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Informal Associations and Mutual Societies as a Self-Insurance Strategy for Informal Sector Workers in South Kivu Province: An Alternative Solution to Social Protection in the Democratic Republic of Congo

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Abstract

Access to healthcare is a concern historically rooted in the construction of social protection and the welfare state (1). Beyond this crisis, the right of access to healthcare for all is a myth in the DRC in general, and in South-Kivu in particular. In South-Kivu, only two to three people in ten have access to healthcare, even though it should be defended as a fundamental value of the healthcare system and affirmed as a prerequisite of any healthcare policy. Today, as a result of the powerlessness of the state and the poverty experienced by the population of South-Kivu most of whom work in the informal sector, grassroots players are turning to savings and credit association models (VSCA) as well as informal community-based mutual societies. The aim of this study is to assess the contribution of Village Savings and Credit Associations (VSCA) and informal mutual societies to the self-care of the population in the province of Sud-Kivu, in the east of the Democratic Republic of Congo. It consists of identifying the socio-eco-

nomic characteristics of workers in the informal sector who are members of associations and various informal mutuality's, in order to assess the level of membership and the impact of Village Savings and Credit Associations (VSCA) on health self-insurance. Qualitative methodology was adopted. Data collection was based on a questionnaire sent to leaders of informal sector workers' associations in nine of the thirty-four Health Zones in South Kivu province. Data processing and analysis were based on the similarity of responses to the same question. Although there are constraints at both individual and collective levels, joining the VSL enables previously vulnerable informal sector workers to get by.

Keywords

Associations, Informal Mutual Societies, Health Self-Insurance Strategy, Informal Sector Workers, South-Kivu Province, An Alternative Solution to Social Protection, Democratic Republic of Congo

1. Introduction

In industrialized countries and many others around the world, reforms have been undertaken to improve the financing of healthcare (Conseil ecécutif de l'Organisation Mondiale de la Santé, 2018). In Africa, health care was free of charge in the 1960s, when many African countries achieved independence. With the global economic crisis, African countries were faced with severe impoverishment, an increasing burden of disease, insufficient financial resources, weak economic growth and inadequate public sector management (Bouras & Djareche, 2020).

Faced with this situation, they embarked on a number of reforms in the 1980s, including the direct cost payment system: given the low purchasing power of households, the latter has been one of the major barriers to access to healthcare services. In 2010, according to the WHO World Health Report, 13 billion of the world's poor have no access to health services (World Health Organization, 2023).

In the DRC, as in most developing countries, associations, mutual societies, foundations and cooperatives have historically had a strong presence in the fields of preventive health care and healthcare. Against a backdrop of declining revenues and public funding, they are continuing and expanding their actions to meet the major social challenges in these fields (healthcare, maternity, death, accidents). The DRC in general, and South-Kivu in particular, like other African countries, have subscribed to the strategies proposed by the World Health Organization (Keugoung, 2017).

Over the past two decades, the health sector in the DRC in general, and in South Kivu province in particular, has experienced an ever-increasing shortage of both internal and external resources (Viller et al., 2023). This under-financing of health services is one of the most worrying problems for the country's authorities. The

way the healthcare system is financed is a crucial factor in determining the health and well-being of the population (Askenazy et al., 2013).

In South Kivu, as in other provinces of the country (DRC) and even in many poor countries, spending is still too low to guarantee equitable access to basic social services (Meessen & Damme, 2005). The reduction or even absence of public resources to subsidize healthcare services and the pricing of healthcare have created dysfunction in public healthcare facilities with a negative impact on households' ability to cope with the burdens of illness and even fewer health facilities are privatized, which further complicates the situation for self-care, as the price of an episode of illness is multiplied by three or even five, making care inaccessible (World Health Organization, 2023). To tackle the problem of health financing, and given that the State has failed in its mission, the population is constantly asking itself a thousand and one questions about how to access basic, quality health care. This is why it has created a strategy *of self-care for health and other basic needs,* "*AVEC*" *for short: village savings a*nd credit associations, because access to healthcare remains one of the major problems facing the population of South Kivu, and one of the major challenges facing the province.

With a population of 5,772,000 and a surface area of 65,070, South Kivu ranks among the country's poorest provinces despite its potential and despite the adoption by the State of several health initiatives since the country's accession to national sovereignty, the health situation in the DRC in general and in South Kivu in particular remains worrying, as evidenced by several health indicators. The DRC has the highest mortality rate in the world, with 10.07 deaths/1000 people (2015), mainly due to infectious and parasitic diseases including HIV, Ebola and COVID 19; we can also say that the DRC has the highest fertility rate in the world, with 4.66 children per woman (family planning in the DRC 2015) (Conseil ecécutif de l'Organisation Mondiale de la Santé, 2018).

In South Kivu, in the town of Bukavu, a study was carried out on mutual health insurance schemes in Bukavu in the Democratic Republic of Congo, on the factors that encourage members to use health services. It was found that payment of the co-payment: due to prior payment of the fees covering the co-payment, 51% of those surveyed did not use health services (Waelkens, 2016).

Households that had difficulty paying the co-payment were 4 times more likely not to use healthcare services. Mutuality, which is a voluntary, not-for-profit insurance structure, seems to be a good social protection system for a fraction of the population able to pay regular contributions; notably salaried employees and civil servants, but those without jobs have problems even paying the co-payment. Private health insurance schemes (profit-making organizations generally reserved for the wealthy minority) cannot represent a solution for the majority of the population, whether in South-Kivu or elsewhere. Thus, informal sector workers have strategies for self-care in the event of illness, known as "self-covered health". One of these strategies is the creation of village savings and credit associations (VSCA).

Belonging to an association is a form of self-insurance, achieved through the very

characteristic rebates. Most of these associations, such as the VSCA, are found in rural areas. Among the health zones studied, we observe a predominance of association members over non-members, with Kabare, Miti-Murhesa, Nyangezi and Nyantende all rural (Allegri et al., 2006). Only in Idjwi and Katana was this trend not confirmed by the interviews.

