, and pharmaceuticals are integrated to enable the implementation of healthcare services (WHO, 2016).

In addition, evidence indicates that the robustness of primary care resources and services in communities and countries has a significant impact on health services equity, particularly in terms of their potential to lower severity (Starfield, 2004). A nation's ability to provide a health care system that tackles all the problems with accessibility, affordability, effectiveness, and quality of care will help to enhance and rationalize population health equity.

Furthermore, concerning leadership and governance there is a need to update the national health policy and strategic plan; update and implement public health laws; and reinforcement of mechanisms for transparency and accountability and intersectional collaboration.

With respect to medicinal products and technologies, Burundi must concentrate on development of formulae for determining the necessities and forecasting for medicines, commodities, essential technologies and infrastructure, and conception of an apparent and accountable procurement system.

Concerning to health financing, Burundi must foster on development of an inclusive health financing policy and a strategic plan; institutionalization of national health accounts

and proficiency monitoring; strengthening of financial administration abilities at all levels; allotment of at least 15% of the national budget to health development.

Building on the fundamentals of indispensable health services, genre of delivery and costs; development of norms, standards and measures for service provision and health infrastructure construction and upkeep; invention of unified service delivery model at all levels including the referral system; development of mechanisms to involve all private health providers in provision of essential health services; development and application of multi-sectorial health promotion policies and strategies to enhance community participation in health development.

5.6 Suggestions for further research

- Develop human resources - research on how best to provide more human capital in the health sector
- Link with other sectors - maybe implementation of the policy was not very effective because the health sector was isolated. There is need for a study to find out whether or not linking the health sector to other national sectors can produce good results.

Support more research - More research into biological, psychosocial, and service provision aspects of diabetes health is needed in order to increase the understanding of the cause, course and outcome of sugar diabetes and to develop more effective treatment services.

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Appendices

Appendix 1: Participant Consent Form

INFORMED CONSENT

My name is David Ntahombaye, a master's student in Public Policy and Governance from Africa University. I am carrying out a study on An Assessment of the Free Health Care Policy for the under 25 Diabetic Patients in Burundi. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them me, the study doctor or the staff.

Purpose of the research

By undertaking this research, it is of great knowledge that it is going to be beneficial in many ways. The government of Burundi, citizens and the policy makers will be the most targeted groups who will benefit from this research. The government will assess its policy on free health care. Residents will also understand free healthcare the government has put in place while the policy makers will be able to measure the success of their policies and see how they can improve in the provision of healthcare in Burundi.

Procedures and duration

If you decide to participate in this study, you will be required to contribute in the focus group discussions or answer interview questions. It is expected that this will take only about 10 to 15 minutes.

To avoid work disruptions, you will be given three days to prepare the topic on which the discussions will be based on. The short interview will be conducted upon placing an appointment.

Risks and discomforts

Participants may fear being labelled and intimidated for openly airing their views and opinions in the research.

The participants may be afraid to lose business time and risk work disruptions whilst attending to the group discussions and interviews.

Benefits and/or compensation

There will be neither direct benefit nor any incentive to you to take part in the research, but your participation is likely to help us find out to what extent the free Health Care Policy was successful to under 25 Diabetic Patients and to find ways in which the provisions in this policy can be improved.

Confidentiality

Given the sensitivity nature of this research, the researcher shall protect the participants making sure that their contributions will be treated with utmost anonymity/confidentially and will be used purely for academic purposes. No names will be captured during the interviews. Only the researchers will know what your number is and we will lock up that information in a cupboard with a lock and key. It will not be discussed with those out of the research.

Voluntary participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all your rights as an employee or citizen will continue to be observed and nothing will change. Please, be advised that you can also decide to stop participating in the study at any point.

Offer to answer questions

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

Authorisation

If you have decided to participate in this study please sign this form in the space provided below as an indication that you have read and understood the information provided above and have agreed to participate.

---------- ----------

Name of Research Participant (please print) Date

Signature of Research Participant or legally authorised representative.

