The governance of Community-Based Health Insurance schemes in fragile settings and community health coverage outcomes in the DRC

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Introduction

Poor individuals' access to health services is a major problem, undermining the achievement of the universal health coverage (UHC) agenda in fragile and war-affected settings. Since the 1970s, UHC has been a worldwide public health ambition which was translated into a global commitment at the 1978 Alma-Ata Conference, where World Health Organization (WHO) member states pursued universal access to point-of-entry services (Stuckler, Feigl, Basu & McKee 2010). In the 2030 Agenda for Sustainable Development adopted by the United Nations General Assembly in September 2015, Member States renewed their commitment to promote the health and well-being of their populations whereby achieving UHC is the key to attaining health-related targets (Goal 3 in its entirety) and other Sustainable Development Goals (WHO 2018). Although considerable progress has been made in improving health and well-being over the past 40 years, with dramatic reductions in maternal, neonatal, and child deaths and in deaths from causes such as HIV/AIDS, malaria, tuberculosis, and vaccine-preventable diseases, health progress has been uneven across and within countries (WHO 2019). The progress in primary health care has remained elusive, and many low-income countries cannot afford UHC (Stuckler *et al.* 2010). These countries still rely on aid which reportedly accounts for about 30% of national spending (UN President of the General Assembly 2019).

In Sub-Saharan Africa, the lack of public health sector funding is the main factor impeding UHC. Community-based health insurance (CBHI) initiatives have thus, over the past three decades, gained currency as a means for achieving UHC in (African) countries with insufficient public funding. This began in 1987, when the Bamako Summit encouraged community

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participation in health services financing to achieve universal primary health care in African countries (McPake, Hanson & Mills 1993). CBHI schemes usually adopt three working principles: access to health through insurance, equitable risk pooling and financial affordability for vulnerable groups, and stakeholder interactions. However, UHC is challenging in poor countries, and it becomes truly daunting in areas affected by conflict or war, where extreme poverty, coupled with an intense weakening of institutions and services, makes achieving UHC very unlikely.

In the Democratic Republic of Congo (DRC), community-based initiatives were developed during the 1980s and 1990s, after the state withdrew from service provision. The Mutuelles de Santé (MUS) were the first provincial CBHI, set up by the Bukavu Catholic Archdiocese in South Kivu to reduce the disease burden among poor households. This study examined two MUS initiatives (in a rural and a semi-urban area of South Kivu) to explore how fragile governance and/or institutional weakness have impacted MUS outcomes regarding equity in access to health services, protection from the financial risk of disease, and the financing of health services. The paper also explores how these multi-actor CBHI mediate the access of war-torn communities to primary health care in a context of structural fragility. As multi-actor arrangements aimed at solving community health issues, the DRC MUS schemes have bearing on network governance, that is, horizontal interactions by which various public and private actors at various levels of government coordinate their interdependencies in order to realise public policies and deliver public services (Klijn & Koppenjan 2012, in Aembe 2017).

According to the DRC Organic Law on Health Insurance Schemes of 08 February 2017 (Loi No. 17/002 du 8 février 2017 déterminant les principes fondamentaux relatifs à la Mutuelle de Santé)[3], the MUS initiatives are earmarked for ensuring UHC by way of providing quality health services to the population through decent costs (RDC Journal officiel 2017). The Organic Law allows for the roles the state should play to promote the development and the effectiveness of CBHI schemes throughout the DRC: offering administrative, technical, and fiscal backing but also financial support according to the proportion of enrolled members of each MUS (Institut de Médécine tropicale 2016; RDC Journal officiel 2017). On the other hand, the DRC's Framework Law on Public Health Organization articulates the principles sustaining the national vision of UHC: health access equity, quality health services and financial protection for all (RDC Journal officiel 2018). The present research examined MUS health coverage outcomes in a

[3] The Organic Law on Health Insurance Schemes was adopted by the parliament in May 2016 and promulgated by the president on 08 February 2017.

rural Health Zone (HZ) of Katana and in the semi-urban HZ of Uvira, asking 'how do non-state actors' arrangements such as CBHI schemes affect health sector network governance at community level, and how do these Mutuelles de Santé contribute to the achievement of universal primary healthcare coverage in war-torn communities experiencing excessive financial hardship and state fragility, like in DRC?'

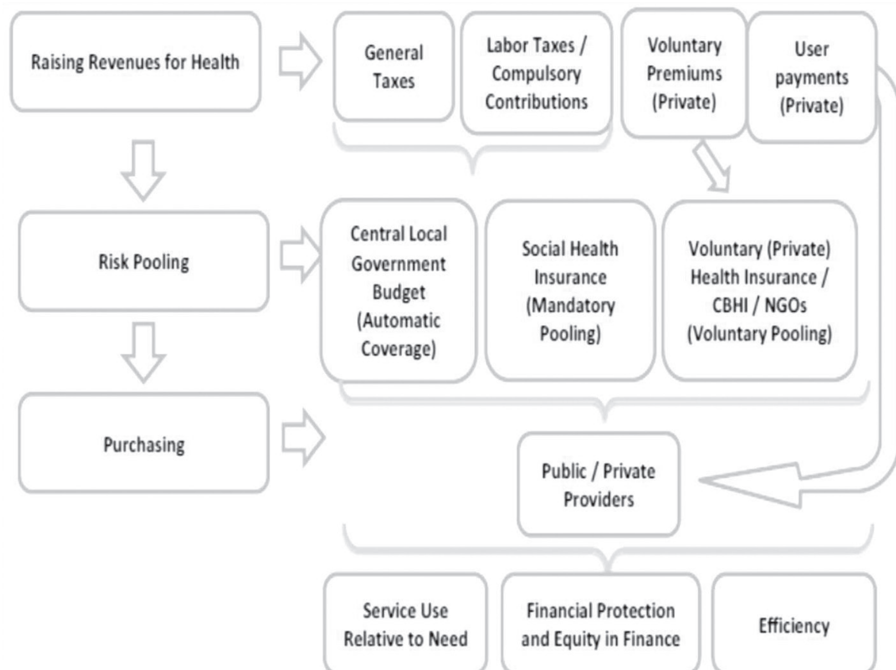
Our interest in these multi-actor initiatives stems from a wider interest in the local realities of conflict-affected institutions. Early assumptions that institutions in conflict settings would cease to function have been replaced by recognition that, especially at the local level, these institutions may continue to function, albeit in a weakened or altered condition. This paper is interested into examining the attempts to strengthen the fragile sector governance and build access to health through micro-insurance schemes, with the objective of contributing to current debates on whether this approach can increase access to health and on how post-conflict recovery can be grounded in local institutions and based on individuals' resilience.

