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Making health insurance responsive to citizens: the management of members' complaints by mutual health organisations in Kinshasa, Democratic Republic of Congo

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ABSTRACT

Introduction In moving towards universal health coverage, a number of low-income and middle-income countries have adopted community-based health insurance (CBHI) as a means to reduce both the inequity in healthcare access and the burden of catastrophic health expenditures linked to user fees. However, organisations managing CBHIs face many challenges, including a poor relationship with their members. In the Democratic Republic of the Congo, CBHI schemes are managed by mutual health organisations (MHOs) and are in the process of enhancing their accountability and responsiveness to members' needs and expectations. This study assessed how MHOs have managed member complaints and their performance in grievance redressal.

Methods Using a sequential mixed-methods approach, we drew insights from four types of sources: review of approximately 50 relevant documents, 25 in-depth interviews (IDIs) with CBHI managers, 9 IDIs with health facility managers, 1063 surveys of MHO members and 15 focus group discussions (FGDs) comprising an additional 153 MHO members. MHO members in this study belonged to three different MHOs (Lisanga, La Borne and Mutuelle de santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel) in the capital, Kinshasa.

Results The document review showed that there were no clear administrative processes for the implementation of the grievance redressal arrangement measures resulting in low member awareness of these measures. These results were confirmed by the IDIs. Of 1044 members surveyed, only 240 (23%) were aware of the complaint measures, and 201 (84%) of these declared they had used the measures at some point in time, 181/201 (90%) users who had used the measures declared being satisfied with the response provided. The FGDs confirmed that most members lack knowledge on the grievance redressal procedures, but those who were aware had made use of them and were often satisfied with the response provided.

Conclusion MHOs should urgently improve communication with their members on the range of redressal measures put in place to address grievances. Attention should be given to properly monitor existing arrangements, and possibly adapt them with well-documented and communicated standard operating procedures.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ There is no national social health insurance system in the Democratic Republic of Congo (DRC), resulting in frequent and large out-of-pocket payments.
⇒ Mutual health organisations (MHOs) in DRC are the organisational vehicle to implement and manage community-based health insurance (CBHI) schemes. However, penetration and enrolment are low.
⇒ Sound design and management of CBHI schemes can reduce catastrophic healthcare expenses and increase timely health-seeking behaviour in the quest for universal health coverage.

WHAT THIS STUDY ADDS

⇒ The study presents an original contribution to the debate on CBHI considering the case study of DRC and, specifically, the urban context of Kinshasa.
⇒ MHOs in DRC have instituted several grievance redressal mechanisms and procedures in order to address CBHI members' complaints. This study reveals important weaknesses in their accountability and responsiveness to the members' expectations.
⇒ The study uncovers weak managerial and administrative procedures of MHOs that lead to low uptake and limited satisfaction. A suite of recommendations on how these can be improved are included.

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HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

⇒ Further research in DRC may investigate ways to improve MHOs communication policy in terms of strengthening CBHI members' knowledge and ability to make better use of grievance redressal mechanisms.

⇒ With respect to practice, MHOs should consider establishing standard operating procedures (SOPs) for use by MHO staff when addressing members' complaints and grievances. These should be coupled with robust monitoring and improvement practices.

⇒ Proper and timely response to member's complaints will contribute to increased use and satisfaction, and consequently improved MHO penetration.

BACKGROUND

The evolution of community-based health insurance schemes to move towards universal health coverage

Health services are underused in several low-income and middle-income countries (LMICs). This is due to a wide range of factors, including poor availability, accessibility and affordability of quality healthcare. Given that insufficient public revenues fail to adequately fund the health system, health services often resort to a cost-recovery strategy funded through direct payment of care by households at the point of delivery, in other words out-of-pocket payments (OOP).[1–3] OOP payment constitutes the predominant form of healthcare financing in several LMICs, and funding generated through it often serves to complement salaries and the operational costs of health facilities.[2 4–6]

In line with the WHO's guidance related to universal health coverage (UHC)[7] in the context of limited capacity to finance sustainable social protection, several governments in LMICs have instituted national health financing reforms. Such reforms seek to enhance household protection against catastrophic health expenditures. They address public expectations through strategies to remove financial barriers to healthcare access.[6 8] To this end, many countries have opted to promote the use of community-based health insurance (CBHI) as one such strategy.[8] CBHI is a financing mechanism characterised by community solidarity, participatory decision-making and management, and a non-profit policy. Other characteristics include affordable premium contributions, financial transparency, fair regulation in the provision of healthcare and adequate funding mechanisms.[9–11] Through CBHI, households can reduce OOP payments which are significant financial barriers to accessing healthcare.[1 12–17]

The management of CBHIs relies considerably on community participation.[2 9 18–21] CBHIs use social accountability mechanisms that require public participation to recognising failures in the delivery of healthcare services and, consequently, can apply pressure on providers for improvement, reform, and accountability to the community.[15 22]

Low awareness on community-based insurance principles among enrollees is a major challenge for CBHIs.[23] This is often on account of poor provision of information around CBHIs as well as broader political economy factors that reinforce power asymmetries between users of health services and providers and government officials, with the latter group not feeling the need to communicate clearly with users of services.[23] The lack of information coupled with inadequate accountability, transparency, trust and poor responsiveness of CBHI constitute barriers to enrolment; thus, compromising progress towards UHC.[3 6 24]

CBHIs in the Democratic Republic of Congo

In the Democratic Republic of Congo (DRC), there is no national social health insurance scheme or programme. In this setting, CBHI is implemented by 'Mutuelles de santé' (mutual health organisations—MHOs). MHOs appeared in the 1990s as healthcare financing and pooling mechanisms to bridge the health financing gap.[25] However, MHO penetration in the country remains low, representing 7% of household payments on health in 2015.[26] In 2017, DRC finally passed a law organising MHOs and published a social protection policy document.[27 28] Both documents described MHOs as a critical health financing mechanism. Employees in the formal sector are enrolled according to the DRC labour law (Loi organique No 17/002) which states that, an employee and his/her family members are entitled to be supported for healthcare by his/her employer.[27] In DRC, some small-sized and medium-sized enterprises rely on CBHI to provide financial healthcare access to their employees, in the geographical area where they are implemented, leading to a kind of group enrolment in a CBHI. Two schemes of MHOs appear in these documents: one for employees in the formal sector with compulsory enrolment and premium contributions deducted from salaries. The second scheme, more organised as a typical CBHI scheme, is mainly intended for workers in the informal sector where the enrolment and premium contributions are individually and voluntary based. In all MHO schemes, healthcare services are offered by private or publicly contracted primary health centres and general referral hospitals based on their locations across the 24 municipalities of the city of Kinshasa. Healthcare services offered at hospital level are accessible only with referral from health centre and approval by an MHO broker, except in case of emergency and life-threatening conditions.

