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Growth of the Kisantu health mutual: Analysis of the involvement of its beneficiaries and healthcare providers and their perception of the need for local institutional anchoring.

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Abstract

The growth or development of a mutual health insurance company depends, among other things, on the commitment of its stakeholders. The experience of Bwamanda is quite revealing, with 32,600 beneficiaries at the start in 1986, then stabilized at around 30% (70,000 beneficiaries) in 2020, thanks to the involvement of stakeholders.

As for the Kisantu health insurance scheme, its membership began with 830 beneficiaries in 2006 and will reach around 10,000 beneficiaries by 2023, representing less than 5% of the population.

In light of the success of Bwamanda, this study seeks to analyze the level of involvement of healthcare providers and mutual members in the growth of the Kisantu health mutual.

This is a qualitative study, using semi-structured interviews and focus groups. It was conducted in the Kisantu health zone, Kongo Central province in the Democratic Republic of Congo, from August 5 to 12, 2024.

The results indicate:

a) Low participation of both health insurance beneficiaries and healthcare providers in its growth and management, characterized by delays in reimbursing healthcare to beneficiaries, failure to consider some of their demands, including the payment of a preferential premium or capping based on household size, and the staggering of premium payments throughout the year.

b) Low accountability characterized by a lack of communication on the reasons for delays in paying providers' invoices, which compromises the quality of care.

c) The mutual's weak anchoring in local political, administrative, and religious structures, the main actors in community mobilization. All of these reasons are the basis for the limited sense of ownership of the mutual health insurance.

Mutual health insurance accountability, with an emphasis on strengthening communication between stakeholders, as well as participation in decision-making, particularly through general meetings or representation by member delegates, are among the avenues that should boost the growth of the Kisantu mutual health insurance.

Keys Word: Growth, health, mutual, Kisantu, Analysis, involvement, beneficiaries, providers, healthcare, need, local, institutional, anchoring.

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I. Introduction.

Health reforms in the Democratic Republic of Congo emphasize universal health coverage (UHC) with the aim of improving healthcare provision in terms of access to quality health services and reducing financial barriers to healthcare. Since 2017, the Congolese government has begun the process of regulating and establishing institutional frameworks for the operationalization of UHC (Driss, Zine and al. 2018; Kadio, Kadidiatou, and al. 2017**).**

The law on mutual insurance companies was promulgated in 2017, the strategic plan for universal health coverage was developed in 2020, and the institutions for implementing universal health coverage were created in 2022. (DRC 2017, DRC 2020)

In this context, mutualist movements appear to be the first initiatives for financial health protection.

It should be remembered that mutual health insurance companies are non-profit community organizations that facilitate access to health care for their beneficiaries by pooling contributions (Fonteneau B et al 2014). Their growth depends on several factors, including the involvement of their beneficiaries and providers (Soors W. et al 2010, Jakab M. et al 2004).

In developing countries, the sustainability of mutual health insurance schemes is a challenge, both in terms of resource mobilization and participatory governance (Ride V. 2021).

In the DRC, this sustainability is undermined by several factors, including the high proportion of the population living below the poverty line, lack of trust, poor quality of care, poor management of mutual health insurance schemes, a low penetration rate, and weak regulation of the health sector. (Sophie Witter and Benjamin Hunter 2021).

Despite this bleak context, some mutual health insurance schemes are examples of successful development. The experience of the Bwamanda mutual health insurance scheme in the South Ubangi province highlights the crucial role of involving all stakeholders in the growth of mutual health insurance schemes. Providers, non-governmental organizations such as the Bwamanda Integral Development Center (CDI), Belgian Technical Cooperation, and other types of rural integral development committees (CRDI) have all contributed to the growth of this mutual health insurance scheme in the South Ubangi province. Its launch began with 32,600 beneficiaries enrolled in 1986, providing coverage for 28% of the population served. The mutual health insurance scheme increased its coverage rate to 61% in 1997 before falling back to its initial level of 30%, with the number of beneficiaries more than doubled, reaching 70,000 in 2020 (Carrin G. 2005).

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This study examines the Kisantu mutual health insurance scheme in Kongo Centrale province, taking a comparative approach to its development, nearly 20 years after that of Bwamanda.