1. Background to CBHI in African fragile states: social protection initiatives for UHC

Since gaining independence, many African countries have faced a lack of health sector financing. The situation has been compounded by the effects of neo-liberalism on African economies. Through contracting out public sector health services since the 1980s, neoliberal structural adjustment programmes prompted the emergence of private care in Africa (Pfeiffer & Chapman, 2010). Almost all countries in Sub-Saharan Africa implemented user fees at government health facilities to supplement inadequate national health budgets (Smith & Sulzbach 2008). However, user fees adversely affect access and equity in the health sector in contexts of economic hardship (Smith & Sulzbach 2008). Low and unstable revenues made worse by public budget cuts mean that African countries are unable to provide free health care for all (Wiesmann & Jütting 2000).

In low-income settings where weak states often fail to respond to the needs of the population, substantial inequities in health remain across population groups (World Bank Group/Independent Evaluation Group, 2014). Therefore, CBHI initiatives have been viewed as a way to increase health care access and protect households from high health care expenditures (Smith & Sulzbach, 2008; Olugbenga 2017; Ridde *et al*. 2018). They are also regarded as one of the important parts of a health financing system which consists of three main functions: raising revenues to finance health, pooling health funds and risks, and purchasing health care (Figure 1).

Figure 1: health financing system



Source: World Bank Group/Independent Evaluation Group (2014).

More countries globally are embracing health insurance schemes as a means of meeting the healthcare needs of their populations (Olugbenga 2017). It is also indicated that national health insurance services (NHIS) are more common in the developed countries of North America and Europe, while social health insurance (SHI) and community-based health insurance (CBHI) are more widespread in Asia and Africa (Olugbenga 2017). However, private health insurance (PHI) schemes thrive in sub-Saharan Africa (Spaan, Mathijssen, Tromp *et al.* 2012 in Olugbenga 2017) because public health systems cannot meet the needs of the entire population (ibid.).

CBHI as a risk pooling mechanism is broadly defined as any scheme managed and operated by an organisation other than a government or private for-profit company that pools risks to cover all or part of individuals' health care costs (Bennet 2004). CBHI schemes are characterised by 'voluntary membership, [a] non-profit character, [the] pre-payment of contributions into a fund and entitlement to specified benefits, [the] important role of the community in the design and running of the schemes, [and an] institutional relationship to one or several health care providers' (Jütting 2004). However, in fragile setting CBHI/ MUS beneficiary populations are of irregular and weak incomes or from the informal sector; their weak financial capacity in

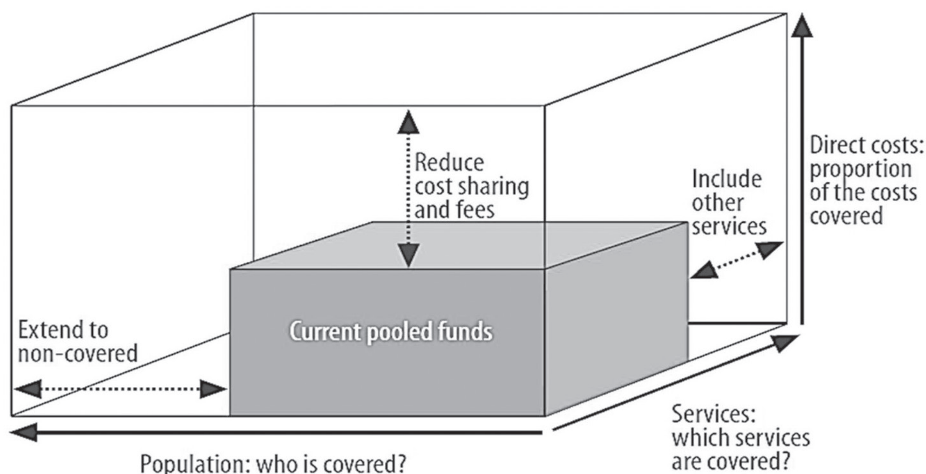
terms of contribution to development of CBHI determines their engagement behaviour (SOLSOC 2019). Nonetheless, these systems pursue fairness in health financing, with members paying according to their means, while providing necessary health services (Carrin, Waelkens & Criel 2005). This is where CBHI meets social equity principles implying 'a fair distribution of the benefits and burdens of health services among groups and individuals' (Marmot *et al.*, 2008). CBHI has been lauded as a promising tool for improving the health system for rural populations in low-income countries, particularly in Sub-Saharan Africa (Dong, de Allegri, Gnawali, Souares & Sauerborn 2009). Further, developing 'a financial risk pooling system that provides cross-subsidies in health systems where ability to pay determines financing contributions and the use of services is on the basis of need for care' has been described as a crucial aspect of achieving UHC (Wang & Pielemeier 2012).

UHC 'ensures that all people can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (Bristol 2014). This definition emphasises three correlated tenets: accessibility of essential health services, [social] protection from financial risk, and equity in health service financing (Stuckler *et al.* 2010). This places CBHI in the category of social protection schemes, which comprise 'the public actions […] taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable' (Norton, Conway & Foster 2001).