If you have any questions concerning this study or consent form beyond those answered by the researcher including questions about the research, your rights as a research participant, or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Africa University Research Ethics Committee on telephone (020) 60075 or 60026 extension 1156 email aurec@africau.edu

Name of Researcher: David Ntahombaye

Appendix 2: Questionnaire Survey Instrument

QUESTIONNAIRE FOR RESPONDENTS AND KEY INFORMANTS

Dear Respondent

I am David Ntahombaye, a Student at Africa University pursuing a Master's Degree in Public Policy and Governance. I am carrying out a research on an assessment of the free health care policy for the diabetic patients in Burundi: the case study of Kabezi district, Burundi. Your business is equally important in this research study therefore you are being kindly requested to contribute to the research by answering the questions on this questionnaire truthfully. You are assured that your responses will be used for academic purposes only. You don't need to identify yourself in any way on the form. Respond by just a tick in the boxes or explain in the spaces provided.

SECTION A: PERSONAL DATA

For this section indicate by a tick () the response that best describes you.

1. Indicate your position status?

Nurse	
Government official	
Diabetes patient	
Others	

2. Indicate your gender?

Male	
Female	

3. How long have you staying with diabetes?

0 – 4 years	
4– 8years	
More than 8 years	

4. Have you ever been to the hospital for treatment?

Yes	
No	

5. If you answer above is no, can you give a brief reason why?

……

6. What is your highest academic qualification?

Form 4	
Form 6.	
Journeyman	
Diploma	
Other (Specify)	

SECTION B

To what extend do you agree with each of the following statements? Please indicate your responses using the 5-point scale where, 1 = Strongly Disagree (SD), 2 = Disagree (D), 3 = Indifferent (I), 4 = Agree (A) and 5 = Strongly Agree (SA).

7. Are you aware of the free healthcare policy which was incepted by the government?

---

8. Challenges faced by diabetes patients

The challenges that are faced are represented by the following table

Challenges	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Transport unavailability					
Religious beliefs					
Inaccessibility					

9. What is your recommendation to address the limitations faced by patients of diabetes in Kabezi?

a)……

b)……

c)……

d)……

e)……

10. What are the benefits of free healthcare policy to patients under the age of 25 in Burundi?

Benefits	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Save money for the guardians					
Eliminate competition from the private sector					
Help the marginalized families					
Safeguard national human capital					

11a. Are you satisfied with the services offered at Kabezi hospital?

Yes …….. No …….

11b. If your answer above is no, can your briefly explain the reason for your answer

……

12. Briefly state any suggestions that can be made by government to improve the diabetes healthcare services

.----------

SECTION C

13. What is the government doing in promoting healthcare services in Burundi?
(a)……

(b)……..……

(c)……

(d)…….……

(e)……

14. Why has there been an increase in the number of deaths due to diabetes despite the introduction of this free healthcare policy?

a)……
b)……
c)……
d)……
e)……

15. Roughly how much do you earn on average per month from the activities you are engaged in?

---

16. Is the income from your activities adequate meet your personal and family needs?
……
……

Thank you for your co-operation.

Appendix 3: Interview Guide

My name is David Ntahombaye (Student No.130358). I am a student at Africa University, College of Business, Peace, Leadership and Governance (IPLG). I am conducting a research titled: An assessment of the Free Health Care Policy for the under 25 Diabetic patients in Burundi: The case study of Kabezi District, Burundi as part of the requirements leading to the award of a Master's in Public Policy and Governance (MPPG). I would therefore be grateful for your assistance in participating in completing the following questions to the best of your knowledge. The responses that you will provide in this research will be treated with confidentiality and are only meant for academic purposes.

Questions

1. At which ages are most people diagnosed with diabetes?
2. What are the provisions of the free health care policy for diabetes patients U25? What does it offer?
3. What are the major factors that affect provision of free health care policy for diabetic patients U25?
4. Are these provisions and services meeting the needs of diabetic people U25?
5. How has the free health care policy for diabetic patients U25 impacted the targeted group?
6. Can the policy be considered a success? And why?
7. How does the government monitor and evaluate the policy?
8. Generally, is the policy on-track or off-track with regards to achieving its objectives?
9. Do you think the government should do more to make the policy more appropriate in curbing the disease among the U25?
10. What are the strategies that you consider can be used to properly implement free health care policy to the under 25 diabetic patients.

THANK YOU VERY MUCH FOR YOUR TIME!!