The context in which the mutual health insurance scheme was launched benefited from several advantages, including the presence of renowned institutions such as Saint Luc Hospital in Kisantu; the financial support provided by the Kisantu health zone, which is one of several Technical and Financial Partners (TFPs); the presence since 2014 of TFPs such as the Secular Development Cooperation Service (SLCD), which financed the start-up of this mutual health insurance scheme; BIT/STEP, which is responsible for technical support at the start-up; ENABEL, Memisa, etc., which have supported the mutual health insurance scheme since 2010; the presence of a Regional Central Office for the Distribution of Essential Medicines for the province's Health Zones; and a relatively high socioeconomic level compared to the province of Sud Ubangi, where the Bwamanda Mutual Health Insurance scheme is located. And yet, despite these advantages, when the health insurance was launched, it had 830 beneficiaries in 2006, before fluctuating around 10,000 beneficiaries in 2023 representing a coverage rate of less than 5% compared to the population served, It had 830 beneficiaries in 2006 and fluctuated around 10,000 beneficiaries in 2023, representing a coverage rate of less than 5% of the population served. (Kisantu Health Insurance 2023).

In comparison with the growth of the Bwamanda health insurance scheme and its ability to maintain a fairly remarkable level of population coverage and beneficiary base, this study was conducted to explore the involvement of affiliated members, healthcare providers, and other local structures in the growth of the Kisantu health mutual.

The growth of the mutual health scheme should be understood as its expansion, in terms of membership and local community involvement.

The providers are healthcare personnel at the health centers and the general referral hospital, as well as the hospital director and the health zone management team, as the health center coordination structure.

The results of the research by Maria-Pia Waelkens et al., 2016, noted the need for continued awareness-raising to enable the growth and visibility of the health insurance scheme; as well as communication on the management of the mutual health insurance, including: the combination of contributions and care packages, the need for co-payments, the possibilities of advance payment, the deadline for submitting healthcare invoices, and compliance with the treatment plan.

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Indeed, awareness and communication on management ensure that members and healthcare providers are fully aware of useful information about the mutual health insurance and, consequently, be able to participate in its development.

However, the study conducted on the Bwamanda mutual health insurance (Pululu Nkutu Jean-Marie 2019), the local community and institutional anchoring has helped strengthen the growth of this mutual health insurance.

These two studies demonstrate the need for stakeholder participation or involvement (beneficiaries, providers, and local partners) in raising awareness and managing the health insurance plan for better growth.

This qualitative study was conducted to explore the perceptions of Kisantu's health insurance plan stakeholders (members and providers) regarding their involvement in its growth.

It is worth noting that while there has been a numerical increase in the number of beneficiaries of the Kisantu health mutual—from 830 in 2006 to 10,000 in 2023—the initial target set at the time of its establishment, as stated in the feasibility study report, was to reach 54,464 individuals, representing 60% of the target population living within a 30-kilometer radius of Saint Luke Hospital in Kisantu.

The research question is: What can promote the growth of the Kisantu health insurance plan in terms of the number of beneficiaries and the proportion of people covered after its 20th anniversary?

Specifically, this study focused on the following two questions:

- What are the opinions of stakeholders, specifically the beneficiaries of the Kisantu health insurance plan and healthcare providers, regarding their involvement in the growth of this health insurance plan?
- What are the opinions of mutual health insurance beneficiaries and healthcare providers on the role that local partners (local institutions) should play in the growth and promotion of their mutual health insurance?

Mutual health insurance provides, among other solutions, access to healthcare. Its growth and sustainability depend, among other things, on the membership and loyalty of its members, as well as the provision of quality care (Soors W. et al. 2010, Jakab M. et al. 2004).

Thus, analyzing perceptions of stakeholder involvement is worth its weight in gold (the first aim) in this study, as it allows us to explore each party's expectations for a thriving and sustainable mutual health insurance.

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II. Materials and Methods.

1. Study Type and Setting

This is a qualitative study conducted in the Kisantu health zone (HZ), Kongo Central province, Democratic Republic of Congo, from August 5 to 12, 2024. This HZ is one of 516 HZs in the DRC and is located in the western part of the DRC and includes 17 health areas.

The study used semi-structured interviews and focus groups. Indeed, qualitative methods aim not to quantify results, but to understand the sequences, logic, and experiences of individuals, and the reasons for their behavior in what they do or in the interpretation of what they do and allow study participants to freely express their opinions and points of view (Paillé, P., & Mucchielli, A. 2012).

In this study, it allows for a deeper understanding of the perceptions of the groups surveyed regarding their involvement in the growth of the mutual health insurance scheme.