Social protection deals with the absolute deprivation and vulnerabilities of the poorest individuals and with the need of the non-poor for security in the face of shocks and life-cycle events (Norton *et al.* 2001). Social protection interventions have protective (providing relief from deprivation), preventive (averting deprivation), promotive (enhancing incomes and capabilities) and transformative (addressing social equity and exclusion concerns) objectives (Hervey, Holmes, Slater & Martin 2007). Consistent with the WHO concept of primary health care and with the goal of 'Health for All', social protection principles form CBHI's foundation. CBHI/MUS schemes in the DRC have bearing on the protective objective, aiming to provide relief from severe financial risks using funding mechanisms based on prepayment and pooling, and on the transformative objective, striving to achieve social equity in access to health services.

For the WHO, even where funding is largely prepaid and pooled, there are trade-offs between the proportion of the population covered, the range of services and the fraction of the total costs paid (World Health Organization 2010b) (Figure 2).

Figure 2: three dimensions to consider when moving towards UHC



Source: WHO (2010b).

In Figure 2, the box labelled 'current pooled funds' depicts the situation in a country where about half of the population is covered for about half of the possible services, but where less than half of the cost of these services is met (WHO 2010b). According to the WHO, to get closer to UHC, the country would need to extend coverage to more people, offer more services and/ or pay more of the costs (WHO 2010b).

2. Health systems and CBHI schemes in fragile settings

Lacking both the capacity and the willingness to perform key government functions, fragile states suffer deficits in governance that hinder development. As the conditions are too unstable for long-term planning and investment, society focusses on short-term coping strategies to secure basic needs (Massing & Jonas 2008). These states are unable to perform basic functions such as maintaining security, enabling economic development, and meeting the essential needs of the population. Further, these states are characterised by weak policy, institutions, and governance (Haar & Rubenstein 2012b).

In fragile states, particularly those that have experienced extended periods of conflict, health systems have typically been seriously eroded: health infrastructure has been destroyed or is non-functional, services are fragmented and differentially available, and financial resources are scarce (Brinkerhoff 2008). As public finance for health declines, private spending on health increases. Better-off citizens may be able to purchase care, but the poor and marginalised have fewer options (Brinkerhoff 2008).

Late last decade, Sub-Saharan Africa accounted for 11% of the world's population, but bore 24% of the global disease burden and commanded less than 1% of global health expenditure (IFC 2008). The burden of non-communicable diseases (NCDs) in sub-Saharan African regions is higher than the global average (Gouda *et al* 2019). According to the International Futures model (IFs), 57% of all deaths in Africa were, in 2015, from communicable diseases, whereas for all the other developing regions in the world, deaths from communicable diseases constituted 18% of all deaths (Narayan & Donnenfeld 2016). Globally, Africa accounts for nearly half (49%) of total deaths from communicable diseases, despite representing, by 2015, only 16% of the world's population (ibid.). A huge portion of Sub-Saharan Africa's total health expenditure is financed by out-of-pocket payments from its largely impoverished population (IFC 2008: vii; WHO/Regional Office for Africa 2013). In contexts of deteriorating governance, arrested development or the early stages of post-conflict transition, humanitarian responses are the primary means of health sector support; however, this support is not designed to be long-term (Sondorp, Ter Veen & Howard 2012). Development assistance requires greater stability than is found in fragile states (Sondorp *et al.* 2012).

In these contexts, institutional weakness and societal fragility impede the functioning of CBHI schemes (Leppert 2012). In most cases, dysfunctional states fail to facilitate the achievement of social goals through CBHI schemes. Despite the appeal of the CBHI concept, it is unclear whether CBHI improves community health outcomes in fragile states (Dong *et al.* 2009; Jütting 2004; Smith & Sulzbach 2008). CBHI coverage in Africa remains relatively low (Tabor 2005; Wiesmann & Jütting 2005; Crawford & Sachdev 2018; Bossyns, Ladrière & Riddle 2018). Deteriorating macroeconomic climate and governance issues in many of the sub-Saharan African region's key economies have been cooling optimism raised by the emerging of CBHI schemes throughout the continent (Crawford & Sachdev 2018). Additionally, unlike social health insurance schemes, which are generally provided by governments (Acharya *et al.* 2011), in many fragile African countries, CBHI schemes have been driven largely by external organisations. Yet scholars maintain that for health insurance to be sustainable, effective and equitable, it should be a public (oriented) organisation, subsidised by government, large-scale (country-wide) and professionalised (Bossyns, Ladrière & Riddle 2018).

Health insurance schemes in countries with long-standing social health protection mechanisms originated as home-grown initiatives involving social actors in designing and implementing the schemes, but, in many fragile African states, CBHI schemes are simply community-based and weakly supported by the state. They have been initiated by health facilities, NGOs, local communities or cooperatives and can be owned and run by any of these

organisations (Wiesmann & Jütting 2005). Yet without functioning state endorsement and political engagement, it is difficult to envision CBHI’s viability, enhancement or scaling-up. This problem has been faced by programmes in China, Ghana, Rwanda, and Thailand (Wang & Pielemeier 2012). Nonetheless, in many African countries such as the DRC, where the state’s role is minimal, CBHI is presented as a rational step towards health system financing for achieving UHC.

3. CBHI initiatives in the DRC

The development of micro-insurance schemes in DRC goes back to the 1950s (Mutabunga *et al.* 2017a). Nonetheless, health based micro-insurance schemes, though widely regarded as the unique way of achieving UHC (Camara & Garand 2018), are an emergent phenomenon which is still unknown to most of Congolese (Mutabunga *et al.* 2017a).