The extension and professionalisation of MHOs are reflected in DRC's UHC strategic plan 2020–2030 which strives to enhance social protection for the citizens.[19 28–30] The extension of social protection through high coverage rate of CBHIs as expected from the strategic plan relies on trusted relationships between MHOs and their members and high satisfaction with services which would facilitate increased penetration.

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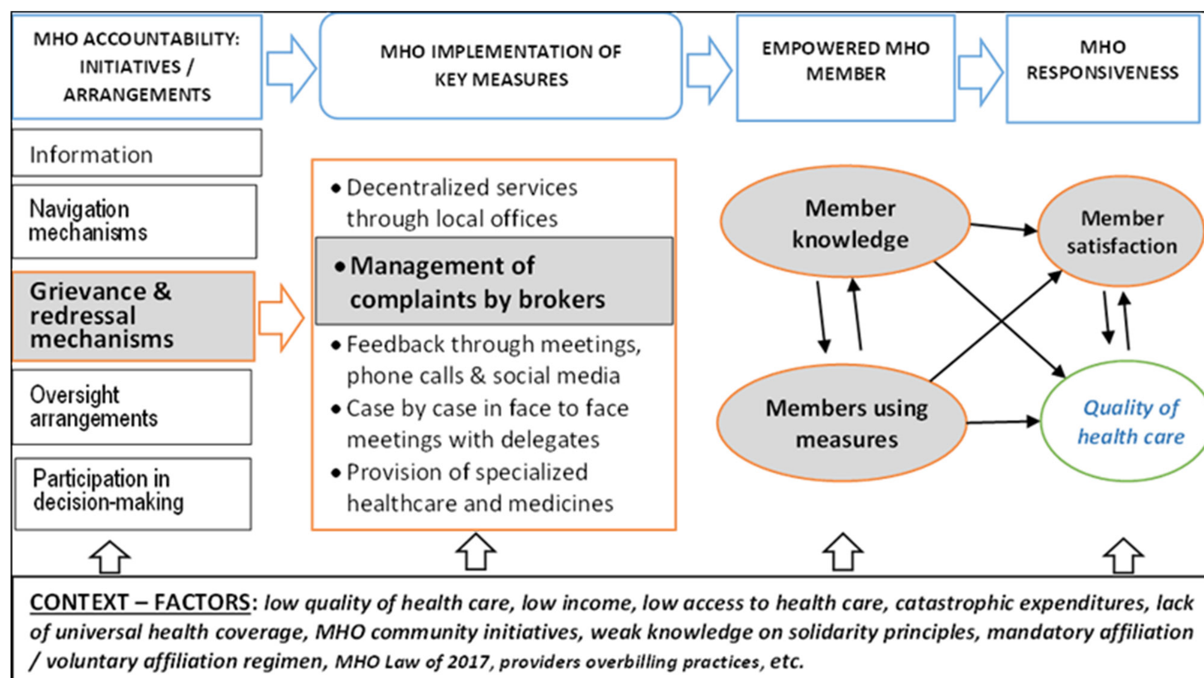

Figure 1 Conceptual framework: theory of intervention of the arrangement measures. Source: adapted from Goetz and Gaventa and Molyneux *et al*.[15 31] MHO, mutaual health organisation

MHO accountability and responsiveness mechanisms in DRC

Inappropriate MHO delivery service discourages members and they often fail to renew their membership in CBHI schemes, or even, to turn into automedication, therefore increasing OOP.[3] MHO schemes have, therefore, instituted several mechanisms to enhance accountability and responsiveness to member needs and expectations, including information provision, navigation mechanisms and grievance redressal mechanisms. Despite oversight arrangements and members participation in decision-making as two other mechanisms to enhance accountability and responsiveness to member needs, few steps have been taken by MHOs to implement these arrangements.[15 31] All the mechanisms mentioned above were brought together in a generic framework describing the institutional arrangements aimed to enhance MHO accountability and responsiveness (figure 1). More details on figure 1 are provided later in this section.

With respect to the provision of information and assisting with navigation, MHOs in DRC provide documentation to members, create channels of communication (phone or face to face), and avail procedures of grievance reporting. These are intended to be accessible to members, MHO brokers and health facility managers. Documents (letters, registration books, survey reports, general assembly reports), emails, phone calls, WhatsApp and face-to-face visits are used to register and track members, as well as record members' complaints and suggestions. In case members are unable to navigate the various processes, they can consult with MHO brokers who are either MHO employees delegated at the health facility or MHO medical advisors. MHO brokers play an intermediary role between providers in health facilities and MHO members in order to address member concerns and to assist them in navigating between health facilities.

With respect to grievances and complaints, MHO members can contact an MHO broker in person or by phone. The MHO brokers are then required to apply the necessary processes. Should this fail, brokers can escalate member complaints to the MHO Committee Board or to its general assembly.

Though MHOs intend to reduce household OOP expenditures, their effectiveness is hindered by a lack of financial support from the government, extreme poverty within the population, provision of poor-quality healthcare, adverse selection of individuals with a history of chronic disease, a history of distrustful relationships with a community and low enrolment rate.[6 32 33] Furthermore, there is a knowledge gap related to the effectiveness of the various processes instituted by the MHO to provide information, sensitise community members and manage the relationships with different partners in the DRC. Thus, it is important to understand how best to enhance the effectiveness of the MHOs accountability and responsiveness toward their members, as MHOs are very suitable organisations that could reach people in their specific communities, even in the remote risky areas throughout the country, including the ones in war-torn North Kivu and Ituri, mineral-rich Haut Katanga and remote Bas Uélé provinces. This would consequently enhance MHO penetration as well as improve their overall functioning,

Figure 1 is adapted from a framework by Goetz and Gaventa[31] and Molyneux *et al*[15] to depict the links we sought to explore. The extent of member empowerment and MHO responsiveness are interlinked and dependent

on member participation organisational accountability to the population being served.[3 34] Increased member knowledge and improved social protection through grievance redressal mechanisms are rooted in the ability of MHOs to empower their members.[35 36]

Study aims

The DRC context is characterised by an insufficiently regulated health system, and by political, economic and social factors that play a major role in influencing how initiatives at the community level translate into empowered MHO members and MHO responsiveness. When preparing tools for data collection and analysis, the framework informed how the interview guides were structured and data analysis planned.

In response to the knowledge gaps and dissatisfaction highlighted above, the study assessed grievance redressal mechanisms that are used by MHOs to manage member complaints (highlighted in grey in figure 1). The study explored three main questions:

a. What are the MHO processes to manage and respond to member complaints and grievances?
b. To what extent are the members knowledgeable about the MHO institutional arrangements, their use of existing grievance processes and their satisfaction with the MHO response?
c. What are some of the factors that influence their knowledge?