Population and Sample

The target population of the study is composed of mutual health insurance beneficiaries and providers in the Kisantu health zone (health centers and the general referral hospital).

2. Data Collection Tools

Data collection was conducted using focus groups in six health areas, selected at random from among the 10 health areas located within 20 km of the general referral hospital. The geographic radius was therefore dictated by access constraints related to poor road conditions.

In addition, semi-structured interviews were conducted with service providers: six staff nurses from the health centers where the focus group took place, five department heads at the Saint Luc General Referral Hospital, two managers from the health area management team, the General Director of Saint Luc Hospital, and the Director of the mutual health insurance company; each was interviewed individually. These interviews, with the exception of the one with the Director of the mutual health insurance company, aimed to gather their opinions, as with the beneficiaries, on the organization and operation of the mutual health insurance company: accountability, conditions of affiliation, renewal and reimbursement of care, sense of belonging to the mutual health insurance company as their business, and the need for institutional anchoring.

The interview with the Director of the mutual health insurance company aimed to obtain his opinion on those expressed by both the mutual health insurance members and the healthcare providers listed above.

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The questions were condensed into an interview guide, designed according to the study objectives. This guide consisted of a series of the following themes:

1) Interviewees' opinions on the mutual health insurance company's accountability and the possibility of their involvement in its expansion.

2) Interviewees' opinions on the conditions of affiliation and renewal, as well as on healthcare reimbursement.

3) Interviewees' opinions on the sense of belonging to the mutual health insurance company. 4) Opinions of respondents on the need for local institutional anchoring in the management of mutual health insurance and the role of providers in the growth of mutual health insurance.

3. Data Collection Process

In the preparatory phase, one day was dedicated to contacting different groups for appointments.

Individual interviews with providers were then conducted over three days, with an average duration of thirty minutes per person. This included one day for the health center providers, one day for the hospital providers, one day for the health zone management team, and the hospital's CEO.

The Director of the mutual health insurance company was interviewed two weeks after the field interviews to allow him to respond to the members' and providers' comments.

The focus group interviews took place in the community, at the residence of a mutual health insurance member who voluntarily agreed to share the space with the group.

Each interview was recorded and conducted by a pair of two previously trained interviewers, including a note-taker and a facilitator. An audio recording was made on the smartphone, with the participants' consent, in addition to notetaking. These interviews took place over three days, with a half-day per health area and an average duration of one hour and twenty-six minutes per group.

However, in each health area, data saturation was reached before reaching the maximum number of eight participants.

The focus groups targeted a total of 75 participants, 48% of whom were men and 52% women. The data collected was based on past experience with the mutual health insurance scheme.

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Table 1 shows the number of respondents by gender in each focus group and the duration of the discussions.

N°	Health area	men	women	Total participants	durations
1	NKANDU	6	8	14	1h16
2	KAVUAYA	6	7	13	1h44
3	KIKONKA	6	9	15	1h27
4	GARE	4	5	9	1h05
5	KINTANU	8	5	13	1h50
6	NGEBA	6	5	11	1h14
Total		**36(48%)**	**39(52%)**	**75**	**Average: 1h26'**

4. Data Analysis

Data analysis was conducted using Nvivo software, with its deductive and inductive approaches. The deductive part followed the Pical theoretical model, with two main research questions and four sub-questions considered as themes. In the inductive part, we searched for emerging codes.

We began with individual interviews, followed by focus group interviews, and concluded with the Director of the health insurance company. These interviews were previously recorded with the consent of the individuals involved and hand-transcribed by two transcribers trained by us. After data collection, the recordings were reviewed to cross-reference opinions with the manuscripts in order to arrive at a summary for each question. These transcriptions and recordings were submitted to a qualitative analysis expert, who reviewed and replayed them to ensure compliance with the coding and verbatim transcription of idioms and verbatim statements.

Finally, the results were interpreted and reported. They were resubmitted to the various groups (only available members participated in the presentation and subsequent validation).

5. Ethical Considerations

This study was subject to approval by the ethics committee of the ISTM Kinshasa doctoral school. The household surveys received approval from the head of the Provincial Health Division and the health zone authorities.

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III. Results

The results present a summary of the focus group opinions, followed by the opinions of the health insurance management, and conclude with the verbatim statements.