Since the later stages of the Mobutu regime in the 1980s-90s, the population of the DRC has experienced the consequences of state fragility and repeated wars. The DRC government formally subscribed to the global UHC agenda (RDC/MINIPLAN 2011), but the state has acknowledged that it faces multiple obstacles to fulfilling population UHC needs. Health system governance, public funding and the financial management of public health are weaknesses that have negatively impacted the entire health system and community health status (RDC/MINIPLAN 2011). Although improvements in education and the health sector are considered strategically beneficial for long-term development, both sectors are poorly funded by the state (World Bank 2015). This means the overwhelming burden of current community health expenses is borne by poor households and international actors.

The management of health service provision and community health coverage in the DRC takes place at the health zone (HZ) level. The HZ is an operational unit entrusted with enforcing national health policy and state public health strategy. HZs vary in size depending on population density, covering at least 100,000 inhabitants in rural areas and 150,000 in urban areas. Each HZ contains at least of one general referral hospital and a network of health centres.

To address the lack of access to health services, in 2011’s second Poverty Reduction Strategy Paper, the DRC government first promoted CBHI. Le Programme National de Promotion des Mutuelles de Santé was a national strategy for the promotion and development of CBHI, aiming to institutionalise, streamline and professionalise CBHI management in light of the UHC agenda. Promoting CBHI schemes is recommended in the DRC’s Health System Strengthening Strategy to improve health service funding and population coverage. This overall strategy is based on the idea of public mobilisation of funding and the necessity for the state to improve its

financial interventions, while the population is also held responsible for financing their health through CBHI (RDC/MINISANTE 2006). In 2015, the DRC government reiterated its commitment to [community-based] health insurance schemes (Mutabunga *et al.* 2017a). In the DRC, two kinds of health insurance schemes are acknowledged: Professional/Corporate and Community-based Health Insurances (ibid). However, the mutualist insurance movement in the DRC is still poorly structured, dispersed and heterogeneous (Camara & Garand 2018; Mutabunga *et al.* 2017a).

This study's relevance lies in its examination of MUS health coverage outcomes in a war-affected context with a state too weak to implement the UHC agenda. Until recently, most debate around UHC addressed health coverage in middle-income countries and emerging economies; how the debates play out in fragile and transitional states is largely unknown (van de Looiji 2014). Our findings are significant for the policy-making process in the DRC, bringing to light the limitations of MUS, which, despite the potential of community resilience, cannot deliver on expected outcomes without the earnest involvement of a working state. The study is also of theoretical relevance, raising awareness of the pertinence of considering state fragility in the pursuit of health equity and UHC.

4. Research methods

The research was conducted in South Kivu from early 2014 to mid-2015, focussing on the Katana and Uvira HZs[4] out of 34 HZs which make up the provincial health zone mapping (Figure 3).

Katana is a rural HZ with a long history of MUS (introduced in 2007). In contrast, Uvira[5] is a semi-urban HZ that is relatively new to MUS (introduced in 2012). Selecting these two HZs enabled the comparison of MUS in two contrasting environments. Katana is a Catholic Church-led HZ. The MUS in Katana has benefitted from the support of the Bureau diocèsain d'œuvre médicale (BDOM, Diocese Office for Medical Activities) and international NGOs' promotion of community health improvement. Uvira is a state-led HZ with no substantial faith-based organisation foothold. The MUS operating in the area relies mostly on population engagement. The semi-urban, ethnically diverse population in Uvira differs from that in rural Katana, whose inhabitants' socio demographic characteristics are almost

[4] Uvira is located in the south of Bukavu (at about 124 km) while Katana situated in the north (about 45 km).

[5] Uvira was politically elevated to town status in early 2019, though nothing has substantially changed in terms of infrastructure, economic status and population living conditions.

Figure 3: South Kivu health zone mapping

uniform. Supplementary data on MUS management and the role of different stakeholders were collected during field visits to Idjwi and Bukavu.

We drew heavily on qualitative approach especially through semi-structured interviews with state officials, health facilities managers, MUS management teams (at provincial level and in Uvira, Fomulac, Bukavu, and Idjwi), community members, and MUS organisational stakeholders (from

the Catholic Church, a Protestant church, and international NGOs). State officials were selected from the Ministry of Health (MoH), which is in charge of primary health care coverage and the management of health facilities. Health facilities management and front-line provider participants came from the Katana and Uvira HZs and from Idjwi. Data were collected from 15 of 17 health centres in Katana and 10 of 22 in Uvira.[6] In every health centre, the head of nursing and the accountant were interviewed. The former provided information regarding the impact of MUS on UHC in terms of health services utilisation; the latter were asked about social protection and health facility financial sustainability outcomes of MUS schemes. Because community connectedness and bonds are strong in rural settings, community contacts and snowball sampling were used to select MUS members in Katana. In urban areas, MUS offices were the contact point for identifying and interacting with MUS members.

To unearth salient themes in our data and to structure these themes in a useful way (Attride-Stirling 2001), we used Nvivo software to conduct a thematic network analysis revolving around three main topics: i) provincial governance of MUS schemes (history, membership procedures and stakeholders interactions); ii) MUS schemes and community health coverage in the HZs (local management, MUS uptake and community penetration of the schemes); and iii) MUS health system financing and equity improvement outcomes in the HZs.

5. Research results and analysis

5.1. Provincial outlook and governance of MUS Schemes in South Kivu

5.1.1. MUS schemes profile: history, membership procedures and stakeholders

MUS schemes were initiated in South Kivu in 1990 (SK/MINSANTE 2011) as private non-profit patterns of partnership with the state. A MU is based on the voluntary subscription of households, participatory democracy, empowerment-ownership, community solidarity, non-profit engagement, and preventive care (SK/MINSANTE 2011). MUS membership in South Kivu more than tripled in five years, from 29,648 in 2007 to 109,908 in 2012 (Dusoulier, Rugarabura & Zawadi 2014). By 2014, 23 MUS schemes operated in 14 of the province's 34 HZs, with 121,163 members – 5% of the population in covered HZs (Dusoulier *et al.* 2014).

