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Exploring People‘s Motivation to join or not to join the Community-based Health Insurance ‘Sina Passenang’ in Sotouboua, Togo

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28 August, 2013

Research Master African Studies Thesis

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1. Introduction

In the 1980s, micro credit emerged as a new concept in the field of international development. The provision of micro credits was seen as a possibility to increase economic growth amongst the poor and subsequently to contribute to a decrease of poverty. In the wake of the sharp rise in popularity of micro credit in the 1990s, the concept was extended from the provision of credits to the provision of insurance. Here, the provision of health insurances has featured prominently. In particular since the early 2000s, community based micro health insurance schemes have proliferated in Sub-Saharan Africa. Given the relative absence of state-sponsored and private insurance schemes in many Sub-Saharan African countries, CBHI schemes have the potential to soften the consequences of falling ill (Jütting, 2004). According to the World Development Report (1990), improvements in the field of health "directly addresses the worst consequences of being poor" (p. 74). The importance of improved health has likewise been stressed by the United Nations Millenium Development Goals, which call for a reduction in under-five mortality rate by two thirds (Goal 4) and improvements on maternal health (Goal 5).

The micro health insurance schemes follow a similar approach as the micro credit initiatives: they provide a service similar to non-micro schemes, but with credits respectively insurance fees which are lower than for conventional insurances, which makes them largely unattractive for for-profit organizations. As a consequence, most of the micro health insurance schemes have been initiated by non-governmental organizations (NGO). Here, a community-based approach is prevalent, leading to the most prominent form of micro health insurance, namely the community-based health insurance (CBHI).

The vast majority of CBHI schemes which have been introduced in Sub-Saharan Africa over the last two decades have struggled with low enrolment rates. Typically, the schemes achieve a rate of enrolment of 5% of the target population, leaving 95% who did not decide to participate. As the schemes operate on a voluntary basis, it is imperative to convince people from the target population to buy a health insurance. In order to understand why people decide to participate or not to participate, it is imperative to gain deeper insight into the motivations to buy or not to buy a health insurance. However, given the novelty of the concept, the reasons for (non-)participation are not yet very well understood. In addition,

most of the studies which explore consumer preferences tend to focus on the individual factors such as income or education, leaving aside the socio-cultural context of a scheme.

In 2008, CBHI schemes were initiated in the two Central Togolese prefectures of Sotouboua and Tchaudjo. They were introduced by a consortium of NGOs, receiving funds from Plan and the European Union. In 2009 and 2011, Dekker and Leliveld (2011) conducted a survey in these two prefectures which aimed at shedding light on the factors which contribute to the enrolment in the scheme. Their analysis has revealed several factors which are relevant for insurance participation. However, there were other aspects which the survey data could not fully explain. This project seeks to complement Dekker and Leliveld's study by shedding light on additional aspects that are relevant to explain participation rates. To do so, it focuses on the CBHI scheme of the prefecture of Sotouboua called Sina Passenang (SP). This project employs a qualitative approach, based on six months of fieldwork in the village of Aouda. Whereas Dekker and Leliveld's study focused predominantly on individual and household characteristics, this study sheds light primarily on contextual factors of the scheme such as local perceptions about health and illness, different notions of solidarity and the quality of the health care system. Next to establishing general patterns of insurance-participation, this thesis further tests why seemingly similar segments within the same village have different rates of participation. In line with the setup, this project aims at answering the following research questions:

1) Why do people in Aouda, Central Togo decide to participate or not to participate in a community-based health insurance scheme?

2) Why are different groups within the village more likely to participate than others? (taking into account the findings from question 1)

Each of the research questions are answer based on the analysis of several variables. The scientific aim of this project is to increase the knowledge on participation in micro health insurances based on the application of a qualitative, contextual approach. In terms of social relevance, this project produces evidence on participation rates which can be taken into account to further improve coming CBHI schemes.