1. Accountability and Health Insurance Management.

The various groups interviewed believe that the mutual health insurance company is not sufficiently transparent in its management of the funds raised. Thus, the information presented by the mutual health insurance company's managers is highly selective and less transparent.

They believe that during general meetings and other gatherings, they do not have enough time or opportunities to express themselves or even take a position.

For their part, providers highlighted the delay in reimbursement (payment of their bills) for care. They linked this to the lack of transparency. This delay, in fact, limits their ability to obtain supplies, including medications, and to pay staff.

One participant said: "I see a lack of transparency and accountability regarding the funds collected. Financial information is not presented clearly enough, and as a result, section heads are unable to provide feedback to the grassroots or enrich the debate" (young male health insurance member, 26 years old, Ngeba section).

Another stated: "I don't understand how the health insurance company's finances are managed. Beneficiaries pay their contributions, but the health insurance company doesn't directly pay the portion allocated for healthcare, even though this is the priority. Reimbursements are sometimes three months or more late. We have no room to complain about this" (registered male nurse, 45 years old, from the Kintanu health area).

The health insurance company's management specifies that accountability is shared between the Director, who reports on his management monthly to the Board of Directors and the Control Committee. The latter report to the representatives of the members of the mutual health insurance company at the general meeting. Outside of this framework, brainstorming sessions are also organized with the section heads representing the members on major decisions to be taken on the contribution, in particular: the rate of the co-payment, the change of statutes and others. Finally, the control commission and the board of directors participate in the restitution of the opinions of the after each closing of the audited accounting year and make a confirmation report at each general meeting.

2. Conditions of affiliation and its renewal, as well as that of reimbursement of care.

Participants were unanimous regarding the conditions of membership and renewal. They stated that the monthly premium is the equivalent of $0.80 payable in Congolese francs per beneficiary

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in each household that joins or renews the mutual insurance plan. Upon joining, a household booklet, listing the names of all declared beneficiaries, is given to the head of the household. Membership is subject to a three-month probationary period for health center visits and six months for hospital visits without receiving care. The premium amount is considered affordable by most respondents. However, it is considered exorbitant and difficult to achieve for large households (more than 10 members). Beneficiaries from these families have difficulty convincing the mutual insurance plan management to adjust the premium by capping or staggering contributions; but also, to receive treatment even outside of their registered health center. After the internship period, the mandatory access route for mutualists is to start with the health center, which alone is authorized to refer the patient to the hospital. At the CS, access is conditional on the payment of a co-payment equivalent to $1.60 instead of paying the full fee, which is at least $5, and at the hospital, it is $4 instead of $14 for consultations. In the event of hospitalization, mutualists pay 25% of the amount billed for pediatric care, 50% of the bill for internal medicine, obstetrics and gynecology, and surgery. For patients, this route is variously appreciated.

The Director of the health zone's general referral hospital said: "The premium amount is less than one dollar per beneficiary, but it sometimes poses a problem for households with multiple beneficiaries. I suggest a cap for large families to make the system more equitable."

One member said, "I don't appreciate the instruction to only receive care at the health center in my section. It's the only center that has the right to refer me to the hospital. The problem is that when I get sick outside my village (for example, I leave my village for a market, a bereavement, or a celebration in another village and get sick there, I can't receive care at the health center in that area." (Female mutualist, Ngeba health area, 39 years old)

Two other members responded:

• *"I agree with the three-month observation period before starting to receive reimbursement for care from the health insurance at the health center, but in my opinion, the six months for the hospital seem too long" (Mutual health insurance member, 55 years old, Kavwaya health area).*

• *"Sometimes I don't pay my premium for two months. So I'll be deprived of care. When I have the money, I double the premium even if I haven't had access to care. It's better to consider beneficiaries who pay regularly and understand their possible delays" (Mutual health insurance member, 46 years old, Kikonka health area).*

The management of the mutual health insurance company responds that the premium set is not in balance with the cost of healthcare. As for care outside the health center of registration, the

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management believes that since the management system is not yet digitalized at this level, this represents a major risk for the mutual insurance company.

3. From the feeling of belonging or ownership of beneficiaries and partnership by providers to the mutual health insurance.

Beneficiaries noted the sense of solidarity in their membership in the mutual health insurance company, as well as the financial protection it offers them in the event of illness, as the main reasons for their membership and loyalty. Providers, for their part, noted the guaranteed cost recovery and improved service utilization as a guarantee of partnership with the mutual health insurance company.