This social protection through self-coverage should in principle be the same as that enjoyed by other self-employed workers. Unfortunately, they are not entitled to reimbursement of healthcare costs, nor do they have the same pension and other rights as any worker affiliated to the social security service. In other words, these informal sector workers should be affiliated to the social security service to enjoy all these rights that other affiliated workers have; but taking into account their monthly assets, 'they should be affiliated in proportion to what they earn, and the rest can be added by the government to reach the minimum threshold of 7,075Fc ($3.5) per working day; i.e. the informal sector worker who can't make $90 from which we get the 18%. He can't contribute $1.5 per working day, and the public authority (government) won't add $1.5 to achieve $3 per working day.

2. Methods and Methodology

2.1. Location Map of the Study Area (Figure 1)

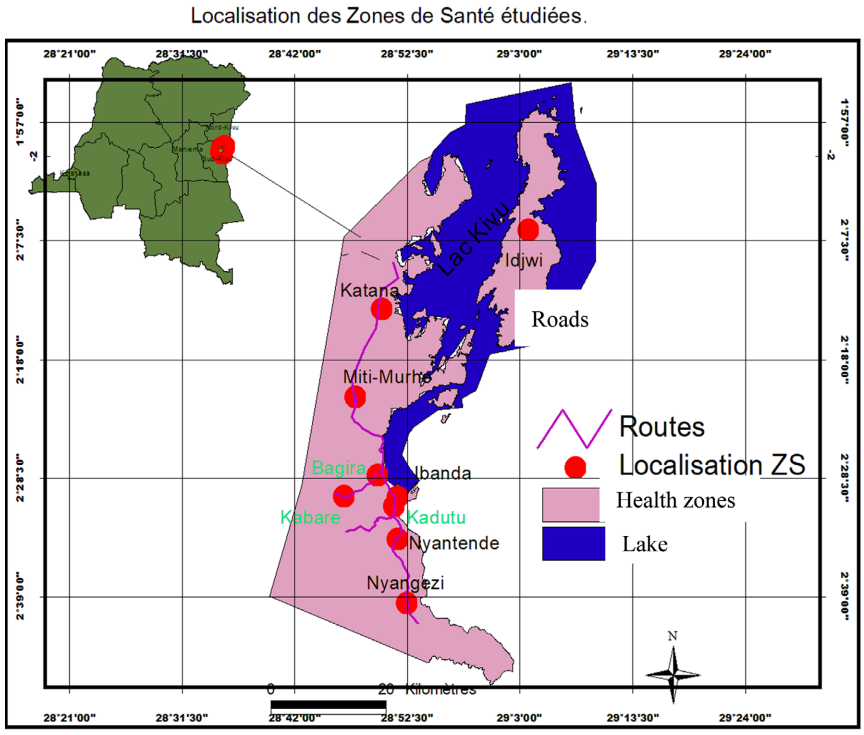


Figure 1. Location of health zones.

2.2. Type of Study

This cross-sectional analytical study was carried out in the eastern DRC province

of South-Kivu, in and around Bukavu, where the vast majority of informal sector workers are concentrated, fleeing the atrocities of armed groups in the province's interior.

2.3. Study Population

The study population was made up of informal sector workers aged between 15 and 65, spread across the nine health zones selected out of the 34 that make up South-Kivu province: Kadutu, Bagira, Bband, Idjwi, Kabare, Miti-Murhesa, Katana, Nyantende and Nyangezi.

2.4. Study Variable

Our study analyses the level of health insurance take-up in South-Kivu province. The following variables were analyzed:

- Socio-demographic characteristics: age, sex, marital status, education level, employment status, household size, residence;
- Economic factors: financial capacity, size of organization or company;
- Geographical factors: distance to travel for declarations and contributions, frequency of declarations and contributions;
- Socio-cultural factors: perception of health insurance contributions, willingness to belong to the health insurance scheme, information, very long period from enrolment to 1st treatment (over 3 months);
- Good Governance, not satisfied with health insurance services.

2.5. Data Collection

Data collection was based on a questionnaire sent to the heads of associations, companies and other groups managing informal sector workers in the nine health zones of South-Kivu province. Other questions were put to informal workers. Two people per health zone were involved in data collection, to avoid missing any information. At the end of the interview, we reviewed all the questions to check all the information and complete them where necessary.

2.6. Data Analysis

Data processing and analysis were based on an analysis of the similarity between the answers given to the same question. The key results to be presented consisted of data collected from two main sources:

- Leaders of associations of informal sector workers in South-Kivu province, leaders of social security and social protection associations or organizations (Health insurance); leaders of sections of partner health agents.
- Data were grouped and analyzed using SPSS Statistica 29 and STATA. The chi2 test was used, with a significance level of 0.05.

To obtain the most nuanced results possible, we used qualitative methods. We met key people, i.e. the heads of associations and other organized groups, and we

set up thematic meeting groups made up of people from different backgrounds: shopkeepers, craftsmen and farmers; these groups reached a total of 383 informal sector workers, through 13 men's groups and 11 women's groups.

With the agreement of the group members, the sessions were recorded and conducted anonymously. After an initial audition of the recording of the meeting, we proceeded to transcribe it; then, after an annotated reading of the transcript, we constructed conceptual categories and filed the information according to these categories (Waelkens, 2016).

2.7. Ethical Considerations

The study protocol was validated by the Ethics Committee of the Official University of Bukavu, the doctoral school of the University of Burundi, the management team of the doctoral school of the University of Rwanda and the management team of the Lwiro natural science research center, and obtained the approval of the management teams of the nine health zones studied: Bagira, Ibanda, Idjwi, Kabare, Kadutu, Katana, Miti Murhesa, Nyangezi and Nyantende. All presented their voluntary consent to participate in the survey of study subjects.