This thesis is structured as follows. The Chapter 2 is devoted to the definition of the project in terms of current debate, theory and methodology. The chapter establishes that there are three interrelated levels which are relevant for participation in SP: firstly the

household-level, secondly a level related to the setup of the scheme and the quality of healthcare, and thirdly the socio-cultural context of the scheme. The subsequent section deals with the theoretical framework of this project. The first part clarifies the nature of the concept of 'insurance', arguing that participation in a CBHI scheme is only one out of several possibilities of risk-coping. On the village level, the CBHI scheme is expected to compete with informal mechanisms of insurance, which operate according to a different logic than the SP. the second part introduces the concept of social capital. In a nutshell, social capital theory argues that outcomes of societal action are the product of the prevailing modes of cooperation within the society. This project treats social capital as a neutral concept which can have positive as well as negative consequences. Moreover, social capital can either be employed to strengthen intra-group relations (bonding) or inter-group relations (bridging). These different dimensions are crucial when it comes to the application of the concept of social capital to participation in SP. Lastly, this chapter describes the methodological considerations of this project. The project employs a qualitative approach, collecting through semi-structured interviews, focus groups and observations during six months of field research in Central Togo. The aim is to establish a 'thick description' of insurance participation. Chapter 3 establishes the regional context of the study. It sheds light on the place or research, the health system in Central Togo and the setup of SP.

Thereupon, the empirical part of the thesis follows in chapter 4-6. Chapter 4 and Chapter 5 deal with general patterns of participation. Chapter 4 argues that first and foremost, differing notions of solidarity and risk-sharing are responsible for low overall rates of enrolment in SP. So far, a personalized solidarity which is executed in a face-to-face community is prevalent in Aouda. Next, the chapter compares the solidarity which is currently exercised in the case of an illness with the solidarity as propagates by SP. It establishes that these two patterns of solidarity differ widely. To exemplify the importance of personalized relations in the case of health care, the role of local volunteers is examined. Moreover, this chapter scrutinizes the influence of the newly introduced abstract solidarity on the pre-existing networks of solidarity based on kinship. Next, the chapter seeks to establish the acceptance of the concept of risk-sharing in Aouda. It finds out that instead of risk-sharing, a system of balanced reciprocity is dominant. Subsequently, the importance of risk-sharing and abstract solidarity is exemplified by the means of a comparison between the health insurance scheme and the more successful local savings group.

Chapter 5 elaborates on some of the most frequently cited reasons for low participation in CBHI schemes. In doing so, it aims at confirming or refuting the centrality of aspects related to social capital as established in the previous chapter. Firstly, local perceptions of health, healthcare and prevention of illnesses are elaborated upon, followed by an investigation of the impact of the Togolese health system. Next, this chapter tests the impact of income on insurance participation. It establishes that most of these aspects are relevant, but also claims that none of these aspects can fully explain low overall rates of enrolment.

Chapter 6 turns towards different rates of participation within the village of Aouda. First of all, the chapter examines whether the variable of age constitutes a cleavage for insurance participation. Then, it examines in how far ethnicity and religion can influence participation, firstly amongst the Christian/Animist Kabye, and afterwards amongst the Muslim Kotokoli, taking into consideration the lower rate of enrolment amongst the Kotokoli. While religious aspects seem to play hardly any role, the Kotokoli's position as an ethnic and religious minority group is crucial to understand the low enrolment rates. Chapter 7 discusses the findings of the project in the light of the theoretical approaches and concludes on the most relevant points.

2. Project Definition

This part develops the foundations of this project. First, a literature review gives an overview about the state of the art with regard to participation in CBHI. Next, the theories which define the frame of analysis of this project are elaborated upon. Subsequently, the methodology on which this paper is based is introduced.

2.1. Literature Review

2.1.1. General Considerations on Participation in CBHI

Participation rates are crucial to determine the success or failure of CBHI schemes (Owusu, 2012, p. 369 ff.). As stated by Owusu et al. (2012), "enrolment determines whether a scheme will be accessible to people or not" (p. 369). In particuar because schemes require a certain infrastructure regardless of the number of participants, it is decisive to have a relatively high number of adherents. As insurance schemes do need a certain number of people who engage in risk-sharing to be feasible, there is a positive relationship between the number of adherents and the benefits and stability for its members (Fonteneau and Galland, 2006, p. 380). Participation In CBHI schemes is voluntary, which means that people need to be convinced that participation in the scheme is more desirable than not being insured. Nevertheless, almost all CBH schemes which have recently been introduced in Africa are struggling to achieve double-digit numbers of participation amongst the target population. As a consequence, considerable effort has been invested in shedding light on people's motives to join or not to join the scheme. Leppert et al. define West Africa, stretching from Mauritania to Cameroon, to be a cluster of CBHI schemes where "spacial learning processes" take place (Leppert et. Al., p. 49). In line with the geographic location of the project in question, the experiences which this chapter rely on mainly stem from this region.