None of these parties expressed any intention of leaving the mutual health insurance company or breaking the health care contract.

Despite this sense of belonging and partnership with the mutual health insurance company, beneficiaries feel that the mutual health insurance company operates more like an insurance company than an association. Providers, for their part, feel they are viewed as healthcare merchants and not as partners in the care of patients, beneficiaries of the mutual health insurance company.

For the health insurance management, the representation of beneficiaries by the section heads they have designated, and the regular and voluntary payment of contributions, even if one does not become ill, are proof of ownership of the health insurance.

This trust is one of the determining factors of the health insurance's institutional viability.

A program to revitalize the sections is underway with the support of the General Directorate of Development (DGD).

The following statements were mentioned in the focus groups:

• "I feel I belong to the health insurance when I realize that my contributions can help treat another sick person, and other people's money can also help me once I become ill" (Female health insurance member, 37, Nkandu health area).

• "If we were involved, we could help manage reimbursements for care that poses problems." We could see to what extent we can support the health insurance company in overcoming this difficulty" (Registered nurse, male, 45 years old, from the Kintanu health area).

• "We mostly consider canceling our agreement with the mutual health insurance company when there are delays in reimbursement. But when I realize that it offers a guaranteed cost

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recovery for care and an improvement in the utilization rate of health facilities (even patients referred from health centers can easily reach the hospital), we think even harder before canceling" (Zone Chief Physician and Director of the General Hospital).

• "What motivated me to join and stay with the mutual health insurance company is the fact that mutual health insurance members pay less for hospital care" (Male mutual health insurance member, 38, Kikonka health area).

• "I've been a member since 2016. I sometimes think about leaving the mutual health insurance company, but since I get sick often, I prefer to stay because of the high hospital costs" (Female mutual health insurance member, 32, Ngeba health area).

4. The need for local institutional anchoring in the management of mutual health insurance and the role of providers in promoting mutual health insurance.

Participants in this study, both members and service providers, deplore the lack of involvement of local structures and organizations to act as leverage to address the health insurance company's management's failings regarding its lack of transparency and accountability. According to them, despite the fact that the general meeting is held once a year, it will not be able to play the crucial role of local structures in improving the health insurance company's governance, including advocacy for the health insurance company, channeling beneficiary complaints, and regulating reimbursements.

Beneficiaries ultimately believe that the current board members have only a consultative role with respect to the health insurance company, rather than a decision-making one.

Management points out that there are credible and rigorous partners (Memisa, Enabel, the European Union, Soxieux) who support the health insurance company with technical and financial assistance; and that the mutual health insurance accounts are audited by international firms and validated by these major institutions.

She also specifies that the head physician of the area and a delegate from the diocesan health office of the Diocese of Kisantu are members of the board of directors and the control committee, respectively.

The providers believe that local institutional support will help ensure the regularity of reimbursements and supervise the management of the mutual health insurance, as well as organize advocacy activities in favor of the mutual health insurance.

The following opinions are shared by the members:

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• "It seems to me that the board of directors does not have enough power or competence to reframe the management process of the mutual health insurance. That is why I propose institutional support capable of demanding transparency" (president of the Ngeba health area mutual insurance section).

• "It is important that certain local institutions participate in strengthening the mutual health insurance; "Because the providers don't take our complaints into consideration" (Male health insurance member, 58, Kikonka health area).

• "In my opinion, the contribution of these local institutions would be not only to support the management of the health insurance, but also to seek ways to support income-increasing initiatives in households" (section head, Kavwaya health area).

As for the perception of the role that providers should play, beneficiaries appreciate the care that health facilities (FOSA) provide to mutual members. While providers believe that their role, limited to providing quality care, should expand to other aspects such as awareness-raising, verifying family affiliations to limit adverse selection during affiliations, and moral hazard during care delivery.

• "FOSA plays a vital role in patient care, because without the provision of care, the health insurance would be meaningless." (35-year-old male mutual health insurance member, Ngeba health area).

• "It's important to involve other institutions that can lead advocacy efforts to supplement the little that mutual health insurance members provide" (Director of a general referral hospital).

IV. **Discussion**.

This study sought to determine whether the involvement or anchoring of the Kisantu mutual health insurance beneficiaries and providers, as well as local institutions, is the basis for its growth, as it was in Bwamanda.