METHODS

Study design and setting

To address the questions above we examined three MHOs (Mutuelle de santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel (MESP) Kinshasa, MHO La Borne and MHO Lisanga) within four administrative districts of Kinshasa city where the three MHOs are located.

The MESP (MHO for Primary, Secondary and Vocational Teachers) in Kinshasa is a non-profit organisation that was launched in 2011. Enrolment into this MHO is mandatory for government employees (teachers and civil servants) working in the primary and secondary education system. In 2012, the government and the teachers' labour union, established an agreement requiring a monthly premium contribution of FC9200 (~US$10) to be paid to the MESP for each employee covering a maximum of five household members. Half of this is to be deducted directly from employee payroll and the remaining half subsidised by the government.

The Centre de Gestion de risque et d'Accompagnement Technique (CGAT in English: Risk Management and Technical Support Centre) was created in 2010.[30] It is a Congolese, non-profit, apolitical, non-religious and autonomous civil society umbrella organisation that provides managerial, technical and financial support to CBHIs offering voluntary-membership. MHOs La Borne and Lisanga are both community-based MHOs and operate under the CGAT umbrella and mentorship. In theory, the unit of enrolment is the entire household, but some exceptions are permitted. The annual standard premium contribution in these MHOs is US$55 (FC110 000 in 2021) per household, whether in the informal or formal sector. Although no government subsidy is offered to these MHOs, some financial support for operating costs is provided by international donor agencies through the CGAT. For the purpose of this paper, we pooled the data of these two MHOs, since both of them operate under the same CGAT umbrella.

Data collection and analysis

Using a sequential mixed-methods approach, the study comprised four types of sources: document review, in-depth interviews (IDIs), household surveys and focus group discussions (FGDs), as presented in the figure 2 below on data collection and analysis pathways.

Qualitative data collection

Documentary review

We started by collecting documents providing insight on the stakeholders involved in MHO activities in DRC. Over the period December 2019 to July 2020, with the consent of the MHO leadership, we accessed approximately 50 documents such as: National Laws on MHOs, National Health Development Plan, National Strategic Plan on UHC, National health account reports, MHO administrative decisions, Institutional Status of Lisanga, La Borne, MESP and CGAT, registration books, manuals of procedures, complaint books, Health package contents, list of health facilities that have contracted with MHOs, list of schools per administrative district of Kinshasa City, minutes of general assembly meetings, annual reports, and operational plans.

We also consulted various MHO member databases. Document reviews occurred in the privacy of the MHO offices and in an iterative manner with more documents being requested as required using a content analysis approach. We searched for information related to the creation of the MHO, the content of the MHO status, the growth of the membership over time, the enrolment conditions, their institutional arrangements and agreements with health facilities, as well as with MHO members on the content of the healthcare package, the premium contributions, the MHO funding sources, user fee payments, the communication protocols with MHO members, and the registration and management of complaints.

In-depth interviews

We conducted IDIs with semistructured interview guides over an extended period (18 February 2020–10 August 2020) due to the COVID-19 measures instituted by the government. We sent official invitations from the Kinshasa School of Public Health to targeted respondents, which were followed up with phone calls for interview dates. All respondents provided written consent before the

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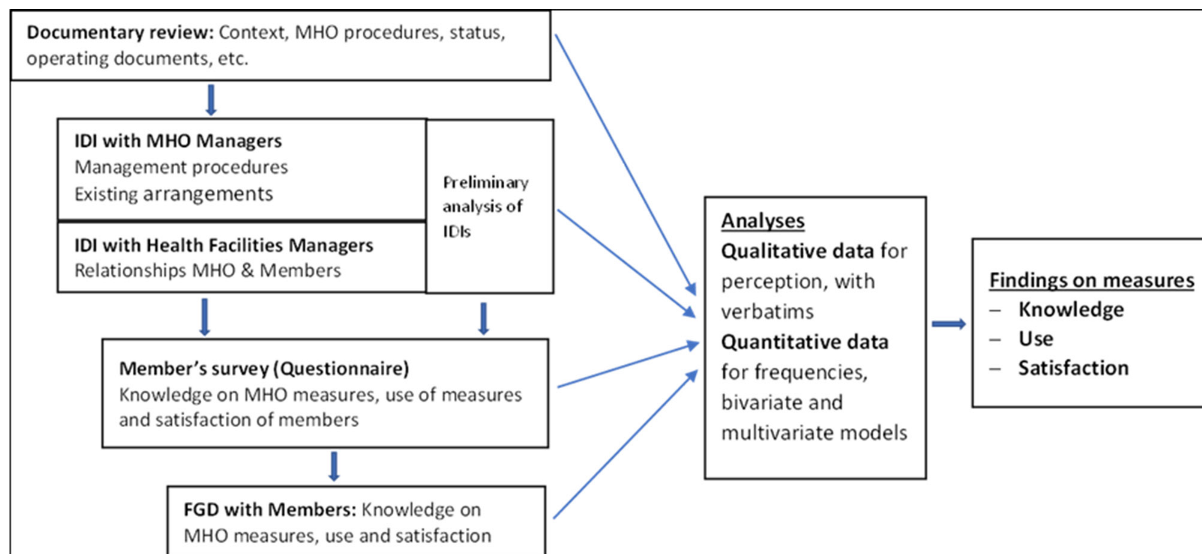

Figure 2 Data collection and analysis pathways. Source: authors self-designed pathways from methods. FGD, focus group discussion; IDI, in-depth interview; MHO, mutual health organisation.

interview. IDIs were conducted in French, as the majority of the population of Kinshasa speaks French, the official administrative language in the DRC. Respondents were interviewed at their workplace by experienced moderators, some of whom are also coauthors on this paper. IDIs were audiorecorded, transcribed verbatim and complemented by written notes. On average, they each lasted approximately 1.5 hours.

For MHO management, inclusion criteria required that respondents held senior positions (Chief Executive Officer (CEO) and senior managers, including MHO brokers), had more than 5 years of experience in the institution, and received authorisation from the top management of their MHO to participate. We excluded anyone who did not meet these criteria above resulting in 25 IDIs (table 1). IDIs focused on MHO member concerns and the corresponding MHO responses, as well as on the exact nature of the MHO institutional arrangements put in place to address member concerns as per our conceptual framework (figure 1).

For health facility respondents, we selected those facilities which contracted with at least two MHOs. This resulted in selecting nine first line health facilities. Within these facilities eligible participants needed to hold a senior position, such as medical director or administrative manager, resulting in a total of nine IDIs (table 1). Questions focused on their opinions on the relationships between MHOs and their members.

We did not conduct IDIs with MHO members, since their views were captured via the household survey and the FGDs.