Figure 1 provides an overview of what according to Owusu (2012) constitute the most decisive factors for enrolment in Ghanaian micro health insurances taken from Owusu. The figure covers a wide range of aspects ranging from quality of care to affordability to the timing of collection of the premiums. The potential relevance of these aspects on insurance participation is relatively uncontroversial. However, one major field of analysis which is

suspiciously absent from Owusu's table is the socio-cultural context of the schemes. Do religious beliefs or local perceptions of health and illness play a role? Does the population agree with the form of solidarity as propagated by the health insurance? These questions and related ones are crucial to make sense of enrolment in CBHI, but they are absent in Owusu's table and are likewise neglected by a wide range of other studies. Instead, these studies focus exclusively on individual factors and factors related to the setup of the scheme to explain patterns of enrolment. Another of these examples of the neglect is shown in Figure 2, which has been published in a CBHI manual from the Swiss Agency for Development and Cooperation based on experiences in Benin. In this case, the organization which executed the scheme inquired into reasons for non-participation. The possible reasons for non-participation were related to (1) a lack of financial resources, (2) deficient provision of services at the clinic, (3) deficient products and (4) deficiencies on the level of management of the insurance. The model thus inquires solely into household-related aspects and those related to the setup of the scheme, while not taking into account context-related factors.

However, by now, a small but increasing number of studies have recognized that also local discourses related to the introduction of a CBHI scheme are relevant to make sense of participation rates (Mladovsky, 2006; Ridde et. Al., 2010; Zhang et. Al., 2006; Blaese, 2012; Batiano and Ouedraogo, 2012, Matul, 2013). This paper focuses predominantly on the socio-cultural explanations in relation to why people decide to enroll or not to enroll in SP. Nevertheless, in order to relate the socio-cultural explanations to the other factors, it is likewise necessary to elaborate on the individual/household characteristics and the provider-related criteria.

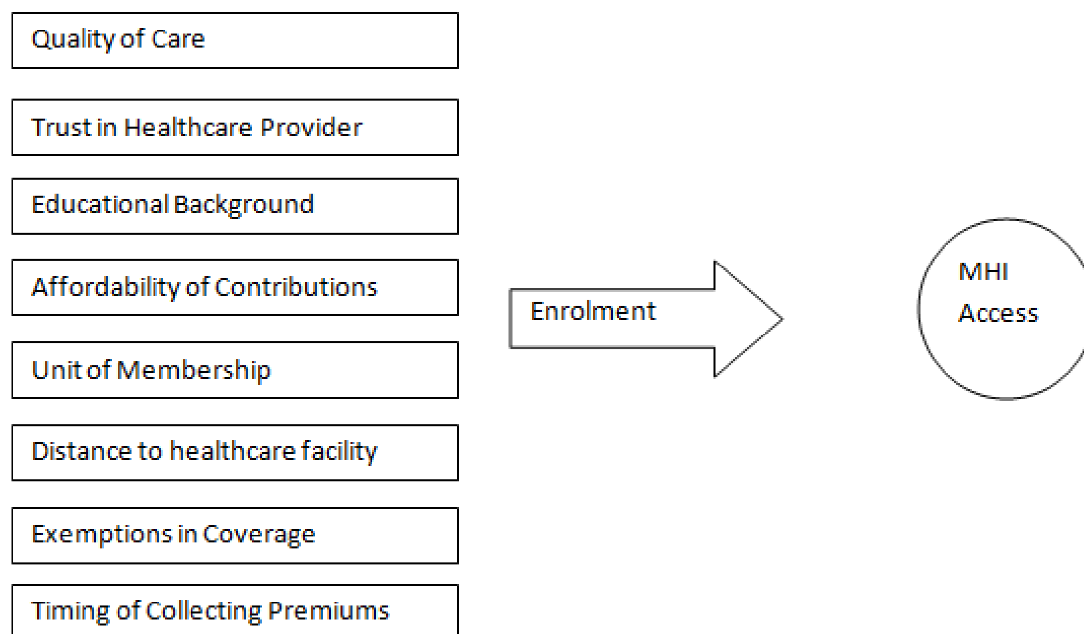


Figure 1: Determining factors for enrolment in micro health insurances. Source: Owusu et. al., 2012, p. 369