2.8. Socio-Demographic Characteristics of Informal Sector Workers Surveyed

The socio-demographic characteristics of the 383 informal sector workers surveyed are shown in Table 1. The proportion of men was 53%, compared with 45.4% for women. Single people accounted for 29%, while the vast majority of informal workers surveyed were married (55.9%), divorced (2.6%), widowed (9.1%) and cohabiting (1%). 30.8% had primary education, 37.6% had secondary education, and 19.3% had higher education. Catholics (559%), Protestants (36.6%), Muslims (4.4%), farmers (41%), but teachers and nurses were also farmers, to the point where the total could reach over 90%. The average age of workers in the informal sector was 40%.

Table 1. Socioeconomic characteristics of informal sector workers.

1.1. HEALTH ZONES	Total	Percentage
Kadutu	56	14.6
Idjwi	50	13.1
Ibanda	78	20.4
Nyangezi	55	14.4
Bagira	28	7.3
Miti-Muresa	23	6.0
Katana	41	10.7

Continued

Nyantende	22	5.7
Kabare	30	7.8
TOTAL	**383**	**100**
1.2. Gender	**Total**	**Percentage**
Male	203	53.0
Female	174	45.4
Non respondents	6	1.6
TOTAL	**383**	**100**
1.3. Civil status	**Total**	**Percentage**
Single	111	29.0
Married	214	55.9
Divorced	10	2.6
Widow/widower	35	9.1
Cohabitation	4	1.0
TOTAL	**383**	**100**
Non respondents	9	2.3
1.4. Level of education	**Total**	**Percentage**
No studies	40	10.4
Primary	118	30.8
Secondary	144	37.6
Superior	74	19.3
Non respondents	7	1.8
TOTAL	**383**	**100**
1.5. Religion	**Total**	**Percentage**
Catholics	214	55.9
Protestants	140	36.6
Muslims	17	4.4
Jehovah's Witnesses	2	0.5
Atheist	2	0.5
Non respondents	8	2.1
TOTAL	**383**	**100**
1.6. Profession	**Total**	**Percentage**

Continued		
Farmers	157	41
Retailers	130	33.9
Artisans	91	23.8
Non respondents	5	1.3
TOTAL	**383**	**100**
1.7. Age range in years		
≤15	0	0
[15 - 25]	73	19.1
[25 - 35]	95	24.8
[35 - 45]	74	19.3
[45 - 55]	79	20.6
[55 - 65]	62	16.2
TOTAL	**383**	**100**

The results have been analyzed in two parts: the first part concerns the descriptive analysis, and the second part concerns the socio-economic analysis using logistic regression (socio-economic characteristics of informal sector workers).

3. Results

3.1. Informal Associations and Mutual Societies as a Strategy for Self-Insurance against Illness

The right of association enables people to come together to share a common interest over the long term; while mutual societies are a specific type of association governed by the French Mutual Code, whose purpose is to prevent social risks, encourage maternity and the cultural, moral and intellectual development of their members, and improve their living conditions (Dumez, 2021), with the common aim of improving healthcare coverage.

In South Kivu, given that public officials have failed in their regalian mission of ensuring the health of the population, some people are getting together to look for strategies to protect themselves against certain social risks, since for a Congolese peasant (worker in the informal sector) to get medical care, you have to sell a piece of land (field), a plot of land or another valuable asset.

Thus, workers in the informal sector have sought strategies for self-care in the event of illness, which is "self-coverage". Among their many strategies, they have opted for the creation of village savings and credit associations (VSCA). Belonging to an association is a form of self-insurance achieved

through rebates, which are very characteristic in the fight against vulnerability.

Among the health zones studied, we observed a predominance of association members over non-members Figure 2 and Figure 3, we note Kabare, Miti-Murhesa, Nyangezi and Nyantende, all rural. Only in Idjwi and Katana was this trend not confirmed (during interviews, although this may not confirm the contrary).

This social protection through self-coverage should in principle be the same as that enjoyed by other self-employed workers. Unfortunately, they are not entitled to reimbursement of healthcare costs, nor do they have the same pension and other rights as any affiliated worker. In other words, these informal sector workers should be affiliated to the social security service to enjoy all the rights that other affiliated workers have; but taking into account their monthly assets, they should be affiliated in proportion to what they earn, and the remainder can be added by the government to reach the minimum threshold of 7075Fc ($3.5) per working day; i.e. the sector worker who cannot realize $90 from which the 18% is drawn. He cannot contribute $1.5 per working day, and the public authority (government) does not add $1.5 to achieve $3 per working day.