[6] The whole Katana HZ contracted with MUS schemes, whereas only 10 of the 22 health centres in Uvira contracted with them.

Organisational stakeholders interacting through or with MUS at provincial level include national and international organisations as well as health facilities. Among the relevant national organisations, through the Cellule d'Appui aux Mutuelles de Santé (CAMS), BDOM plays the flagship role for MUS in South Kivu. BDOM represents the Catholic Church, which has championed MUS in the province. The Programme Solidarité-Santé (PSS) serves as the interface between MUS schemes and the state. International organisations at the foreground of MUS include Mutualité chretienne Hainaut Picardie, Malteser and Cordaid. These donor organisations provide MUS with technical and financial support. Health facilities are a critical stakeholder, providing community health services and expecting MUS schemes to support their financial sustainability. MUS schemes reflect community ownership more at local level than at provincial level, because all MUS schemes are locally independent structures with similar management structures across the province.

Procedures for setting up and managing MUS schemes follow the same pattern across the province. Every community-level MUS is a decentralised entity, but they depend on Bukavu for guidance on some administration and management issues. To start a local scheme, the community organises itself and sends a letter to BDOM requesting permission to open a local MUS. BDOM examines the local possibilities for scheme viability. According to the CAMS coordinator, 'this process is justified, because poor groups may express the desire to open a MUS scheme without having the ability to make it viable'.[7] To be accepted, the applying group must be able to mobilise a certain number of community members to ensure the scheme's funding. For example, in 2008, the Bukavu/Ibanda community was asked to mobilise 3000 community members before being granted a MUS scheme.

Most community MUS schemes were initiated by the Catholic Church and endorsed by BDOM. Once accepted, community schemes elect an executive board and a two-member management committee (Comité de Gestion, COGES). The executive board consists of a president, a vice-president, two secretaries, and four advisers. An auditing commission comprises two staff members and is set up for financial and administrative control. The two on-the-ground staff members of the COGES are preferably appointed with gender balance (one man and one woman).[8] They are tasked with the day-to-day running of MUS scheme activities including mobilising the community for enrolment, registering members, reporting, paying health service costs to health facilities and monitoring the quality of the health care provided to members. This entity is critical as an arena of interactions between the

7 Interview with provincial coordinator of CAMS, Bukavu, 16 October 2013.

8 In Idjwi this was not the case. There, there were two men.

community and both the MUS scheme and the health facilities. The general assembly of COGES convenes twice yearly; all other administrative entities meet twice each quarter. The management committees work on a daily basis.

The COGES completes contracts with health facilities for preferential costs and mobilises both the community and the health facilities. Members rate services received through the MUS to the COGES. The committee also conveys the needs of MUS members to health facilities and issues credentials (i.e. membership cards and vouchers required to access health services). Additionally, the COGES monitors compliance with the terms of the contracts between MUS schemes and health facilities. To ensure high quality in health care provision, COGES staff members visit health facilities and collect feedback on MUS members' experiences.

The household is MUS's subscribing unit and is expected to enrol all family members yearly. The enrolment period for the following year is October-December. However, as of 14 January 2016, the Uvira MUS did not yet know the exact number of members for 2016, because enrolment was still ongoing. Membership premiums vary significantly across local MUS schemes and sites, even within the HZs. For example, in urban Bukavu (Ibanda) and semi-urban Uvira, according to the Ibanda MUS office, the yearly premium in 2014 was 7.00 USD per member;[9] this figure was 5.00 USD in Katana and Idjwi villages.[10]

Allocations for health care payments appear to be standardised across schemes, with members paying co-payments of 20% for hospitalisation and 50% for ambulatory care. The pricing system is standardised within HZs. The premiums collected are allocated as follows: 75% for health care, 15% for a fund to cover potential membership declines, and 10% for pooling funds for other MUS schemes incurring bankruptcy.

MUS schemes cover minimum (treatment at health centres) and complementary (treatment at hospitals) services; tertiary (care in specialised provincial or national hospitals) interventions are not covered. The schemes try to achieve risk pooling while guaranteeing financial viability for their health facility partners. The negotiated fees vary according to the type of treatment, resources invested, and service package.

A CBHI membership card is required to access preferential services at health facilities. A primary health provider referral is also required. We found that not all facilities adhere to the agreed fees. Most claims of this were made in Uvira, where the general hospital, which has signed a MUS contract, was repeatedly criticised for noncompliance with the tariff agreement. Health facilities were also critical of the practices of the MUS, noting delays and irregularities in payments.

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[9] Interview with Ibanda/Bukavu COGES staff, 20 February 2015.

[10] Interview data from Katana and Idjwi, 2014.

5.1.2. MUS as a networked governance arrangement for multi-stakeholder processes

MUS schemes serve as an arena of interactions for civil society, the state and international NGOs. As an open arena aiming to serve the public interest, MUS schemes are a public space, where the state operates alongside non-state actors (Animashaun 2009). These schemes are an example of networked governance of the Congolese health system. The Catholic Church has played a leading role in this sphere. This is both an asset and a challenge for CBHI schemes. The Church has an outstanding record in managing community-based initiatives and civil service organisations. It is the largest faith-based organisation in the region, and it has a great capacity for social framing and mobilisation. However, many view MUS schemes as Catholic-affiliated, restricting their reach in non-Catholic settings. The Uvira COGES president asserted that, although the MUS is an open public space, 'Catholic priests are more involved in the MUS than are Protestant pastors, but also the power is more scattered among Protestants than in the Catholic Church'.[11] Nevertheless, MUS managers and state officials throughout the province asserted that the schemes are being transformed into a nonreligious public space. MUS leaders acknowledged the predominance of Catholic members but said that Catholics receive no preferential treatment.