Regarding the mutual's accountability and the potential for their involvement in its expansion. The results revealed a low level of accountability of the mutual health insurance managers to the beneficiaries. This contributes to a loss of trust and credibility that is likely to limit the mutual health insurance's growth and influence and increase its penetration rate in the community.

It is with this in mind that Ridde (2019) presents participatory governance and financial transparency as essential for maintaining trust in the mutual system. These parameters are also essential for attracting institutional support (Mbaka K. et al. 2023, Kitenge s. et al. 2022).

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Furthermore, providers' concerns about late payment of healthcare bills would be addressed if claims funds were properly managed.

Indeed, the importance of this fund is also highlighted in the context of mutual insurance companies in sub-Saharan Africa, where its role in improving beneficiary trust and loyalty to the mutual insurance company has been highlighted (Tine J et al 2021).

The establishment of this claims fund is an essential practice for the resilience and sustainability of mutual insurance companies in fragile socio-economic contexts (Koulibaly L et al 2023).

In Bwamanda, for example, where premiums are collected annually, the provider's share (claims) is paid at the end of the campaign, and this does not create any frustration.

Most members are familiar with the conditions of membership and renewal, as well as those for healthcare reimbursement. Some have decried the financial burden these places on households with more than 10 members, even suggesting benefits for these families.

This concern is significant. It is shared by Kimani et al. (2016) and Ridde & Queuille (2017), who argue that these families are often disadvantaged in flat-rate contribution systems. The latter authors recommended a revision of the pricing model to make the system more equitable, including government subsidies or a contribution cap, as proposed in some groups.

Such an experiment was attempted in Rwanda where the number of contributions was set at US$7.9 per year for a family of 7 people: US$1.5 per additional member and US$5.7 for a single person (Musango L. 2004).

As part of the proposals to be made for the contributions of large households, it seems relevant to us to suggest the strategy of staggering contributions, mentioned by Diop and Sène (2023) and Ndahayo (2022), in order to make mutual health insurance contributions more affordable, particularly for low-income households.

Indeed, these authors suggest the following techniques to implement this strategy:

i) Staggering according to contributory capacity: This involves adjusting the number of contributions according to the financial capacity of the beneficiaries; either according to income or by capping for large families, often faced with a high cumulative burden.

ii) Payment frequency to ease the financial pressure on beneficiaries. This could include a choice between monthly, quarterly, or annual payments.

iii) Flexibility in payment deadlines, meaning that late contributions do not automatically result in exclusion from healthcare.

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iv) Incentives for regular payments: This involves granting discounts or benefits to encourage regular or early payments. For example, an annual contribution paid for one installment could include a reduction of a few percent. Or beneficiaries who contribute regularly could be eligible for reimbursements or additional benefits.

The affiliation process highlights the fact that, at the time of registration, a household record book is given to the head of the household. This record book lists the names of the beneficiaries declared by the head of household. However, this approach opens up the possibility of adverse selection. It would have been better to involve registered nurses in producing family records kept at the health center and updated annually. When the head of household registers their household, the mutual health insurance company (MHI) will check with the health center to ensure that all beneficiaries in the household are on the list.

Regarding the sense of belonging, respondents expressed a sense of solidarity as the basis for their membership in the mutual health insurance company.

This represents a form of community anchoring for the mutual's growth.

In a study conducted in Cameroon, solidarity was identified as the main motivation for joining a mutual health insurance company, as it helps reduce individual healthcare costs (Fouda A. et al. 2018).

Added to this spirit of solidarity is the perception of protection against catastrophic healthcare costs (Chuma J. 2018).

Indeed, since hospital care costs are high, this solidarity protects household income from healthcare expenses.

Furthermore, providers are guaranteed to recover the cost of care, even if delayed, when patients struggle to pay. This gives them confidence that they can minimize their shortfall (Mills A. et al. 2018).

The focus groups highlighted the importance of institutional support for the growth of mutual health insurance, the channeling of beneficiary claims, and the regulation of reimbursements.

Similarly, the study by Bennett S. et al. (2004) asserts that the institutional anchoring of mutual health insurance is a determining factor in the establishment of inclusive social protection, which strengthens solidarity mechanisms, promotes equity in access to care, and ensures the sustainability of these initiatives.

The study also noted a low level of involvement among providers and local partners, which can compromise the quality of care and beneficiary satisfaction (Mathauer ,2011). According to Bennett et al. (2020) and Gnawali et al. (2015), increased institutional support, such as that of

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local health authorities or NGOs, helps improve the quality of services, ensure transparent management, and provide ongoing training to mutual health insurance staff, while guaranteeing regular reimbursements.