Motives for non-partcipation	Adherents	Non-Adherents	Former adherents
Lack of financial capital	74%	26%	75%
Service at healthcare-providers	17%	19%	22%
Low availability of medical products	29%	20%	20%
mismanagement of the insurance	22%	10%	16%
Total responses	1.42	0.74	1.32

Figure 2: Reasons for non-cotization at the CBHI-scheme. Source: Aladji Boni et. Al., 2009, p. 11

2.1.2. Micro level demand side: Individual and household characteristics

Several studies have sought to establish a link between low participation rates and an insufficient understanding of the value they can derive from insurances (Criel & Waelkens, 2006, De Allegri, 2006a; De Allegri, 2006b; Cole, 2011; Matul et al., 2012). Matul et al. (2012) conducted a survey among insurers in Sub-Saharan Africa which shows that 80% of them are

of the opinion that people do not understand the value of the respective CBHI. Such results are in line with Bonan's findings that 70% of the non-participants of a CBHI scheme in rural Senegal stated that they would not participate because of a lack of information and understanding of the scheme (2012, p. 15). In contrast, several studies have established that participants as well as non-participants do understand the concept of insurance (Criel&Waelkens, 2003, De Allegri, 2006a, Jehu-Appiah, 2012). In addition, Cole (2011) has conducted workshops on financial literacy in India. His findings show that afterwards, people would still not participate in the scheme. However, at the same time these studies show that the majority of the respondents cannot recall the details of the insurance, for example what diseases exactly are covered, and the percentage of the co-payment (Criel &Waelkens, 2003, De Allegri, 2006a). A lack of understanding thus seems to be one of the potentially relevant aspects for non-participation in a CBHI.

Owusu's table (figure 1) suggests that education plays a role in participating in the insurance. However, the evidence on this issue is not entirely consistent. Several studies did indeed find a positive relationship between education and insurance participation (Jehu-Appiah, 2012, Bending, 2011), Likewise, Dekker and Lelieveld (2011) have established that being literate increases the likelihood of joining a scheme. However, there are other studies which found that "being educated has no effect on MHO take-up; households whose heads have attended primary school, secondary school, or more, are not more likely to join an MHO than those who have never attended school" (Bonan, 2011, p. 15). Still, no studies reported that education correlates negatively with insurance participation.

One of the most prominently discussed reasons for non-participation is the 'liquidity constrain' (Matul, 2013, p. 8 ff.). According to Aladji Boni (2011), not having enough money is the most frequently stated answer amongst non-insured for not buying an insurance. After being confronted with a similar result, Cole (2011) conducted an experiment to test whether an increase in liquidity leads to higher enrolment rates. He provided two sums of money to randomly assigned poor households. Those who received the higher sum of money were 40 % more likely to join the scheme than those who received the small smaller amount. Such experiments suggest that financial constraints are indeed a reason for low participation rates. The results of Dekker and Leliveld's study (2011) is more ambiguous. They have established that participation is higher in comparatively wealthy sub-regions and for households with a regularly salaried job , their data does not reveal an overall correlation

between household wealth and insurance participation. However, several studies are cautious to overestimate the importance of liquidity constrains as the decisive factor to explain CBHI enrolment rates. While a study in Burkina Faso acknowledges that poverty certainly is a constraint, they argue that what is stated as a liquidity constraint might rather refer to a general unwillingness to participate (Batiano, 2012). Moreover, establishing that poverty leads to lower rates on enrolment also fuels criticism on CBHI schemes, namely that they have not managed to provide insurance to the poorest, but only to those who are better off. Also Matul (2012) argues that CBHI schemes do not have the potential to attract everyone. As demonstrated in Figure 4, she holds that participation in a CBHI scheme is not of interest for the better off, whereas the destitute do not have enough financial capital to join. The prospective insurance members are thus what Matul classifies as the 'vulnerable non-poor' and the 'poor'.