The state is − or is expected to be − another key player regarding MUS. In the view of those associated with MUS and the health facilities, state involvement is required for achieving positive MUS health outcomes. Many knowledgeable key informants believed that MUS could be beneficial for the population with the state's earnest involvement and collaboration with other stakeholders, and that groundwork should be laid prior to the introduction of MUS. These informants maintained that there are still many 'grey zones' relating to organisational management, the allocation of roles among stakeholders and the management of the expectations of both the population and the health facilities. Some state officials expressed the same opinion. For instance, a provincial public official noted that 'the role of the state resides only in providing laws, regulation, and technical advice'.[12]According to a Public Health Department official, 'the state will not engage earnestly for fear that it should be required to start paying MUS personnel'.[13]

Officially, the state claims to engage actively through the PSS, which has operated since 2011. The state also declares that it enacted MUS schemes as an official mode for health sector financing (SK/PSS 2011). However, in this research, state actors had no clear answer to how MUS would work in

[11] Focus group with Uvira's COGES staff, 16 September 2014.
[12] Interview with the head of PSS, 20 October 2013.
[13] Interview at a provincial health department, 21 November 2014.

rural zones in the context of abject poverty. From the state perspective, the collaboration between the state and the MUS is a public–private partnership based on public ownership. In this respect, a state official working in the health sector maintained that the state's expectation is that the 'community organises itself, formulates its by-laws and submits them for the review and approval of the state, because MUS schemes are in essence non-state initiatives, but their provincial coordination is a state-led structure with the mission of accompanying them on behalf of the state'.[14]

Donor organisations have a substantial influence on MUS governance. Mutuelle chretienne is the main supporter providing MUS with administrative means, especially to fund the payment of provincial staff members. In 2015, the reluctance of the state to engage in supporting MUS schemes led donor organisations to rethink the governance of the schemes to ensure their continual support, concluding that the area bishop's offices should take the lead role. Unfortunately, this will confirm the idea that MUS schemes are Catholic Church-owned. This change is currently underway in Uvira.

This raises questions regarding the extent to which MUS governance is community-based. Empirical observations revealed that MUS schemes are community-based in that their success is dependent on community members joining. However, in most cases, MUS schemes were only adopted – not designed – at community level. In other words, MUS schemes in South Kivu are not yet community-driven. A provincial MUS manager made it clear that 'although they are called community-based, there are some limits communities cannot cross'. For all of the participants in this study, MUS sustainability depends upon improvements in population uptake, scheme penetration and social protection engagement from the state.

5.2. MUS and community health coverage in Katana and Uvira

5.2.1. Local governance, MUS uptake, and community penetration in Katana and Uvira

MUS governance follows the same standards in the two HZs, with both schemes following BDOM guidance. In both HZs, the MUS scheme has a permanent office comprising two management staff members and an executive board, within which the Catholic Church has a large influence. In the management of the local MUS, the COGES develops ties with influential social actors such as churches, civil society, the HZ Central Office, and state representatives. The HZ Central Office provides technical advice regarding public health issues and also represents the MoH.

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[14] Interview with the provincial coordinator of PSS, Bukavu, 20 October 2013.

The HZ board was observed to have more influence over the MUS in Katana than in Uvira. During a field visit to the Birava MUS branch in the Katana HZ, the local coordinator was very reluctant to provide information on MUS activities without the HZ board's clear authorisation. Despite being presented with an authorisation letter from the HZ Central Office, this coordinator phoned the Office to ask whether she should respond to the questions. The Uvira case proved very different, as the coordinators went as far as voicing critical opinions regarding the HZ and its relationship with the MUS.

MUS schemes first appeared in Katana in 2007-2008, and MUS membership in Katana has been growing since then, although not in proportion to regional population increases. In 2015, MUS members accounted for 5.2% of Katana's HZ catchment population (10,907 members out of 209,746 inhabitants, July).[15] In Uvira, MUS schemes were first introduced in 2012. In that same year, the MUS registered 4,501 of 305,535 people. In 2013, the membership increased slightly (to 4,576 people) before decreasing steeply to 3,282 in 2014 and to 2,883 in 2015.[16] By July 2015, the catchment population for the Uvira HZ was 315,008.

Regarding the membership profile in both HZs, the MUS schemes rely on expanding community penetration for improving UHC and for ensuring the MUS's sustainability. However, we found that the MUS concept of 'community members' is not well defined. Both MUS schemes strive to enrol staff members from public and private organisations such as schools, microcredit financial cooperatives, health facilities, and governmental offices. From the MUS and health facilities' accounts in both HZs, it was clear that enrolling organisation staff members in this way constitutes a safety net for the financial sustainability of the MUS schemes and health facilities. These workers, unlike many ordinary community members, can pay the necessary membership premiums. In most cases, arrangements are made with employers for enrolling staff members. The premium pricing system is standardised according to the setting, regardless of the subscriber's income, undermining the equity and social justice principles in CBHI. Increasing the rate of registration of 'common' community members was nevertheless repeatedly stressed by the MUS schemes.

Clearly, MUS penetration and population uptake remain low in both HZs, although the membership is at different levels. In Katana, there are small increases in membership, but membership is declining in Uvira. However, in both settings, most community members acknowledged the benefits of MUS schemes. Members' experience-based accounts indicated that MUS

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[15] Data provided by the administration office of Katana HZ, May 2016.
[16] Data provided by the Uvira MUS office, May 2016.

contributes significantly to health service affordability, although some noted that certain health facilities valued vouchers used by international NGO personnel above MUS membership cards. MUS members felt that they faced a situation of skewed consideration, especially in terms of individual conditions and social rankings. Many informants maintained that the client's social position impacts the consideration received in many health facilities. Some public health officials said this was because health facilities are self-reliant without public funding.