Qualitative data analysis

The IDIs and documentary reviews allowed us to identify all of the practices applied by MHOs to gather and address grievances. These practices were categorised along the lines of the institutional arrangements presented in the conceptual framework shown in figure 1.

We applied both inductive and deductive analyses of the qualitative data to generate thematic codes and subcodes. These were used to create a comprehensive codebook. Coding was done using ATLAS.ti. Responses from the IDIs informed the household survey.

Quantitative data collection and analysis

Member sampling for survey

To calculate the number of members needed to survey, we used the formula $n \geq \frac{Z^2 * pq}{d^2}$, where 'p' refers to the proportion of members who are aware the MHO grievance mechanisms in each MHO (0.5 to have a maximum sample), 'q' the opposite proportion (1−p=0.5), 'z' the confidence coefficient at 95% (meaning z=1.96), and 'd' the precision level of 0.05, thus, assuming a normal distribution of our outcome in the reference population. We ended up with a minimum of 384 household representatives (members) to be selected in each MHO category. This sample size was increased by 30% to reach a minimum of 500 household representatives in each MHO scheme, given the difficulties of reaching all households identified within the context of Kinshasa city.

For the two CGAT MHOs, household members were randomly selected from the existing member address list, spread over the four administrative districts of Kinshasa city. The inclusion criteria required that the respondent be the head of household or spouse and >18 years of age. This resulted in a total of 508 members: 136 in La Borne and 372 in Lisanga, which is proportional to the number of households in each MHO. Any incorrect address or non-consent resulted in replacement by members in the next available household.

For the MESP, inaccuracy within the member database led to shifting to a two-stage sampling process using

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Table 1 Key informants interviewed during in-depth interviews

No.	Functions	Institutions	Sex
	MHO managers		
1	National coordinator	CGAT	Female
2	Provincial coordinator Kinshasa		Male
3	Manager (CEO)	Lisanga MS/CGAT	Male
4	Assistant manager		Female
5	Medical advisor CGAT1		Male
6	Manager (CEO)	La Borne MS/CGAT	Female
7	Chairman of the board committee		Male
8	Medical advisor CGAT2		Male
9	National executive secretary (CEO)	MESP	Female
10	Provincial executive secretary Kinshasa		Female
11	Assistant of the technical director		Male
12	Head of tariffs and contracts department		Female
13	Head of insurability department		Female
14	Lead of the pool of medical advisers in Kinshasa		Male
15	Broadcaster MESP N'djili		Female
16	MESP healthcare facility delegate 1		Female
17	MESP healthcare facility delegate 2		Male
18	MESP healthcare facility delegate 3		Male
19	MESP healthcare facility delegate 4		Female
20	Executive secretary (CEO)	POMUCO/CGAT	Male
21	Director of the programme	PNPMS/MESP	Male
22	Deputy director		Male
23	Head of studies, statistics and planning division		Male
24	Health economics expert coordinator		Male
25	Director of the programme	PNPS/MESP	Male
	Health facilities (Providers)		
26	Administrative and financial manager CME BUMBU	Public hospital	Male
27	Administrative and financial manager HP Kalembe Lembe	Public hospital	Male
28	Health facility director CS EMILIA/Matete	Private clinic	Male
29	Health facility director CS Moyi mwa Tongo/Limete	Faith-based hospital	Male
30	Health facility director Clinique des Anges/Ngaliema	Private clinic	Female
31	Health facility advisor Clinique Promedis/Limete	Private clinic	Male
32	Acting health facility director CH Elykia/Kimbaseke	Faith-based hospital	Male
33	Health facility contract's officer Clinique Riviera/Bandalungwa	Private clinic	Female
34	Health facility director CH Ntombwa ya Maria/Masina	Faith-based hospital	Male

CGAT, Centre de Gestion de risque et d'Accompagnement Technique; MESP, Mutuelle de santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel; MHO, mutual health organisation; PNPMS, Programme National de Promotion des Mutuelles de Santé; PNPS, Programme National d'appui à la Protection Sociale; POMUCO, Plateforme des Organisations Promotrices des Mutuelles de Santé.

school addresses instead of member addresses. First, we randomly selected 53 schools (out of 5013 governmental schools) distributed across the 24 municipalities of Kinshasa. The selection was proportional to the weight of the number of schools in each of the four administrative districts (Funa 27%, Lukunga 22%, Mont Amba 38% and Tshangu 13%). The second stage involved convenience sampling of 10 MESP members among all those who attended the school on the survey day. Respondents had to be a member of the MESP. We excluded new teachers who were not yet enrolled as members of the MESP. Overall, 6–7 respondents were selected among school

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teachers, and 3–4 among other types of school employees for each school, totalling 555 MESP respondents.

A total of 1063 households with one member representing each household were thus included in the study.

Survey data collection and analysis

The questionnaire was pretested during the training session of surveyors that took place from 8 December 2020 to 12 December 2020 at Kinshasa University. Data were collected from 17 December 2020 to 15 March 2021 using Open data kit software and sent to a server after checking for inconsistency or missing data. Both SPSS V.26 and STATA V.17 software were used to generate univariate frequencies for all variables in order to find inappropriate data records. Some inconsistencies were corrected, and missing data were removed from records when it was plausible to do so. This resulted in a final pooled sample of 1044 respondents: 497 for CGAT (11 dropped) and 547 for MESP (8 dropped).

The study has three dependent variables, organised sequentially, with variable B being conditional on A; and variable C being conditional on B: (A) Members knowledge of the complaint procedures, that is, the number of respondents who declared being aware of the procedures among all respondents; (B) Members' effective use of the complaint procedures, that is, the number of respondents who ever used the procedures among all those who declared knowing them and (C) Members satisfaction when making use of the complaint procedures, that is, the number of respondents who expressed satisfaction among those users who used them. These three outcome variables reflect the conceptual dimensions of interest in the framework and they informed questions asked to collect the relevant data. The logic between these three dependent variables is that knowledge is a necessary condition for use, and use is necessary to know whether the initiative is functioning or not, and if it is leading to satisfaction.

The independent variables were related to sociodemographic and economic characteristics, and related information on MHOs. Selection was done in relation to the DRC context, and according to the literature and local knowledge. Respondent age, education, gender, religion and household size were used as predictors of MOH membership enrolment.[3 33]

Respondents' perception of 'trend in new enrolments' was considered as an independent variable, since studies have shown that a positive trend in membership provides members with more confidence, thereby encouraging more households to join, and is used by MHOs as an argument for membership retention.[37 38]

For the analysis, we performed an overall univariate analysis for the entire database without distinguishing the MHOs to which respondents belonged because of small numbers of observations in the dependent variables. For all variables, we produced frequency tables using values recorded during the interviews. Variables that had more than two categories were transformed into binary values to facilitate bivariate and multivariate analyses.