3.2. Informal Sector Workers' Level of Association Membership

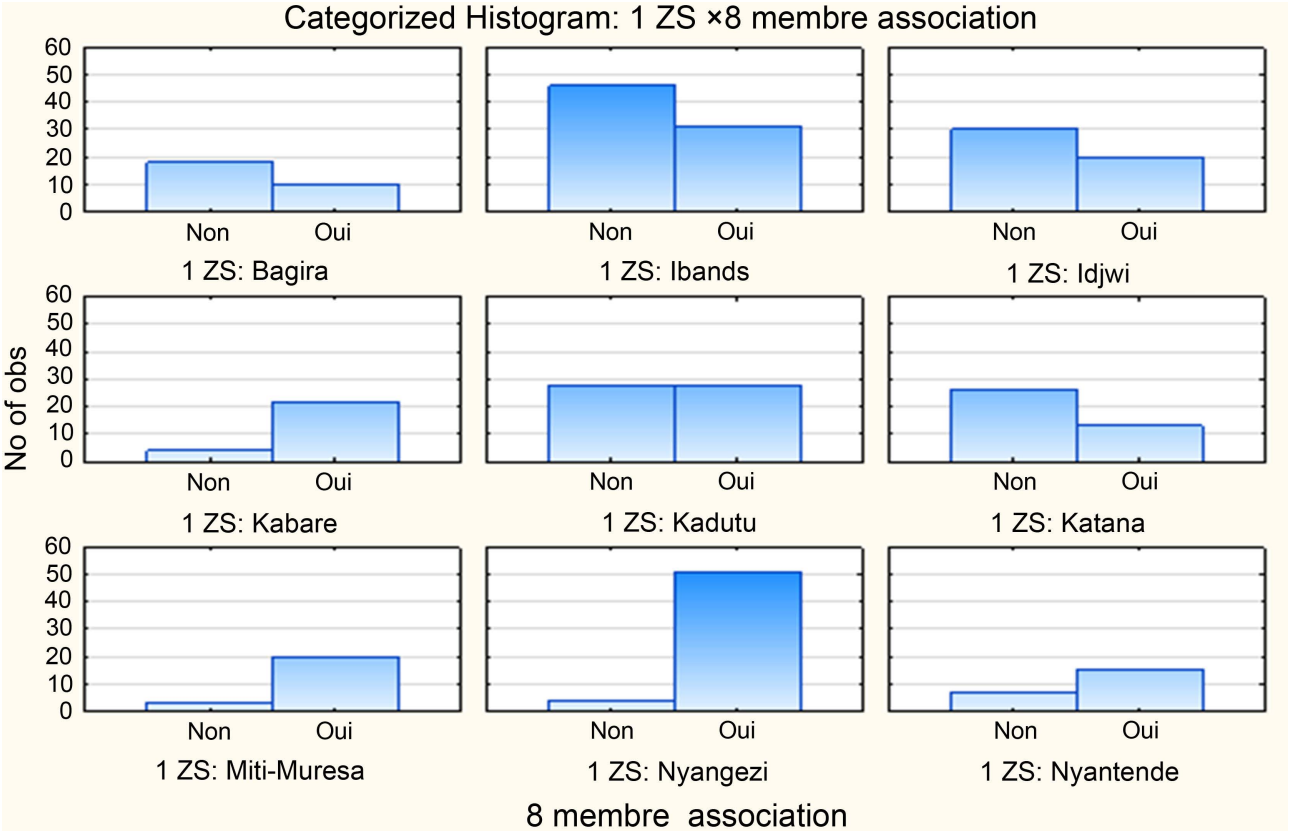
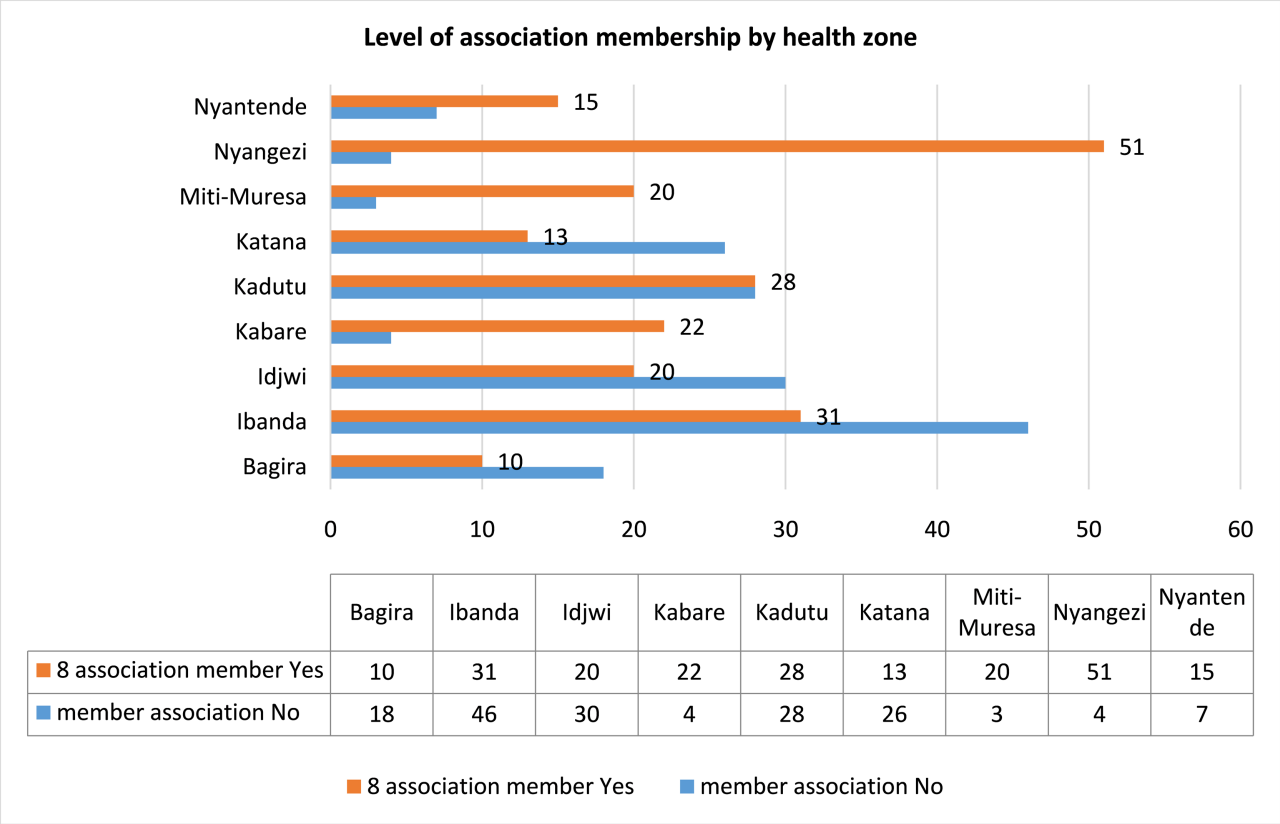


Figure 2. Level of membership of informal sector workers in associations by health zone.