5.2.2. Differences between Katana and Uvira

The nuances in findings in the two settings result from multiple factors. For example, in Katana, a Cordaid programme supported enrolling poor people in MUS schemes. There was no such programme in Uvira, where the scheme received no donor support. Although Cordaid's engagement in Katana was declining, its impact on the overall trend was still perceptible in 2014. Another difference concerned the required cost for enrolment (7 USD/year in Uvira vs. 5 USD/year in Katana in 2014). However, these differences might not reflect different income opportunities, especially for the poor. The relatively high degree of ethnic homogeneity found in Katana might be another factor facilitating quick adherence to community-based initiatives, because social bonds tend to be closer in this type of context.

Another plausible explanation for the observed differences concerns the duration of the presence of MUS schemes and the population's experience of previous community-based micro-credit schemes. The Katana MUS has been operational since 2007, so it is supposedly well-embedded in the community. Uvira is a new MUS, introduced in 2012. Additionally, Uvira had negative experiences with former micro-credit cooperatives. In the 2000s, many risk-pooling initiatives, such as a *tontine*,[17] Gala Letu's Community-Based Credit Cooperative, and Imara Cooperative, pooled monies from many members of the population but then went bankrupt and disappeared without compensating their members. This experience contributed to people's current suspicion of initiatives championing fund pooling for social protection.[18]

Our interactions with community members revealed that, in addition to mistrust based on past exploitative experiences, many people do not have a good understanding of the schemes. This points to a weakness in the process of awareness raising. Our findings indicate that much remains to be done to inform community members of the relevance of MUS.

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[17] A *tontine* is a system for raising capital in which individuals pay into a common pool of money and then receive a dividend based on their share.

[18] Interview Uvira/MUS branch office, 01 October 2014.

Another explanatory factor for MUS enrolment declines in Uvira is related to the attitude of Uvira General Hospital. In both studied HZs, most health facility representatives mentioned delays in payments from the MUS. In Uvira, MUS representatives described the unsupportive attitudes of health facilities, especially the referral general hospital, which disregarded a signed agreement with the MUS. This attitude has been detrimental to the development of MUS in Uvira, as CBHI dysfunction is known as a factor accounting for a weak rate of community uptake (Mutabunga *et al.* 2017b).

The MUS scheme in Katana is implemented throughout the HZ, whereas only 10 of 22 health centres in Uvira have made agreements with the MUS. In both locations, participants mentioned weak follow-up from provincial structures and the state's inadequate involvement in the promotion of community health, despite the provincial government's adoption of MUS schemes as a public model for health sector financing.

5.3. MUS health system financing and equity improvement in Uvira and Katana

Examining how MUS schemes improve equity in the allocation of health services and the effectiveness of the fund-pooling process is important for understanding MUS outcomes on the UHC agenda in Katana and Uvira.

5.3.1. Health service equity improvement

The objective of UHC is: 'Financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality and affordable essential medicines and vaccines for all' (WHO 2017). Assuring equity is an underpinning principle of CBHI. Building on the WHO dimensions of UHC (see Figure 1), MUS outcomes can be assessed on the breadth/width (population coverage), depth (coverage of services) and height (financial coverage) of CBHI coverage (Soors, Devadasan, Durairaj & Criel 2010).

a. Breadth of MUS schemes

Trends in MUS population coverage can be assessed by examining the uptake density and expansion of the covered geographical area. As was described above, there is a low rate of MUS uptake in both study sites. In Uvira, the geographic coverage is limited to a few health centres, whereas almost the entire HZ is covered by the scheme in Katana.

In Uvira, MUS members made up 0.92% of the population (2,883 of 315,008 people) in 2015. Most of these members worked for institutions and health facilities partnering with MUS schemes. These are not the community members most in need, whose adherence is prevented by the financial unaffordability of the schemes, although these schemes were purportedly

designed to assist community members with the greatest need. In Katana, the higher MUS membership level does not mean that the coverage is broad or equitable. The fact that the 2015 MUS membership in Katana made up 5.2% of the population (10,907 of 209,746 people) betrays the shallowness of the scheme's penetration.

The major difference between the two HZs is that, although its coverage is only superficially penetrating, the Katana MUS seems to be more embedded in the community, compared with Uvira. In many villages, there are MUS branches in charge of raising population awareness about the schemes. This means Katana is more community-rooted, despite relying on health facility and school personnel as a safety net for membership stability. In both contexts, equity in terms of breath of coverage is still a distant goal, as the poorest community members lack access to both health services and the MUS schemes.

b. Depth and height of MUS schemes

According to CAMS, 'MUS insurance is earmarked for minimum and complementary health care packages provided locally'.[19] This means that covered services include primary health care, with second-level care provided through referrals. However, these services are not always actually covered, because many health facilities remain reluctant to participate in the MUS schemes. MUS insurance does not cover tertiary care outside of the HZ, not all sicknesses are covered, and insured members can receive treatment only four times per operational year. For these reasons, some people did not consider MUS schemes to provide real insurance coverage.

MUS schemes have not yet achieved equity in depth or height in the provision of health services. Considering access, utilisation and quality of care, equity remains a challenge for the DRC health system. Equity improvements require a comprehensive approach involving opportunity distributions and social justice in the social system as a whole. Without the influence of a working state, equality of access remains beyond the purview of MUS schemes.

5.3.2. MUS resource mobilisation for health sector financial sustainability

MUS schemes face problems regarding resource mobilisation and the financial sustainability of health services, mostly related to the unreliability of MUS resource mobilisation and membership enrolment. The situation is compounded by extremely difficult living conditions for most people.