All variables of interest were used for bivariate analysis. A χ^2 calculation using crosstab bivariate analysis was performed for all of the explanatory or predictive variables and for each specific dependent variable. The selection of predictors derived from our review, as globally papers refer to them as being instrumental. Therefore, independent variables having a statistically significant relationship ($p<0.10$) with each of the dependent variables in the logistical regression model were commented on as key results. Our assumptions were that member's knowledge, use and satisfaction are each associated or explained by each of the predictors in the bivariate analysis.

The association in the logistic regression is presented as an adjusted OR with a 95% CI. We ran three logistic regression models, one for each dependent variable in the order stated above.

FGD respondent selection and data analysis

FGDs with MHO members were conducted from 12 June 2021 to 21 July 2021 after a pretest on 1 June 2021 and 2 June 2021. This was timed with the aim to contextualise the information from the survey which occurred in the months prior. Questions revolved around understanding why some measures or decisions related to the institutional arrangements were not well known despite MHO managers' declarations that they used specific channels to provide information and to collect claims. Those who participated in the survey were excluded from the FGDs. The final selection of participants was based on two key criteria: the availability of the targeted member and as much as possible, consideration of gender. The study included a total of 153 participants in 15 FGDs distributed as follows: 8 for the MESP and 7 for the CGAT (4 for Lisanga and 3 for La borne). FGDs were conducted in French or the local language (Lingala with a translated guide) by five experienced moderators, including members of our research team. Participants provided written consent. FGDs lasted between 1.5 and 2 hours, were audio recorded and complemented by written notes. Recordings were then transcribed and translated into French when necessary.

Patient and public involvement statement

There were no patients involved in this study. Participants were members of the MHOs as described above. A consent form was presented and explained by team members prior to each IDI, survey and FGD. Each participant was required to sign the forms to indicate informed consent. The results of the study will be disseminated to participants through workshops for validation of results for the concerned MHOs, the development of policy briefs for decision makers and dialogues for the MHO platforms.

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RESULTS

We combined quantitative and qualitative findings to better illustrate our findings. Results are organised in four main sections as follows: processes for grievance redressal; MHO responses to members complaints; members' knowledge of MHO institutional procedures, their use and satisfaction and overall member opinions on their relationships with MHOs.

Processes for grievance redressal

We found limited information on institutional arrangements, implementation measures or management of member complaints in the document review. However, IDIs with MHO managers confirmed the presence of five institutional arrangements presented in the conceptual framework in figure 1. Our study focused on one institutional arrangement measure, which is the 'procedure of the management of member complaints'. This arrangement was selected as it is probably the most used by MHO members.

According to the MHO managers, all members are informed about the processes for registering and addressing complaints. MHO managers indicated that MHOs have instituted several mechanisms to channel member concerns and complaints. These include complaint books to register verbal member claims and claim letters, suggestion boxes in the MHO offices and in the contracted health facilities, telephone calls, face-to-face meetings between MHO brokers and members, the MHO' General assembly and occasional member surveys. In the absence of a policy or guidance to address a particular type of complaint, MHO brokers escalate the case successively to the MHO Committee Board, its general assembly, or the MHO platform.

Of all these channels, MHO managers indicated complaints by phone was most common likely due to the faster response times.

Complaints during face-to-face contact are supposed to be addressed by MHO brokers at the health facility level for MESP members, and in some cases at the level of MHO headquarters for all of the MHOs. At the health facility level, direct contact is the most frequently used channel, much more than the registration book of complaints. In some instances, members channelled their concerns to the MHO via health providers.

In general, MHO brokers at the health facility level are responsible for managing member complaints given their front-line access to members. They play an intermediary role between health facilities and MHO members to discuss members' concerns and encourage MHO responsiveness. One IDI respondent stated that:

> Members are free to make an appointment with a medical advisor on a daily basis. A member can come and tell us about his dissatisfaction with the healthcare or quality of care in a health facility. (CGAT MHO Medical advisor)

We found, however, that regardless of channel used, registration and archiving of member complaints and suggestions was not systematic and often absent. In addition, MHOs did not have adequate systems to track their responses to members as noted below by an MESP delegate:

> All complaints received are not properly reported in our activity report book or in using the periodic reporting software (SKYNET)—mainly if we can deal with it directly without escalating the complaint to the MESP headquarters. (MESP delegate, CH Elykia / Kimbaseke)

MHO management and response to member complaints and grievances

MHO managers mentioned some limitations with managing complaints using the existing procedures. MHO managers in both schemes cited stock-outs of medicines in health facilities and inadequate procedures to improve patient navigation as recurring member complaints. In response, all MHOs have made provisions to offer medicines directly to their members in the case of health facility stockout. For navigation, member complaints are mostly related to delays in getting the approval from the broker to attend another health facility. Other claims include issues such as reimbursement for prepaid medicines by the members.

Managers from both MHO schemes said that they annually organise rapid member satisfaction surveys. The MESP does this through phone calls and CGAT through select household visits. These surveys allow them to address identified problems and prevent reoccurrence. Survey reports are usually presented at the general assembly.

Member knowledge of MHO institutional arrangements, use of the grievance processes and their satisfaction with it

Survey respondent overview

In the pooled sample, 76% of respondents were ≥40 years old (MESP 89% and CGAT 61%), 66% were Catholic or Protestant, 77% were married or living in union, 60% had a secondary school degree and 78% were living with salary as the only source of revenue (MESP 91% and CGAT 64%). We noticed that 73% had been members for more than 2 years (MESP 97% and CGAT 48%), 36% had all household members covered by their MHO (MESP 19% and CGAT 55%). But 85% perceived the trend of memberships in their MHO as decreasing or stationary.

Knowledge

According to the member survey results, only 177/497 (36%) of CGAT member respondents and 63/547 (12%) of MESP member respondents were aware of the existence of the grievance and redressal arrangement and related measures (total n=240/1044 (23%)). This was corroborated by the FGDs, in which a few members indicated being aware of the processes put in place to regulate their relationships with the MHOs. Contradicting the statement by MHO managers that members are informed of all processes, members indicated a lack of

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relevant information, as demonstrated in the following two quotes:

> There is no communication with our MESP managers. We have been registered as members, that is it. No one provided information on how the MESP operates. (MESP members, FGD Reverand Nzumba)

In the same FGD, another member stated that:

> With MESP, no meeting was convened, and we even don't know how much our premium contribution to this MHO is. (MESP members, FGD Reverand Nzumba)

Two main channels for the management of member complaints were mentioned: phone calls and direct contact with MHO brokers. Due to the handling of claims in emergency mode, brokers have little or no time to duly follow-up the process in registering the claims. In the process from receipt of a claim to decision making, members participating in the FGDs thought that:

> MHOs are accountable to the members because they belong to them. Therefore, the handling of complaints must first consider the interests of members, and they should not be told or informed of the decision regarding their claims in front of the medical consultation in health facilities without any prior explanation of the decision. Such a situation often creates tension between health facilities and members. (FGD Bahumbu for MESP)

Another MESP member stated that:

> Yes, we are MESP members, but we know nothing about MESP management. We just attend the health facility for healthcare, that is all. Those who manage MESP are not school teachers. Therefore, we can't get sufficient and needed information. (FGD Bahumbu for MESP)

Similar to MESP respondents, most of the CGAT respondents who were enrolled by their employers do not know how much their premium contributions are, do not attend general assemblies, and do not have enough information about grievance redressal measures. Furthermore, they are not familiar with the copayment fees and the health package contents, as stated by one of them: 'Everything about the MHO rules is known by our employers.'