	Bagira	Ibanda	Idjwi	Kabare	Kadutu	Katana	Miti-Muresa	Nyangezi	Nyantende
8 association member Yes	10	31	20	22	28	13	20	51	15
member association No	18	46	30	4	28	26	3	4	7

Figure 3. Informal sector workers' level of association membership by health zone.

3.3. Level of Appearance of Informal Sector Workers in Associations and Level of Education

The results show that this spirit of association, as an indirect means of securing social security and/or social protection, is negatively influenced by school education. The least educated showed a high propensity to join associations and mutual health organizations, from the illiterate through the adult literate, the primairian, the person with secondary education through to university.

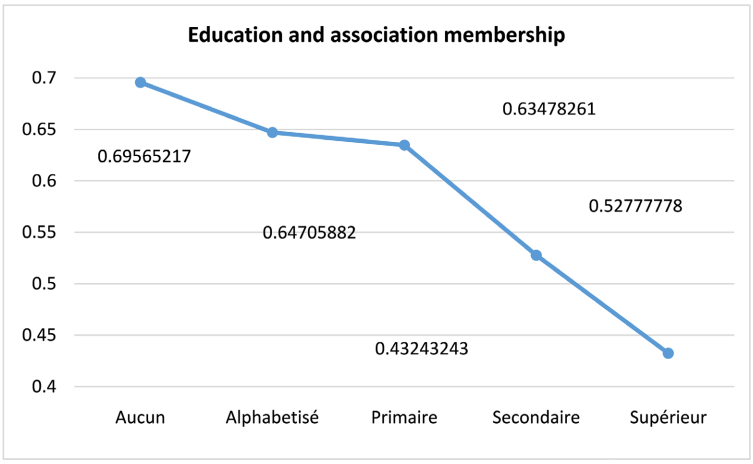


Figure 4. Informal sector workers' level of association membership and level of education.

Figure 4 is interesting and unexpected, since we could expect a spirit of collaboration, association and cooperation in the educated person, who would develop the ability to learn and collaborate on many opportunities and on various private or social issues as a result of increased open-mindedness. It would be a true ferment of society.

On the other hand, it's possible that this educated person, in line with Socrates' thought that the great aim of education is to produce an "autonomous moral personality", could use his autonomy to avoid associating with, and therefore depending on, anyone. From this perspective, the less educated person could be looking for solidarity all the time, by tradition, by necessity in unsatisfied needs, with less chance of finding a paying job that requires training.

3.4. Informal Sector Workers' Membership of Associations by Occupation

Figure 5 shows a high rate of association membership among farmers, who predominate at 90% in rural areas, where even teachers and nurses are also farmers. When expressed as a %, association membership is particularly high among tradesmen (100%) and craftsmen. The propensity to belong to professional associations is average (>60%) among craftsmen (stone crushers, tailors), truck drivers classified as itinerant traders, mechanics also classified as craftsmen, who may group together in a small roadside garage, but each working for himself, Carpenters, who are also classified as artisans, do the same, looking for a way to earn a living that is becoming untenable in the province. Call unit dealers and money changers, classified as street traders, welders, dockers and bricklayers, also classified as artisans, are all players in the informal sector, working only for tomorrow.

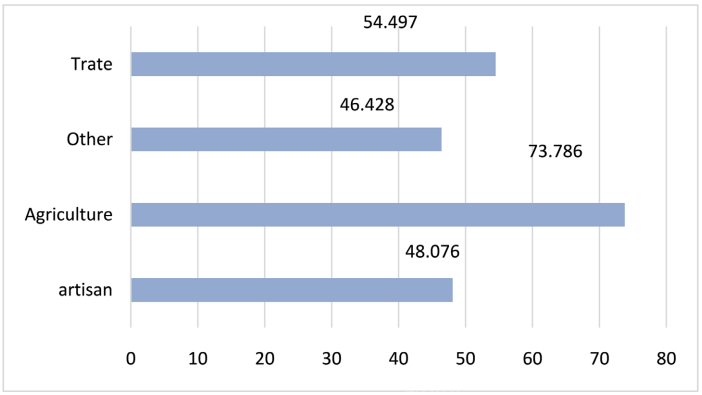


Figure 5. Affiliation to communities based mutual insurancesser profession MUSA membership rate.

3.5. Informal Sector Workers' Main Self-Insurance Strategies

Figure 6 shows that self-medication is a way of obtaining natural or pharmaceutical medicines at low cost, without having to consult a doctor because of a lack of access to the established social security system. The same applies to the use of traditional medicine by traditional practitioners (herbalists).

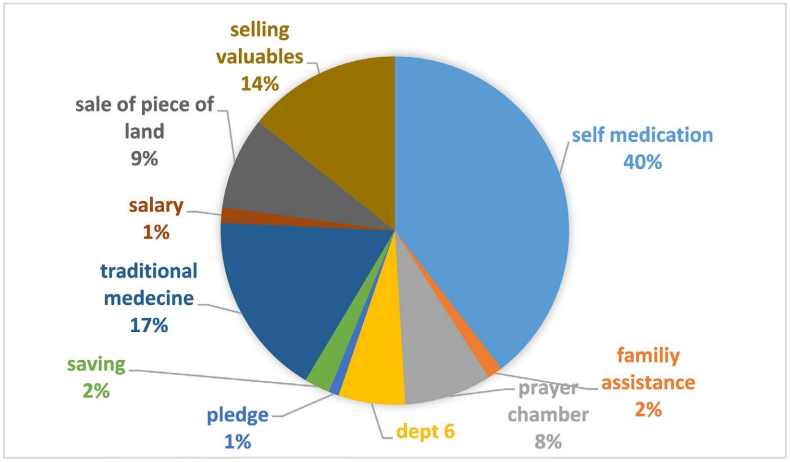


Figure 6. Strategies for informal sector workers to access healthcare.