[19] Interview, Bukavu, 16 October 2013.

a. Fund pooling system

The system of collecting premiums inspires no hope for the sustainability of MUS schemes or health facilities. Membership premiums employ a regressive system, where everyone pays the same amount regardless of earnings. This differs from a progressive tariff system, where the percentage of income paid is higher for higher income levels, and from a proportional system, where everyone pays the same percentage (Roach 2010). In MUS schemes, the cost of the premium is exorbitant for some and almost nothing for others. For example, in Bukavu, the staff of COOPEC Nyawera, Bukavu municipality and members of parliament are asked for the same 7 USD required from unsheltered households living in Nyamugo shantytown. This reveals the lack of vertical equity and fairness in the Congolese health system, as was explained by a key informant in Uvira:

> 'The prospect of MUS sustainability is questionable. They enrol both rich and poor in the same manner with the same co-payment, whereas at health facilities the rich are treated better than the poor. The rich also demand special care and expensive services.'[20]

Another challenge relates to institutional employee MUS members. The Uvira MUS office said that members from some public institutions, such as the Office Congolais du Contrôle, consume a large share of the yearly pooled fund, abusing the MUS membership paid by their employers. To obtain drugs such as paracetamol, they use a MUS scheme voucher. According to the MUS office, in minor cases (e.g. a simple headache), members cannot use their MUS membership cards, especially when they do not need medical consultation and follow-up, and membership vouchers can only be used four times a year. However, members from certain institutions do not follow those basic regulations. Because this occurred many times, trivial health care influenced overall spending. By October 2014, the Uvira MUS had no funds to cover members' health expenses for the remainder of the year.

According to the MUS management in Uvira, this trend could explain some of the scheme's overdue payments and the resultant mistrust between the MUS and several health facilities. According to the head of nursing at a health centre in Katana, 'MUS schemes are not prompt in paying the bills for the treatment of their members'.[21] Similar to other health workers in both sites, the same participant also noted that 'by the time you are trying to urge them for payment, they just give a flat sum without considering the real cost'. This declaration is one of several expressions of frustration and uncertainty made by participants regarding MUS financial sustainability.

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[20] Interview with a key informant in Uvira, 16 September 2014.

[21] Focus group with Mugeri Health Centre staff in Katana, 24 May 2014.

Irregularities and delays in paying health facility bills affect not only the financial sustainability of health facilities but also the moral ground for MUS schemes regarding monitoring the quality of the health services. Some health facility managers maintained that it is hard for their structures to work on the basis of the MUS contract. They asserted that MUS advocates for preferential health service pricing, but the health facilities have no other source of income. Some of these participants said that they preferred receiving out-of-pocket payments because they are higher and are made up front. At Wanume Hospital in Uvira, for example, a surgical procedure costs 140 USD in cash for uninsured patients but only 80 USD paid on credit for MUS-insured patients. For this reason, some health facilities intended to withdraw from the MUS schemes, which they saw as undermining their facilities' viability.

b. Membership enrolment and population social conditions

Most participants mentioned abject poverty as a major factor affecting the social penetration and population uptake of MUS schemes in both HZs. For example, explaining the declining Uvira MUS membership, the provincial head of CAMS noted that the population is poor and that there is a high degree of what she called 'adverse selection'. In her view, which was echoed by MUS coordinators, because the population is poor, only those household members with the highest potential of ill health enrol. She further maintained that the 'adverse selection that is prevailing is turning MUS into a sick-based health insurance rather than being community-based'.[22] Adversely selected members consume relatively more resources, making it harder for the MUS budget to cover the expenses realised. Accounts from beneficiaries evidenced this trend regarding the motives for subscribing. A woman in Katana, for example, noted that because she did not fall sick in the year she had subscribed to a MUS scheme, the following year she refrained from renewing the membership, 'as MUS is for sick people'.[23] This has a negative effect on both the MUS schemes and the financial sustainability of health facilities. It also undermines the overall vision of risk pooling, because adverse selection puts MUS schemes and health facilities at risk of bankruptcy.

Interviews with community members, especially in Katana, revealed that some insured MUS members were unable to afford the co-payments, and many others were unable to afford membership. The context of poor living conditions and lacking prospects for a better future positions MUS schemes at the forefront of a huge crowd of deprived bodies whose health needs are beyond the only medical care available.

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[22] Interview, 16 October 2013.
[23] Focus group at Katana centre, 26 April 2014.

Conclusion

MUS schemes have gained the attention of multiple primary healthcare stakeholders. These schemes are a form of network governance based on horizontal interactions whereby various public and private actors at various levels of government coordinate their interdependencies in order to realise public policies and deliver public services. The functioning of MUS schemes at community level is in essence an epitome of multi-actor engagement around public policy issues concerning health services coverage. Although relevant for mediating healthcare access, MUS schemes' penetration and uptake, and thus equity, remain low across South Kivu. Regarding equitable access and social protection effects, MUS schemes do mediate access to health care for a portion of the population. However, achieving equity in health requires systems thinking, which deals with the broader social determinants of health inequities. This is why MUS penetration remains shallow in both study sites, with population uptake stagnating in Katana and declining in Uvira.

Concerning the resource mobilisation and health sector financial sustainability outcomes, MUS schemes in South Kivu have not yet proven reliable for mobilising resources for health services. The regressive fund-pooling system and its management have not lived up to the principles of CBHI. This has led to extended indebtedness and failure to pay for health services, undermining the trust between health facilities and the MUS, as well as weakening the MUS schemes' ability to monitor the quality of health care services and the state's ability to perform its regulatory role. Because of prevailing social and financial conditions, most potential members from the community are financially unable to access MUS membership. Although a primary goal of the MUS schemes is providing help to the most disadvantaged, this group faces problems accessing both health care and MUS membership.

Examining the MUS schemes' UHC outcomes in South Kivu revealed that the schemes are relevant for community health coverage. However, the schemes continue to face management and institutional challenges, compounded by contextual fragility. To enable these schemes to contribute to the universal coverage of primary health in South Kivu, the state should reinforce its stewardship presence by supporting the schemes, streamlining interactions between stakeholders, providing financing and strengthening the schemes' management.

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