In the case of the MESP, participation in the general assembly is only by the labour union representatives. Overall, MESP members were very pessimistic, whereas those from the CGAT MHOs had more moderate points of view.

In trying to understand why some members were unaware of MHO phone numbers, we learnt that members often thought that phone numbers mentioned on the membership cards was that of the health facility physicians rather than that of the CGAT MHO medical advisors or MESP MHO delegates at the health facility.

When trying to investigate our survey data more deeply, a bivariate analysis showed that greater knowledge of the management of complaint measures could be explained by the influence of four variables, with unadjusted OR at 95% CI: (1) members who had <2 years of membership in their MHOs (OR=1.80 (95% CI 1.32 to 2.45); (2) households with complete enrolment coverage (OR=1.64 (95% CI 1.22 to 2.20)); (3) members who perceived a positive trend in the membership of their MHOs (OR=2.03 (95% CI 1.41 to 2.91)) and (4) members who were covered by a voluntary enrolment scheme, that is, CGAT (OR=4.25 (95% CI 3.08 to 5.85)). The logistic regression model revealed that greater knowledge of the measures is mainly associated with two variables: member's positive perception of an increased trend in new enrolments in their MHO (adjusted OR, AOR=1.65 (95% CI 1.12 to 2.43)), and members who were under a voluntary enrolment scheme, that is, CGAT (AOR=4.63 (95% CI 3.07 to 6.99)).

Use

The quantitative survey from both MHOs revealed that 201/240 (83%) of the household respondents who were aware of the existence of MHO complaint mechanisms said they have used them. Among them, 158/177 (89%) belonged to CGAT and 43/63 (68%) belonged to MESP. The bivariate analysis revealed that living with more than one source of household income was significantly associated with the utilisation (have used) (OR=5.1 (95% CI 1.74 to 14.92)), as well members who were under a voluntary enrolment scheme, that is, CGAT were also more likely to have used the measures (OR=3.87 (95% CI 1.9 to 7.89)) than those under a mandatory enrolment scheme. For the logistic regression, being in a voluntary enrolment scheme was the only factor that suggested a link with the use of the grievance redressal measures (AOR=9.06 (95% CI 2.8 to 29.32)).

Satisfaction

Among household respondents who reported having used the grievance redressal mechanism, 181/201 (90%) declared that they were satisfied after having used it (table 1; 145 from CGAT and 36 from MESP). The bivariate analysis of member satisfaction indicated that having ≤2 years of membership in the MHO was significantly associated with satisfaction (OR=3.41 (95% CI 0.96 to 12.07)). However, in the logistic regression, we did not find any significant variables associated with satisfaction, when using the measure. Table 2 depicts results from the bivariate analysis and table 3 presents the regression logistic models.

Members overall opinions on relationships with MHOs

Majority of the FGD participants expressed their dissatisfaction with respect to relationships with their MHOs. The following complaints were highlighted when trying to take advantage of their MHO benefits: unavailability of drugs in health facilities, poor reception by healthcare providers, delay in the reimbursement of prepaid services or specialised medicines, poor quality of care and medication, and lack of permission to get healthcare via outsourcing or specialised healthcare and medicines.

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Table 2 Overall univariate and bivariate analyses: member knowledge, utilisation and satisfaction

	Descriptive (n=1044)		Bivariate analysis (dependent variables)											
			Member knowledge of measures (n=1044)				Member using measures (n=240)				Member satisfaction when using (n=201)			
Independent variables	**Freq.**	**%**	**Yes**	**No**	**Unadjusted OR (95% CI)**	**P value**	**Yes**	**No**	**Unadjusted OR (95% CI)**	**P value**	**Yes**	**No**	**Unadjusted OR (95% CI)**	**P value**
1. Respondent's age														
► <40 years = 0	253	24.2	62	191	1.12 (0.80 to 1.56)	0.510	51	11	0.87 (0.40 to 1.86)	0.712	46	5	1.02 (0.35 to 2.97)	0.968
► ≥40 years=1	791	75.8	178	613	1		150	28	1		135	15	1	
2. Respondent's religion														
► Catholic/ Protest.= 0	684	65.5	159	525	1.04 (0.77 to 1.41)	0.786	140	19	242 (1.20 to 4.85)	0.011	126	14	0.98 (0.36 to 2.69)	0.972
► Other=1	360	34.5	81	279	1		61	20	1		55	6	1	
3. Respondent's marital status														
► Married in union=0	802	77.1	188	614	1.1 (0.77 to 1.55)	0.609	159	29	1.31 (0.59 to 2.89)	0.510	141	18	0.39 (0.09 to 1.76)	0.207
► Other=1	238	22.9	52	186	1		42	10	1		40	2	1	
4. Respondent's seniority in the MHO														
► ≤2 years = 0	280	26.8	87	193	1.80 (1.32 to 2.45)	0.000	71	16	0.79 (0.39 to 1.58)	0.498	68	3	3,41 (0.96 to 12.07)	0.045
► >2 years = 1	764	73.2	153	611	1		130	23	1		113	17	1	
5. Respondent's education level														
► College degree and above=0	627	60.2	143	484	0.97 (0.72 to 1.30)	0.832	118	25	0.80 (0.39 to 1.62)	0.530	107	11	1.18 (0.47 to 3.00)	0.973
► Less than college degree=1	415	39.8	97	318	1		83	14	1		74	9	1	
6. Household enrolment coverage														
► Complete (all household members) = 0	375	35.9	108	267	1.64 (1.22 to 2.20)	0.001	91	17	1.07 (0.54 to 2.14)	0.847	81	10	0.81 (0.32 to 2.04)	0.655

Continued

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Table 2 Continued

	Descriptive (n=1044)		Bivariate analysis (dependent variables)											
			Member knowledge of measures (n=1044)				Member using measures (n=240)				Member satisfaction when using (n=201)			
► Partial (limited number) =1	668	64.0	132	536			110	22	1		100	10	1	
7. Respondent's perception of trend in new enrolments														
► Increase=0	161	15.4	56	105	2.03 (1.41 to 2.91)	0.000	49	7	1.47 (0.61 to 3.55)	0.385	44	5	0.96 (0.33 to 2.80)	0.940
► Decrease or no change=1	883	84.6	184	699	1		152	32	1		137	15	1	
8. MHO scheme type														
► Voluntary-based affiliation (CGAT)=0	497	47.6	177	320	4.25 (3.08 to 5.85)	0.000	158	19	3.87 (1.9 to 7.89)	0.000	145	13	2.17 (0.81 to 5.83)	0.118
► Mandatory affiliation (MESP)=1	547	52.4	63	484	1		43	20	1		36	7	1	

CGAT, Centre de Gestion de risque et d'Accompagnement Technique; MESP, Mutuelle de santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel; MHO, mutual health organisation.