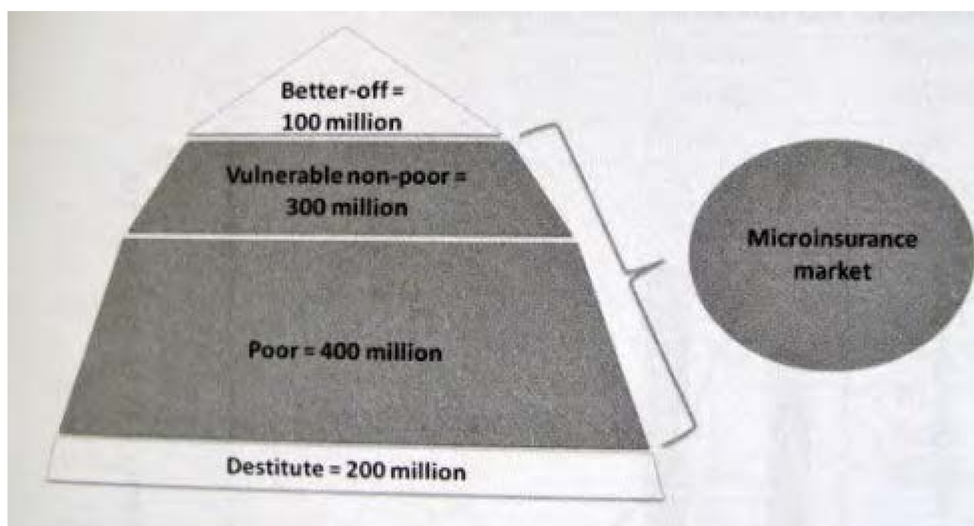


Figure 3: Potential for Micro-Health insurances in Africa. Source: Matul et al., 2012, p. 65

2.1.3. The supply-side: aspects related to the setup of the scheme and the treatment in the hospital

Also factors related to the institutional setup of the scheme can have a considerable influence on its success. This is true about the setup of the scheme itself as well as the satisfaction with the healthcare providers.

Adverse selection is one of the classical problems of insurances. It refers to the issue of attracting only those who are more likely to need services provided by the insurance. In the West African CBHI schemes on which data is available, the effect of adverse selection is marginal (Jütting, 2005) or not relevant at all (Criel & Waelkens, 2003). However, this might be related to measures which have been implemented to overcome the effect of adverse selection. Firstly, a time window between enrolment and benefits has been established. Those who enroll can now only seek treatment a certain period after they have paid the fees (De Allegri, 2006a). The measure aims at discouraging those who are only willing to pay for the insurance if they know that they need treatment very soon. Another precautionary measure which has been put in place by all projects was to define the household as the unit which is insured instead of allowing for individuals to insure (Jütting 2005, p. 129, De Allegri 2006a). This measure intends to avoid that families only insure those members which are more likely to need treatment. Overall, to minimize the effect of adverse selection seeks to ensure that the CBHI schemes remain financially viable. However, at the same time these measures can have detrimental effects on participation for bigger families which cannot afford to insure all family members.

In relation to possible financial constraints which prospective participants of the insurance face, the timing of the collection of insurance fees can be crucial in particular in rural areas. There, income is more readily available during and shortly after the harvest season, whereas it can be scarce at other times of the year. According to de Allegri (2006a), institutional rigidities with regard to the collection of the premiums might even be a bigger constrain for insurance participation than the liquidity constrain. Therefore, the schemes need to maintain flexible arrangements of paying the fees in terms of both timing and the way of collecting. The most effective way of collecting the annual fees has proven to be to arrange door to door collection with an option to pay in installments (Matul, 2013, p. 8). However, this system requires a considerable amount of time and effort (ibid.). An alternative solution might be to link the CBHI scheme to other financial instruments such as savings groups or micro credit organizations to facilitate the collection of the premiums. However, the experiences in how far such a linkage can provide positive results for both sides remain mixed (ibid.; Andrews, 2012).