Furthermore, in the context of the Kisantu mutual health insurance scheme, which relies on extensive technical and financial assistance, the end of the partnership risks causing it to collapse. Therefore, it is important to consider a sustainable local presence.

It can therefore be assumed that this growth in membership is largely driven by external assistance, which, in our view, poses a risk to the long-term sustainability of the health mutual. It is thus essential that such assistance be gradually replaced by strong local community and institutional anchoring.

As for the role of providers in the growth of the mutual health insurance scheme, according to the experience of the Bwamanda CDI in the Sud Ubangi province of DR Congo, affiliation is carried out at the health center level based on the family record previously established by the staff nurse; this minimizes the risk of adverse selection in this family affiliation system. However, for the Kisantu mutual health insurance company, the only role played by service providers is to care for patients within the framework of the health care agreement, by providing quality care. They do not provide any opinion on the effectiveness of family affiliation.

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V. Conclusion.

This study showed that low accountability and a lack of transparency, resulting in delayed payment of services to providers, and consequently poor quality of care, are among the reasons for the low growth of the mutual health insurance scheme.

In addition, the study also demonstrated that the lack of community and institutional involvement reduces the opportunities for mobilizing new members and resources, as well as advocacy and channeling complaints from various stakeholders: in particular, the desire of large family households and prompt payment of healthcare bills, based on claims rates.

Thus, participants advocated local institutional support, through local structures, to channel the efforts of various stakeholders in the management of the mutual health insurance scheme.

Conflicts of Interest: The authors declare no conflicts of interest.

What is known about this topic?

• The existence of the Kisantu mutual health insurance scheme

• The experience of the Bwamanda mutual health insurance scheme with regard to institutional and community anchoring.

• Rwanda's experience with family contributions.

What does your study bring to the table that's new?

Include a maximum of 3 key points on what your study brings to the table that's new:

• Local institutional anchoring improves the growth of the mutual health insurance scheme

• The involvement of healthcare providers in affiliations helps limit adverse selection in the declaration of members by the head of household.

• Rigorous management of claims rates promotes regular reimbursement.

Author Contributions

Jean-Marie Nkutu Pululu: Drafting of the study (introduction and methods, data interpretation, discussion, and conclusion)

Gabriel Vodiena Nsakala: Focus on the topic, editing the text, and rewording verbatim transcripts.

Fulbert Nappa Kwilu: In-depth editing of the text and the title, and additional discussion.

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Tables

Table 1: Number of respondents by sex and health area.

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References.

1. **Bennett S, et al.** Strengthening institutional support for health insurance schemes in Africa. *J Health Econ*. 2020.
2. **Bennett S, Creese A, Monasch R. Health insurance schemes for people outside formal sector employment. World Health Organization; 2004.**
3. Carrin G, Waelkens MP, Criel B. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems. Trop Med Int Health. 2005;10(8):799-811.
4. **Chuma J, Okungu V. Community health insurance: motivations for enrollment and the role of solidarity. BMC Health Serv Res. 2021.**
5. **Diop S, Sène A. Mobilisation des ressources pour les mutuelles de santé : Une approche communautaire. Santé Développement. 2023;9(2):78-95.**
6. Driss, Zine Eddine El Idrissi Moulay, Özaltin Emre, Haazen Dominic, Juquois Maud. Couverture sanitaire universelle et secteur informel en Afrique de l'Ouest francophone : Etat actuel, perspectives et proposition d'orientations stratégiques. Washington, DC, Groupe de la Banque mondiale, juin 2018
7. Fonteneau B, Galland B. Les mutuelles de santé en Afrique : quelle contribution à la couverture sanitaire universelle ? Rev. Tiers Monde. 2014;(217):29-47.
8. **Fouda A, et al. L'assurance maladie communautaire au Cameroun: motivations des bénéficiaires et des prestataires. Santé Publique. 2018.**
9. Gnawali D, et al. Partenariats institutionnels pour le développement des mutuelles de santé au Sénégal. *Afr Dév*. 2015.
10. Jakab M, Krishnan C. Community involvement in health care financing: impact, strengths, and weaknesses. In: Preker A, Carrin G, editors. Health Financing for Poor People: Resource Mobilization and Risk Sharing. Washington, DC: World Bank; 2004. p. 53-88.
11. Kadio, Kadidiatou, et al. « Émergence et formulation d'un programme de solidarité pour affilier les plus pauvres à une assurance maladie au Burkina Faso », Sciences sociales et santé, vol. vol. 35, no. 2, 2017, pp. 43-68.
12. **Kimani D, et al. financial barriers to healthcare access: the role of health insurance in Sub-Saharan Africa. Int J Health Policy Manag. 2016.**
13. **Kitenge S, Molobi D. L'impact de la redevabilité dans les mutuelles de santé : Cas du Congo. Rev Francophone Santé Gestion. 2022;7(2):104-17.**