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Table 3 Regression logistic models: variables associated with the dependent variables

Associated variables	Dependent variables (adjusted OR (95% CI))					
	Member knowledge of measures		Member using measures		Member satisfaction when using	
1. Respondent's age						
► <40 years=0	0.74 (0.51 to 1.08)	0.123	0.61 (0.23 to 1.61)	0.320	0.76 (0.21 to 2.7)	0.666
► ≥40 years=1	1		1		1	
2. Respondent's religion						
► Catholic/Protest.= 0	1.29 (0.93 to 1.80)	0.133	2.62 (1.22 to 5.65)	0.014	1.12 (0.36 to 3.5)	0.843
► Other=1	1		1		1	
3. Respondent's marital status						
► Married/in union=0	1.04 (0.71 to 1.52)	0.850	1.48 (0.59 to 3.73)	0.404	0.38 (0.08 to 1.8)	0.221
► Other=1	1		1		1	
4. Respondent's seniority in the MHO						
► ≤2 years=0	0.87 (0.60 to 1.27)	0.469	0.29 (0.10 to 0.88)	0.028	3.06 (0.74 to 12.64)	0.122
► >2 years=1	1		1		1	
5. Respondent's education level						
► College degree and above=0	1.04 (0.76 to 1.42)	0.810	1.01 (0.46 to 2.23)	0.982	1.16 (0.43 to 3.15)	0.765
► Less than college degree=1	1		1		1	
6. Household enrolment coverage						
► Complete (all household members) = 0	1.02 (0.73 to 1.43)	0.899	0.70 (0.31 to 1.61)	0.408	0.56 (0.20 to 1.58)	0.273
► Partial (limited number) =1	1		1		1	
7. Respondent's perception of trend in new enrolments						
► Increase=0	1.65 (1.12 to 2.43)	0.011	0.86 (0.32 to 2.34)	0.771	0.93 (0.30 to 2.94)	0.904
► Decrease or no change=1	1		1		1	
8. MHO scheme type						
► Voluntary-based affiliation (CGAT)=0	4.63 (3.07 to 6.99)	0.000	9.06 (2.8 to 29.32)	0.000	2.75 (0.76 to 9.94)	0.122
► Mandatory affiliation (MESP)=1	1		1		1	

CGAT, Centre de Gestion de risque et d'Accompagnement Technique; MESP, Mutuelle de santé des Enseignants de l'Enseignement Primaire, Secondaire et Professionnel; MHO, mutual health organisation.

For example, MESP members believe that the responsibility of their MHO is to ensure quality care, mainly the availability of quality medicines in the health facilities, which are not available all the time. With respect to the use of phone calls to complain, even in the absence of a clear understanding of whose phone number was on the membership card, most of the MESP participants claimed that:

> Even if you call these numbers, it usually takes longer before someone picks up the phone. Most of the time, the phone call does not go through, and we give up calling. (FGD Bahumbu, MESP and others)

CGAT members were relatively positive and recognised the effectiveness of using different channels for making a claim:

> Communication channels do exist, such as suggestion boxes or direct contact with MHO delegates. However, the main problem is that members do not know how their complaints and suggestions are being managed by the MHOs, and this is one of the reasons for their dissatisfaction. (FGD Eglise La Borne/ CGAT)

Although CGAT members recognised the effectiveness of using different channels for submitting claims, members of the MESP declared that submitting a claim is

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a challenge, as everything has been imposed on members with little flexibility. When they do try to make a claim, the process is frustrating:

> In our MHO, it seems that there is no channel, no mechanism for recording and managing complaints. For those who also have the possibility to complain, their grievances seem to be completely ignored. Members do not know on what basis their claims are selected and handled, even how long this process is taking before receiving an acceptable answer, even if our subscriptions say that we are fully covered. (FGD Saint Theo de Lemba/MESP)

Similarly, members mentioned their dissatisfaction in terms of communication with MHOs. For most of them, communication systems put in place by the MHOs were lacking or suboptimal. The following declaration confirmed this position:

> There is no real information that comes to us unless you have difficulties with one or more hospitals, so you can contact them to get information. Otherwise, there is no information, neither among us, nor with the hierarchy. (FGD Saint Theo de Lemba/MESP)

The poor effective communication was further elaborated by another member:

> Members could only be satisfied whenever they are quickly receiving feedback on their complaints… when they themselves have purchased specialized medicine to start a treatment and get the reimbursement of the amount spent within the same period as the sickness. (FGD of Lisanga—MHO/CGAT)

However, CGAT members complained that their MHO offices were usually closed or the MHO managers were not present in their offices.

It appeared that members were generally interacting among themselves on grievance and redressal mechanisms when facing issues in accessing healthcare. The best-informed people were those who had previously experienced difficulties and had consulted with MHO brokers for solutions. This was then an opportunity for MHO brokers to share information regarding the existing measures and on how members should use them to claim their rights.