Satisfaction with the services which are provided at the clinic can be another crucial aspect to ensure high enrolment rates. In several cases, the perceived care and treatment of

the providers has been perceived to be inadequate (Allegri, 2006a, Criel et al., 2003, Jehu-Appiah, 2012). In the context of a CBHI scheme in Burkina Faso, de Allegri has established that assigning certain villages to particular health clinics is problemtic. Due to village rivalries, people from some villages refused to visit clinics in other villages, which in turn proved to be detrimental for the insurance participation. In another case, the arrogant behavior of the clinic personnel and the resulting lack of trust were seen as one of the most important factors which almost brought the CBHI scheme to a stop (Criel et. al., 2003). Finally; Ridde (2010) found that in Benin, the trust is highest towards the lowest-ranking health institutions, which are perceived to be 'closer' to the community than the hospitals in the cities (p. 471).

2.1.4. Macro level demand side: Cultural and context-related factors

Next to the aspects described o far, also context-related macro level variables need to be taken into account. These are related to the society as a whole, either through perceptions of certain aspects or through the prevailing type of solidarity. As mentioned before, evidence on these factors is scarcer than on the individual level. Nevertheless, some studies have elaborated on these matters. The evidence which is presented in this chapter is also related to the theoretical considerations on social capital.

With regard to the composition of society, Criel (1998) has established that a high degree of social cohesion in the region where the scheme is executed contributes to high participation rates. It leads to a higher feeling of togetherness, thus people feel more comfortable to share risks within this group than with someone from another group. Comparing the pre-conditions for successful CBHI schemes in India and Ghana, Blaese similarly holds that in order to create a bond amongst the participants of the insurance, the presence of a uniform target group with regard to ethnicity, values and religion is helpful (Blaese, 2012, p. 398).

The matter of solidarity within a society and participation in a CBHI scheme has also been dealt with by the authors of a study in Burkina Faso (Batiano et al., 2012). They are more critical than other authors, arguing that it is difficult to establish the level of solidarity which is required for high participation rates in a CBHI amongst a big group of people. The degree of solidarity required for risk-sharing "is usually reached only in small groups or

among close relatives, but not at the village level" (ibid., p. 424). Consequently, Batiano et al. come to the conclusion that "the social practices of community solidarity and the perceptions of family solidarity are the main factors that explain the low rates of adherence to mutual health organizations in Burkina Faso" (Batiano, 2012, p. 426). A study from Ridde (2010) inquires in a similar direction, asking about the level of trust in the region where a CBHI had been introduced. He establishes that in the context of a Beninese scheme, there is only a certain level of trust amongst the members, and fraught used to be common until new regulations were introduced (p. 470 ff.). Moreover, the study has established that even though a high level of trust towards the participating institutions was given, this factor was not sufficient to trigger high rates of enrolment (ibid.).

A range of studies have examined the factor of ethnic composition. The results are somewhat ambiguous. A study from Senegal shows that members of the ethnic group of the Wolof are more likely to participate than those from the group of the Peuls. Next to the Wolof's relative wealth and the Peul's occupation as nomads, this discrepancy is traced back to a general open-mindedness of Wolofs with respect to innovation (Jütting and Tine, 2000, p. 16). A similar explanation for differing rates of participation between ethnic groups is also found in Burkina Faso, where the ethnic minority group of Bwaba was more likely to participate than other ethnic groups in the region. According to the author, this group "hold different risk perceptions regarding disease from that of other groups, and displayed greater openness towards new health initiatives" (Sarker et. Al. in De Allegri, 2006b, p. 855). A study conducted on another scheme in Burkina Faso comes to a different conclusion (Batiano, 2012). Within a short period, the scheme had lost more than half of its members. Of this loss, 84 % could be attributed to members of ethnic migrants, mostly Mossi. Being an ethnic minority, they presumably left the scheme because they did not feel represented by it (ibid., p. 423). Overall, the factor of ethnicity seems to e relevant to understand patterns of insurance participation, even though it can have differing explanations.