Apart from this, informal sector players resort to selling off their precious assets, such as plots of land. This is serious when a farmer with a household of 8 people and less than a hectare is obliged to sell part of his often inherited land capital. They also turn to family solidarity for help in the event of illness. It's not uncommon for them to take on debt (8%), which is a major burden, since interest rates are high, reaching 40%. At the same time, access to debt is difficult. They turn to prayer for divine help (8%). They can sometimes pawn an object of value to avoid solitary confinement, or rely on their small savings. Remarkably, it is only "a minima" that they rely on a salary or bonus (1%).

In this self-insurance strategy: Self-medication >> herbalists (traditional healers) = sale of precious objects > sale of plots of land = prayer = indebtedness > family assistance = savings = salary = savings = pledge of valuable objects.

The results of the logistic regression (Table 1) show that the propensity to join associations and health mutual is significantly influenced by age ($P > 0.001$) and rurality ($P = 0.004$). Thus, in the active age interval analyzed between 30 - 37 years, an increase of one year increases the chance of joining associations and health mutual by 49%. On the other hand, we observe that rural informal actors are 2.12 times more likely to join an association or mutual health insurance scheme for their health insurance than their urban counterparts, for whom the chance of doing so is 47% (Table 2, Table 3).

Table 2. The propensity to join associations and health mutual.

Rurality	Member association No	Member association Yes	
Urban	92	69	161
Rural	74	141	215
All Grps	166	210	376

Chi^2 =; Logistic regression; Number of obs = 332; LR chi2 (5) = 38.03; Prob > chi2 = 0.0000; Log likelihood = -207.02254; Pseudo R^2 = 0.0841.

Table 3. Spirit of association.

Association	Odds Ratio	Std. Err.	z	$P>z$	[95% Conf.	Interval
Age	1.048789	0.0122286	4.09	**0**	1.025094	1.073033
Rurality	0.4771637	0.1220121	−2.89	**0.004**	0.2890764	0.7876296
Employer	1.749443	0.6408363	1.53	0.127	0.8532909	3.58676
Gender	0.9459799	0.227092	−0.23	0.817	0.5909387	1.514333
Study	0.8733776	0.1066967	−1.11	0.268	0.6874078	1.109659
_cons	0.5622103	0.3595586	−0.9	0.368	0.1605156	1.969156

The spirit of association is very important for social security and/or social protection, as it influences the propensity to join the mutual health insurance schemes that prevail among informal sector players in the health zones studied in the east of the Democratic Republic of Congo. Philanthropy plays a minor role in this system.

In fact, the founders of health mutuals in South-Kivu also likened them to an association, as illustrated by the case of the genesis of the Idjwi health mutual, a true precursor.

4. Discussion

The aim of this study was to determine the strategy of self-coverage by health insurance for workers in the informal sector in the province of Sud-Kivu in the DRC.

4.1. Socio-Demographic Characteristics of Informal Sector Workers Surveyed

According to the analysis of the survey results, of the 383 participants in the study, men represented 53% of the sample against 454% of women. Single people accounted for 29%, while 55.9% were married, 2.6% were divorced, 9.1% were widowed and 1% were cohabiting.

4.2. Influence of Level of Education on Membership of Associations and Mutual Health Insurance Companies

The level of education in relation to membership of associations and health mutual is interesting and even unexpected, since we might expect a spirit of collaboration, association and cooperation among educated informal sector workers, who would develop their capacity to learn, collaborate and even innovate on many opportunities and on various private or social issues as a result of increased open-mindednes. Paradoxically, however, these educated informal sector workers are less likely to join associations and health mutuals. Our results do not corroborate those of studies carried out in Ziguinchor in Senegal in 2017.

Figure 5 shows that self-medication was the way to obtain cheap natural or phar-

maceutical medicines without recourse to medical consultation, because of lack of access to the established social protection system, forgetting that self-medication can lead to misuse of medicines and a worsening of the sick person's state of health (Allegri et al., 2006). This misuse can take a number of forms, such as dosage errors and the simultaneous use of different drugs, which mutually modify their efficacy. The same applies to the use of traditional (herbal) medicine by traditional practitioners.

Apart from this, informal sector players resort to selling their precious assets, such as plots of land. This is serious when a farmer with a household of 8 people and less than a hectare is obliged to sell part of his often inherited land capital, which constitutes the livelihood of around 60% of the continent's working population, accounting for 17% of the total gross domestic product and 40% of its foreign currency earnings (Waelkens, 2016). They also rely on family solidarity for help in the event of illness. It is not uncommon for them to take on debt (8%), which is a major burden, since interest rates are high, reaching 40%. At the same time, access to debt is difficult. They turn to prayer for divine help (8%). They can sometimes pawn an object of value to avoid solitary confinement, or rely on their small savings. Remarkably, it is only "a minima" that they count on a salary or bonus (1%) often not exceeding two hundred thousand Congolese francs for a primary school teacher or an A^2 nurse (graduate nurse), whereas a parliamentarian (National Deputy) that he has been elected has easily twenty-one thousand dollars as emolument plus sixty-four thousand dollars as parliamentary vacation expenses per quarter according to the Congolese opponent Martin FAYULU in an article published on September 12, 2022 on RFI on invite Afrique. Yet these national deputies were elected so that at least one edict could be passed, if only for "health insurance", but alas, not one of them dares lift a finger to plead this very noble cause.

When you compare the average salaries of civil servants, doctors, soldiers currently at the front, policemen and teachers, it's truly shocking and disappointing. How can someone in such a corrupt situation think of pleading the cause of the other citizens he has left to his own devices? He must be afraid if he pleads, we'll say, that these emoluments can be reduced and distributed to others (Bortel et al., 1996) As part of their self-help strategies, i.e. self-coverage in the event of illness and other life hazards, they have set up village savings and credit associations (VSCA), whose primary objective was to teach their members, who are workers in the informal sector, how to save in order to combat certain risks and other life hazards. These informal sector workers organized three "VSCA" associations in three villages in the BUGARULA/RUBENGA chiefdom cluster.