The majority of the MESP FGD participants declared that the procedure for delivering their membership card was poorly organised. Furthermore, access to healthcare at the designated facility was often denied when the MESP delegate/broker was not present to assist. This results in either the member having to return on another day or the health facility keeping the member's card for presentation to the delegate (broker) at a later time. In the event of loss, the member is charged a replacement cost of approximately FC10 000 in 2021 (US$5), or else further access to the health facility is denied. As a school teacher said:

> All the school teachers go at the same time to the ITI N'djili (decentralized MESP office) and they can spend 3 to 4 hours waiting. In my family, nobody has a card currently. Why can't the MESP schedule the distribution of the cards by school and by specific day of the week for every school? Between MESP and us, the dialogue falls on deaf ears. (FGD Ndjili for MESP)

DISCUSSION

This study makes an important contribution to the literature by showing that MHOs in DRC have put in place a set of practices, grouped under a variety of institutional arrangements, which support MHO accountability and responsiveness vis-à-vis their members. Grievance redressal mechanisms are among these arrangements. Strikingly, however, we did not find administrative documents describing these arrangements or their implementation in our documentary review. Grievance redressal measures are implemented on an ad-hoc basis during MHO steering committee meetings, in the absence of any sort of well-established administrative procedure, despite the fact that MHO managers were trained to properly manage their organisations.[18 32]

Provision of medicine to members during shortages at the health facilities is one of the principal actions that characterises MHO responsiveness to their members. FGD participants mentioned a long delay in getting the drugs and in help in navigating the health system. This is a concern for members and a challenge for MHO managers who are confronted with a scarcity of resources. Therefore, even with a limited membership size, without substantial support from the government or donors, this issue remains challenging and compromises the MHO's capacity to respond.[4 18 26 32]

Communication channels and the process of managing information from MHOs to their members are not effective even though MHO managers and brokers stated that members are informed and using grievance redressal mechanisms. Our findings suggest that the very low proportion of properly informed members contradicts the MHO managers' opinions of the level of information that is shared. As repeatedly stated by members, poor communication could explain the low level of knowledge of MHO members on complaint processes, as well as the low trust in the MHOs. Therefore, similar to other studies,[28–31] it is not surprising that members' disappointment and frustration vis-a-vis the management of member complaints could contribute to membership abandonment, as well as to an eventual decrease in the enrolment of new members. The influence of effective communication regarding the knowledge of member rights and entitlements has been pointed out by many other studies in the African region where activists and media also play fundamental role in disseminating actionable information to build awareness.[1 24–34 39–47]

At the individual member level, lack of awareness on member rights in terms of access to MHO services and healthcare remain of great concern. This has also been reported in other studies in Ethiopia and Kenya.[44 45] To be effective, information provision should be intensive,

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frequent, and diverse in order to foster membership adherence and a feeling of ownership.[3]

In our study, the existence of better-informed members is associated with increasing member enrolment over time, especially in the case of voluntary enrolment schemes. Peer influence through relatives and friends has been found to be an important enrolment factor.[3] In the case of mandatory affiliation, the choice to get enrolled is collective and decided by the employer or labour union delegates. This may explain why voluntary, rather than mandatory, affiliation appears to be associated with members being more attentive to their rights and entitlements. Similar findings concerning CBHIs have also been reported in Ethiopia.[24 39]

Given that more than 75% of members are not aware of the existing mechanisms, the information gap needs to be addressed urgently by the MHOs. When focusing on the 25% minority of well-informed members, our findings indicate that more than 80% of them (201/240) did indeed make use of the grievance redressal measures. This is consistent with our conceptual model of the lack of awareness being a critical constraint. The high levels of satisfaction may result from the fact that members report a variety of reasons for being satisfied including that the problem was solved, the process through which the complaint was taken up was itself expedient, or that members were happy with their MHO in general. However, these findings may not be generalisable beyond the context of the Kinshasa city in DRC.

Our FGD discussions revealed that members sometimes share information among themselves or get it from the health facility. It remains, however, difficult to establish if knowledge of the arrangements preceded its use, or if awareness and effective use occurred simultaneously. For instance, whether a member discovered the existence of a grievance redressal arrangement only when trying to find a solution for a particular problem and consequently made use of it.

Members who used the grievance redressal arrangements were mostly those who had more than 2 years of enrolment, and belong to the voluntary enrolment scheme (CGAT). An increase in membership duration likely allows greater familiarity with administrative formalities compared with newcomers. This may explain why more time is associated with the use of complaint processes, even if our results shown that newcomers were more satisfied than members with more than 2 years of duration. This dichotomy may suggest that those who were enrolled longer were more likely to use, but were less likely to be satisfied, as satisfaction changes over time and old members become less easy to satisfy.

Poor member satisfaction in our study was derived from limited information sharing, limited understanding of the MHO procedures that led to suboptimal uptake and use, and poor relationships between MHOs and their members. In the specific case of the MESP, wherein membership is compulsory, members seem to be less aware of their rights, thus knowing less and using the complaint processes less. Poor management of their MHO has probably reinforced member dissatisfaction, as shown in the FGD results. In addition, the poor management process for complaints may be on account of a lack of systems to manage complaints, even if the use of MHO measures by members translated into the effectiveness of member empowerment, as shown in the conceptual framework. The lack of professionalisation and the poor relationships with members characterises many mutual health insurances in LMICs.[11 37 48 49]

As reported by other studies, robust management and documented administrative procedures are essential for the long-term sustainability of MHO schemes.[3 50] Therefore, government, donor agencies and MHO platforms should contribute to strengthening MHO administrative and managerial capabilities,[51 52] especially in the quest for UHC. Future studies should focus on the professionalisation of MHOs in DRC as a means of strengthening their effective contribution to UHC. In addition, MHO managers need to be trained on management practices, such as standard operating procedures (SOPs), to better document and trace member complaints, among other related themes.

Study strengths and limitations

To our knowledge, this study is the first to explore the knowledge, use and satisfaction of grievance redressal mechanisms instituted by MHOs in the DRC. Our study comes at a critical time as DRC is considering strengthening its health financing reforms from a UHC perspective. The mixed-methods approach that we used provided multiple sources of information and contributed to enhancing the validity and reliability of our findings.

The study also comes with some limitations. It was conducted in the specific urbanised environment of Kinshasa, DRC's capital city. This is not necessarily representative of the situation of MHO accountability and responsiveness in the rest of the country. Furthermore, the study also does not explore important intrahousehold dynamics. In addition, some social desirability bias linked to some variables were not taken into consideration. However, it should be noticed that the results obtained from the qualitative approach have provided similar results to the quantitative approach, thus minimising these limitations. Finally, the study does not gather qualitative information on the broader relationship between MHO managers and users in terms of locating this within the broader political economy of the DRC.

CONCLUSION

The management of complaints and grievance redressal of MHOs in the DRC is highly problematic. The limited knowledge of MHO members of the existence of grievance and redressal arrangements points to the urgent need to expand and improve effective communication and briefing of members. In addition, attention should be given to properly monitor existing arrangements put

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in place, and possibly adapt them with well documented SOPs.

Such action is crucial in shaping and upgrading the overall trustworthiness of MHOs in DRC. It is not only a matter of effectiveness of MHOs in facilitating member' access to quality healthcare, but also a question of ethics. MHO members face multiple needs and have invested some of their scarce resources in paying for MHO membership. They are, therefore, entitled to expect MHOs to be genuinely responsive to their needs, helping them navigate the health system, and be accountable regarding how and for what their resources are being used. If these challenges are not rapidly addressed, the role of MHOs in strengthening the Congolese health system may be jeopardised.

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