Moreover, beliefs of illness, healing and healthcare can contribute to determining rates of enrolment in a CBHI scheme. As stated by Blaese, "most societies' world view encompasses a continuum from material-earthly to religious-transcendental, wherein deities, ghosts, ancestors and other supernatural forces represent an essential component. This world view leads to two different concepts of causes of illness: the scientific-rational cause, which traces the illness back to a dysfunction of specific organs or germs, and the

supernatural cause, in which witchcraft, an ancestor's punishment or demons cause the illness" (ibid, p. 399). The author holds that the belief in a supranational explanation of illness might lead to a lower likelihood to buy a health insurance, as these illnesses are seen as incurable through medicine from the 'scientific-rational' explanation. Blaese holds that next to the effect on health-seeking behavior, widespread beliefs of witchcraft can reduce the levels of trust within a society, and consequently result in a reduced willingness to share risks within a wider group (ibid.). In line with these concerns, de Allegri (2006 b) has established that in Burkina Faso, cultural beliefs about health and illness partly determine the enrollment rates, even though she states that the respondents were reluctant to explain the low participation rates in terms of culture. In particular, people were reluctant to put money aside for health issues, because that would be equivalent to wishing oneself a disease (ibid., p. 1524 ff.). Given the geographical proximity to Central Togo, in particular the results from Burkina Faso might be relevant.

2.2. Theoretical Framework

The theoretical framework is developed based on the setup of this project coupled with the state of the art in research on CBHI participation. The theoretical part focuses particularly on the macro-level of insurance participation as described above. Firstly, a section elaborates on the notions of risk and insurance and works out differences within the field of insurances. It establishes the fundamental concepts which are the basis for an analysis of an insurance scheme. These constitute then the fundament for the empirical section. The next section elaborates on the theory of social capital and its merits of application in the field of CBHI. A theory of social capital helps to test in how far aspects related to solidarity within the society can influence patterns of enrolment in CBHI. It is thus not a theory which is applicable throughout the paper. Rather, the other variables which are elaborated upon in Chapter 5– the health system, income, perceptions of health – as well as parts of Chapter 6 rather serve as 'control variables' which intend to confirm or refute the importance of social capital theory.

2.2.1. Conceptualizing insurance

In order to understand the issues related to the introduction of CBHI, it is necessary to describe the underlying assumptions of insurance. The underlying assumption of any insurance, including (micro) health insurance is that an individual is exposed to a certain risk, which cannot be avoided. The task of insurance is to soften the consequences of the risk by means of a financial compensation in case the insured event occurs. Applied to the case of heath insurances, this is to say that insurance does not prevent someone from getting sick in the first place, but it allows for better treatment if the risk of sickness materializes.

Ewald (1991) elaborates on the ambiguous meaning of the term 'insurance'. He sees each insurance mechanism as a separate institution. According to him, "each insurance institution differs from the others in its purpose, its clientele, its legal basis" (p. 197). However, "insurance institutions are not *the* application of a technology of risk, they are always just one of its possible applications" (p. 198). He therefore argues that societies make a choice in favor of or against one particular type of insurance, and that it should be the role of the scientist to analyze the context and social conditions which lead to a society's choice (ibid.). Given that insurances are the consequence of the existence of a risk, Ewald defines several characteristics of such risks in the context of insurances: Firstly they are calculable (i.e. the chance of risk can be predicted), secondly they are collective (a whole segment of the society is at risk), and thirdly the risks can be assigned to a certain amount of capital (which is distributed after the damage has already occurred) (ibid. p. 201 ff.).