4.3. Organization and Types of Informal Mutual Societies in South-Kivu

4.3.1. An Example in Vogue: (VSCA) on IDJWI Island in the RUBENGA Chiefdom in the DRC

In groups of 15 to 25 people per association, members save together and take out small loans to protect themselves against certain social risks, such as illness, death

and schooling for their children. These (VSCA) activities operate in "cycles" lasting around a year, at the end of which the accumulated savings and profits from the loans are distributed among the members in proportion to the amount they have saved.

Wherever possible, (VSCA) have been set up on the basis of pre-existing, organized women's groups. Relying on such structures ensures that women already trust each other, have a regular income and are already familiar with the system of Rotating Savings and Credit Associations. The latter are beginning to be numerous and sufficiently important even in urban areas in the province of South Kivu to explain the significant results of the benefits enabled by the adoption of a new practice that they (associations) can provide as a stopgap for low-income earners.

According to the VSL (Village Savings and Loans) Associates methodology, Village Savings and Loans Associations operate as follows: For 1 to 3 months, members save by buying between 1 and 5 shares at each weekly meeting. The value of a share is decided by VSL at the beginning of each cycle. Members may decide to set up a Solidarity Fund to provide small grants (with or without reimbursement) when members are in distress. The Credit Fund is made up of money from savings shares and profits from loans (service charges). At the start of each cycle, loan service charges are determined by members as a monthly percentage of 10% of the amount received. Members have the right to borrow up to a maximum of 3 times the value of their savings.

Loans are obtained and repaid once every 4 weeks after 2 or 3 months of savings. All loans must be repaid within a maximum of 12 weeks during the first cycle in general, but the deadline can be changed by members at the start of each cycle. All VSCA transactions are carried out in front of members during meetings to ensure greater transparency and maintain trust between members. Each member has an account book in which share purchases and outstanding credits are recorded.

To ensure that transactions do not take place outside Association meetings, money and account books are kept in a box locked with three padlocks. The three keys are held by three members of the Association, who are not members of the Management Committee. This is a very important measure, as it prevents falsification of the records of shares purchased by members, as well as their loan registers (Soors et al., 2016).

At the end of each annual cycle, all outstanding loans to members (workers in the informal sector) are recovered and the Credit Fund is distributed among the members. The Credit Fund (which includes profits from loans) is divided by the total number of shares purchased by members during the cycle to calculate the value of a share. Each member then receives his or her portion of the fund according to the number of shares purchased.

The 2017 study by Morgan et al in Chad also showed that at the end of the cycle, members share the entire sum. In this case, 1,484,880 FCFA are divided

between the 20 members, or 74,000 FCFA. This figure is 40% higher than if a member had saved 1000 FCFA per week for a year. Village Savings and Credit Associations: an approach adapted to the poorest households has shown that The Credit Fund comprises the money from savings shares and the profits from loans (service charges). At the start of each cycle, the service charge for loans is determined by the members as a monthly percentage (Generally between 5% and 10%).

To ensure their families' health, food supplies, schooling and their children's education, these associations have set up an innovative approach: Village Savings and Credit Associations (VSCA). These Village Savings and Credit Associations (VSCA) are solidarity-based groups bringing together men and women who are essentially destitute, have irregular incomes and are supposed to be on the same social level. Every penny saved or earned by the group is generated by the members themselves, because during the lean season, most workers in the informal sector have nothing, which is why they have to make reserves when they have little money (Neubourg et al., 2017; Programme des Nations Unies pour le Développement (PNUD), Unité de lutte contre la pauvreté, 2013). ILO studies on health mutuals and micro-entrepreneurs' associations (guide) published in 2001 proved that in every society there are two foresight mechanisms that are still organized: prepayment and insurance. This is why men and women everywhere have developed foresight mechanisms to protect themselves from risk (Gottret et Schieber, 2008).

These women on the Idjwi Island have developed a different microcredit strategy to meet the financial needs of the poorest people, based on their small local and peasant financial organizations, as mentioned above, promoting local, independent savings and credit associations run by the poorest people for the poorest people. These associations are completely independent of commercial banks or other microfinance institutions in the province, both financially and institutionally. Borrowing is based solely on the savings of group members, with no outside funding.

These organizations have also been studied recently by Mwete (also to protect the needs of their families). This is a model of peasant grouping that is being popularized in South Kivu by various non-state actors. They aim to improve socio-economic living conditions by promoting and supporting small local entrepreneurs. As the traditional mechanism for accessing start-up funds for entrepreneurial units had become opaque, this model of farmer grouping was designed to pool local efforts and create a local mechanism for accessing basic financial services to support their families. The study revealed that 33.9% of the members of this structure are traders, as some of them have easy access to start-up funds and/or business development support. These small businesses employ fewer than 10 people and are run on an informal basis.

The types of business developed thanks to the VSCA program essentially include small-scale trading in essential household goods, including foodstuffs, in a

context where most of the food consumed is imported from Rwanda, Burundi in particular. and handicrafts also for household use (23.8), such as the manufacture of chairs, beds, doors and windows, which would hinder the family's ability to earn a living.

4.3.2. Selection Criteria for VSCA Members

These associations have to adhere strictly to the VSCA member selection criteria, as members were afraid of going bankrupt or being swindled. VSCA must not be mistaken for what they are not, i.e. a humanitarian activity aimed solely at the most vulnerable. While it is possible to extend the activity to people categorized as poor, or even very poor, these vulnerable households must not be the only category making up the VSCA, otherwise, its effectiveness and sustainability will be compromised. Nonetheless, given the high rates of return on small loans, mainly taken out by the poorest households, the services provided by VSCA can still be adapted to vulnerable households (Conseil ecécutif de l'Organisation Mondiale de la Santé, 2018).