African Scientific Journal
ISSN : 2658-9311
Vol : 03, Numéro 31 Aout 2025

14. Koulibaly L, et al. Modèles de prévoyance et fonds de sinistralité dans les systèmes de mutuelles en Afrique francophone. Rev Int Gestion Santé. 2023;9(2):98-117.
15. Maria-Pia Waelkens, Sylvain Shomba, Fulbert Kwilu Nappa, Mulinganya Nsimire, Bart Criel, 2016, Etude des mutuelles de santé en RDC dans le cadre de la couverture sanitaire universelle, Institut de Médecine Tropicale, Anvers, Belgique, 2016
16. Mathauer I, Carrin G. The role of institutional design and organizational practice for health financing performance and universal coverage. Health Policy. 2011;99(3):183-92.
17. **Mbaka K, et al. Les mutuelles de santé au Congo : Entre défis de gouvernance et perspectives d'avenir. Rev Congo Santé Publique. 2023;18(1):33-48.**
18. **Mills A, et al. Health insurance systems and financial stability for healthcare providers in developing countries. Lancet Glob Health. 2018.**
19. **Musango L, Martiny P, Porignon D, Dujardin B. Le profil des bénéficiaires et des non-bénéficiaires des mutuelles de santé du Rwanda: le cas du district sanitaire de Kabutare. Cah Santé. 2004;14(2):93-9.**
20. Mutuelle de santé de Kisantu, Rapport annuel Mutuelle de santé de Kisantu 2023.
21. **Ndahayo T. La perception des cotisations et le sentiment d'appartenance des bénéficiaires. Santé Publique Innov Soc. 2022;11(3):300-17.**
22. Paillé P, Mucchielli A. *L'analyse qualitative en sciences humaines et sociales*. 4e éd. Paris : Armand Colin ; 2016.
23. **Pululu Nkutu JM.** Ancrage et pérennisation des mutuelles de santé. Mouvements et enjeux sociaux, revue de la chaire dynamique sociale de l'université de Kinshasa. 2019 Jan-Mar;108:81-88.
24. République Démocratique du Congo, Loi déterminant les principes fondamentaux relatifs à la mutualité, février 2017, 33 pages.
25. République Démocratique du Congo, Plan stratégique national pour la couverture santé universelle 2020-2030, janvier 2020, 69 pages.
26. **Ridde V, et al. Transparence et gestion financière dans les mutuelles de santé en Afrique de l'Ouest. Cah Études Rech Francoph/Santé. 2019.**
27. **Ridde V, Queuille L. Les défis des mutuelles de santé en Afrique de l'Ouest: enjeux financiers et d'équité. Rev Int Santé Publique. 2017.**
28. Soors W, Devadasan N, Durairaj V, Criel B. Community health insurance and universal coverage: multiple paths, many rivers to cross. World Health Report. 2010.

African Scientific Journal
ISSN : 2658-9311
Vol : 03, Numéro 31 Aout 2025

29. Sophie Witter et Benjamin Hunter, Comment progresser vers la couverture sanitaire universelle en situation de crise : enseignements tirés de la recherche. Document de synthèse, https://rebuildconsortium.com/media/1661/series_briefing-3_june_17-french.pdf, visité 20-01-2021
30. Tine J, Faye B. Les mutuelles de santé en Afrique subsaharienne : défis financiers et fonds de sinistralité. Cah Santé Communautaire. 2021;8(4):201-18.
31. Valery Ridde, N. B. Mbow Sane. Vers une couverture sanitaire universelle en 2030 ? : réformes en Afrique subsaharienne. Ed. Science et Bien Commun, 827 p., 2021, 978-2-925128-08-3. ff10.5281/zenodo.5166925ff. ffhal-04154376f