Appendix 4: Focus Group Discussion Guide for Diabetic Patients

My name is David Ntahombaye (Student No.130358). I am a student at Africa University, College of Business, Peace, Leadership and Governance (IPLG). I am conducting a research titled: An assessment of the Free Health Care Policy for the under 25 Diabetic patients in Burundi: The case study of Kabezi District, Burundi as part of the requirements leading to the award of a Master's in Public Policy and Governance (MPPG). I would therefore be grateful for your assistance in participating in the discussion about the following themes to the best of your knowledge. The responses that you will provide in this research will be treated with confidentiality and are only meant for academic purposes.

Thank you for your cooperation.

Themes for discussion

1. Ages at which most people were diagnosed with diabetes.
2. The provisions of the free health care policy for diabetes patients U25. What does it offer?
3. The major factors that are affecting the provision of free health care policy for diabetic patients U25?
4. Are these provisions and services meeting the needs of diabetic people U25?
5. How has the free health care policy for diabetic patients U25 impacted the targeted group?
6. Can the policy be considered a success? And why?
7. Do you think the government should do more to make the policy more appropriate in curbing the disease among the U25? Why?
8. What are the strategies that you consider can be implemented to properly implement free health care policy to the under 25 diabetic patients?

THANK YOU VERY MUCH FOR YOUR TIME!!!

Appendix 5: AUREC Approval Letter

AFRICA UNIVERSITY
United Methodist-Related Institution
INVESTING IN AFRICA'S FUTURE

AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE (AUREC)

P.O. Box 1320 Mutare, Zimbabwe, Off Nyanga Road, Old Mutare-Tel (+263-20) 60075/60026/61611 Fax: (+263 20) 61785 website: www.africau.edu

Ref: AU1107//19

14 November, 2019

David Ntahombaye
C/O CBPLG
Africa University
Box 1320
Mutare

Provisional approval

RE: AN ASSESSMENT OF FREE HEALTH CARE POLICY FOR THE UNDER 25 PATIENTS IN BURUNDI: THE CASE STUDY OF KABEZI DISTRICT

Thank you for the above titled proposal that you submitted to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and provisionally approved your application to conduct the above research.

RESEARCH ETHICS COMMITTEE (AUREC)
14 NOV 2019
APPROVED
P.O. BOX 1320, MUTARE, ZIMBABWE

The approval is based on the following.

a) Research proposal
b) Questionnaires
c) Informed consent form

- **APPROVAL NUMBER** AUREC1107/19

This number should be used on all correspondences, consent forms, and appropriate documents.

- **AUREC MEETING DATE** NA
- **PROVISIOAL APPROVAL DATE** November 14, 2019
- **EXPIRATION DATE** January 15, 2019
- **TYPE OF MEETING** Expedited

After the expiration date this research may only continue upon renewal. For purposes of renewal, a progress report on a standard AUREC form should be submitted a month before expiration date.

- **SERIOUS ADVERSE EVENTS** All serious problems having to do with subject safety must be reported to AUREC within 3 working days on standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

Yours Faithfully

MARY CHINZOU – A/AUREC ADMINISTRATOR
FOR CHAIRPERSON, AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE

Appendix 6: Field Approval Letter

REPUBLIC OF BURUNDI

MINISTRY OF PUBLIC HEALTH AND
OF THE FIGHT AGAINST AIDS
DIRECTORATE GENERAL OF HEALTH SERVICES
AND THE FIGHT AGAINST AIDS
BUJUMBURA SANITARY PROVINCE
KABEZI HEALTH DISTRIC

Object : ANSWER TO YOUR REQUEST

Dear David NTAHOMBAYE,

Thank you for your interest in conducting your Master's research entitled **« An Assessment of the free healthcare policy for the under 25 diabetic patients in Burundi: The case study of KABEZI Health District»**; in the District under my responsibility and I hereby, mark my approval.

I and my staff are ready to assist for any related matters that will rise and will be happy to get a copy of your final work to serve as a basis for future researches.

We wish you all the best in your research and we look forward to assisting you.

February 24 2020

Medical officer of KABEZI Heath District

Dr Arcade HATUNGIMANA

CC :

- **Africa University Research and Ethic Committee**