4.3.3. To Assess the Impact of VSCA on Living Conditions, Qualitative Elements Must Be Included

While quantitative benefits are undeniably the primary reason for activity, they are rarely what members retain as their main advantages. While members praise the merits of credit, the opportunities for childcare and education, and even more, the feeling of belonging to a new family, are widely emphasized. Other indicators could also be used.

4.3.4. Long-Term Evaluation of VSCA Results

In the present case, the project has placed VSCA in an economic logic, using the evolution of members' overall financial capital as the sole indicator of success. However, this is tantamount to valuing short-term investment, which is not always the best way to improve people's resilience. The evaluation of financial capital remains an essential variable for identifying problems and successes, but also for promoting the activity to other populations in the intervention zone. From another point of view, from a resilience perspective, it might be preferable for a woman to acquire a plough and ensure the health of her entire household (thus avoiding the risk of worsening the asset/asset ratio) rather than just increasing her short-term business investments.

4.3.5. Case Study of VSCA d'Idjwi in South-Kivu

Follow-up meeting of the VSCA de Bulega in the Bugarula group in Idjwi. VSCA meet on a regular basis, once a quarter, to encourage spontaneous AVEC initiatives. The VSCA of Bulega idjwi invited other VSCA to celebrate their success and exchange ideas on development and cooperation opportunities. The 3 VSCA of the Bugarula group, including Bulega, Kashiraboba and Ngula, have set up a mutual aid fund without any support from the association, innovating with regard to the method without taking any risks. VSCA members have shown initiative, and

other women have wanted to imitate this practice. These spontaneous VSCA creations should be supported.

4.3.6. Setting Up Individual and Collective Financial Monitoring of VSCA

In order to quickly identify problems and adapt support, VSCA needs to be rigorously monitored and equipped with the right tools to collect the right information and ensure maximum sustainability of the associations. In particular, the supporting association and its members need to have access to at least the financial situation of the VSCA and the use made of the credits, as well as their evolution, in order to ensure a long-term analysis. In this context, regular capacity building in small business management for members of the VSCA could complement the credit support inherent in the activity.

4.4. Lack of Access to Healthcare for Low-Income Workers in the Informal Sector

Our study revealed that only two out of ten people have access to healthcare, leaving eight others without access to healthcare in the province of South Kivu. The HIRONDELE Foundation study also found that in the Democratic Republic of Congo, healthcare is inaccessible to a large proportion of the population. Access to healthcare is a real problem for a large number of the population in South-Kivu in particular, and in the DRC as a whole, especially for vulnerable people working in the informal sector.

The risk of epidemics is high, endangering the lives of the most vulnerable. In many public and private health facilities, access to health care is conditional on payment in advance, or else half the bill is required as a deposit, which is why many people give valuables as collateral to gain access to care. This high cost for many people means that they prefer to resort to self-medication or traditional medicine, or to prayer rooms. Many people die for lack of security, especially those working in the informal sector.

France Assos health survey on access to healthcare, published in the JDD in 2020, revealed the difficulties encountered by millions of French people in accessing healthcare (Parrod et al., 2020). In South Kivu in the DRC, some patients flee without paying because their bills show an astronomical amount they are unable to pay, while others are released after being found unable to pay their bills or demand work at the hospital until their debts are cleared. Yet by 2022, the DRC should have the first healthcare package to be offered to the Congolese people.

4.5. Health Coverage for All: A Project That Should Bring Relief to the Congolese People

The Congolese state has resolved to implement universal health coverage, but this project has always been stifled by certain politicians fearing a reduction in their emoluments and other benefits. A national coordination committee was set up by presidential decree in June 2021 to provide health coverage, which, if respected,

would enable the Congolese people to have access to quality care, without having to go into financial ruin. Unfortunately, good decisions are always taken, but they are stifled by certain politicians in the country and in the same government; indeed, for the most part, one wonders why the national assembly exists at all. This program of the first health care package, which will start in 2022, has not yet been heard of, even though it is essential for the full development of the DRC, Countries that have developed have first protected their populations against health risks (Dévieux et al., 2015). This program should be financed through national solidarity and targeted at the entire population, but essential care should be provided free of charge.

4.6. The Financial Barrier to Healthcare

Increasingly marked financial barriers are entrenching a multi-speed healthcare system. As this survey shows, more and more French people simply can't afford proper healthcare.

5. Conclusion

Social exclusion only increases health inequalities and makes access to healthcare even more difficult in the DRC. Today in the DRC, as everywhere else in the country and particularly in the province of South-Kivu, despite the many measures taken, a growing number of people have no access to healthcare. In our country, access to healthcare is linked to certain conditions: you have to be a worker for an NGO or a trader, a politician, etc. Apart from that, you have to sell a plot of land if you live in a village, sell an object of value or mortgage a precious object. The most vulnerable people are not always able to meet these conditions. For many, this high cost means that they prefer to resort to self-medication or traditional medicine, or to prayer rooms. Many people die for lack of security, especially informal sector workers who are unable to look after themselves, but rely on the solidarity of their savings and credit associations VSCA to help them cope.

Recommendations

Improving access to healthcare in the DRC remains a challenge, as only two to three people have access to healthcare in the province of South-Kivu. Difficulties in access to healthcare persist because the supply of care is insufficient and inequitably distributed across the country and between populations, since the government has entrusted the management of health structures to the private sector, which has turned them into a business where the vulnerable have no access. To address this, we recommend It is therefore necessary for the government to deploy resources to improve access to health care for the population throughout the national territory through universal health coverage. This will help guarantee better access to health care for certain categories of people, in particular by combating health inequalities for people in precarious situations or with disabilities, and by

improving care for the elderly.

Conflicts of Interest

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

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