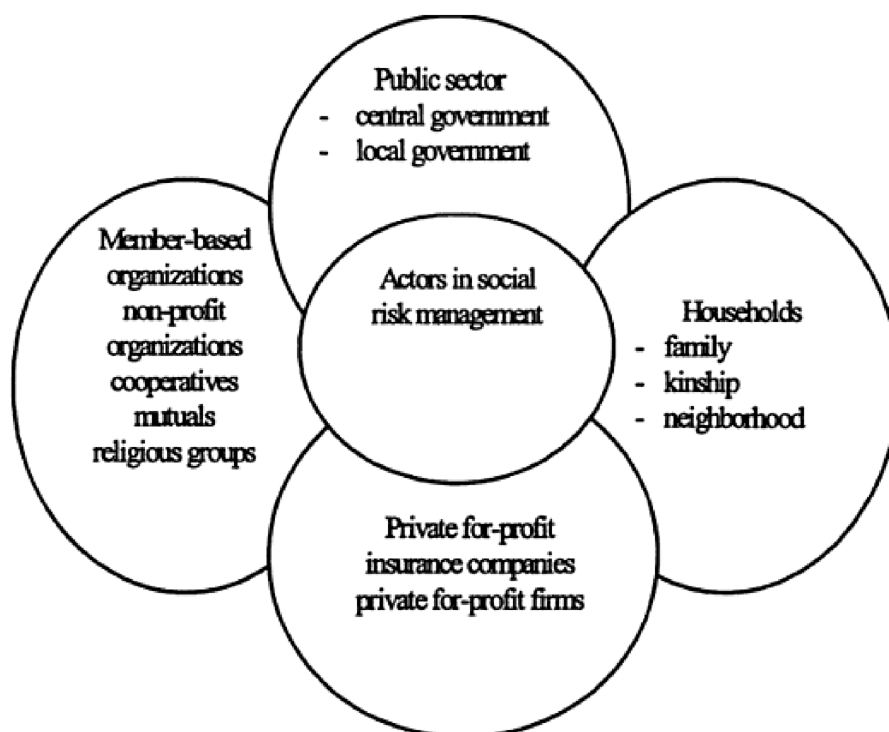


Figure 4. Main actors in Social Risk Management. Source: Jütting, 2005, p. 14

While the mechanisms of insurance are largely uniform, insurance has manifested in different ways, each leading to a unique type of institution. From a different perspective, also proponents of Social Risk Management hold that a wide range of actors and institutions exists in the field of insurance. As shown in Figure 4, next to government-initiated insurance and private-for-profit ones, also member-based institutions and households are seen as relevant actors in the provision of social security. Potentially, a new CBHI would thus have to compete with other mechanisms of health care financing which are executed parallel to it. In the case of Sotouboua, one of the possibilities can be ruled out rather quickly, as 'private for profit' insurance companies are absent. Likewise, even though a state-run system of health insurance provides, it only has a marginal influence on overall participation rates in CBHI (see Section 5.5). As established by feasibility study conducted prior to the launch of SP (Al Kourdi et al., 2005), the vast majority of the financial burden in the case of illness is either shouldered by the individual or by his family, thus belonging to the 'household' financing in Figure 5. In practice, SP is expected to be in direct competition to these informal arrangements of risk-sharing which have existed prior to the introduction of the CBHI scheme. In order to be attractive for prospective members of SP, participation in a CBHI must lead to added value when compared to risk-sharing as executed currently. To do so,

the scheme must be perceived in line with local perceptions on health care financing and related concepts, while at the same time being seen as an improvement to the status-quo of health financing.

Compared to informal insurance, the newly introduced CBHI schemes have certain disadvantages. Their setup requires to have an elaborates set of rules leading to higher transaction costs, which in informal insurances are internalized (Matul et al., 2013, p. 15). Moreover, informal arrangements have an advantage with regard to information, as monitoring within the circles of informal risk-sharing is often taking place automatically (ibid.). In theory, a well-functioning informal insurance network can potentially crowd-out more formalized forms of insurance (Arnott and Stiglitz, 1991). However, a number of studies have shown that often, the safety net established by informal risk-sharing mechanisms does not provide an optimal degree of protection (De Weerdt and Dercon, 2006; Dercon, 2003; Morduch, 1999). Matul et al. argue that CBHI is most effective when they do not attempt to substitute, but to complement the existing mechanisms of risk-coping (2013, p. 17).

One major difference between informal and formal insurance schemes is the coping mechanism. Informal insurances rely on an ex-post approach, meaning that contributions are made in a case of illness. In contrast, formal schemes such as the CBHI employ a ex-ante approach, in which fees are collected prior to a hypothetical insured event. To be seen as an improvement to the status quo, prospective adherents of a CBHI need to appreciate the different nature of that risk-sharing scheme with regard to the ex-post and ex-ante mechanism. In practice, participation in a CBHI equals a bet on an insured event – some win the bet, while others loose. However, all cases taken together, the financial losses and gains equal out. This in turn means that prospective members of a CBHI are not likely to make an immediate financial profit from participation in the scheme. Still, there are certain potential benefits which members can derive from participation in a CBHI scheme. As insurance fees have to be paid once a year, the members of the insurance can now also afford to visit the clinic in periods when money is scarce, for example in the period before the harvest starts (Ahuja and Jütting, 2003). The insurance thus helps to minimize the effect of seasonal fluctuations, leading to an overall increase in healthcare utilization. Moreover, participation in a CBHI also increases their bargaining-power vis-à-vis the health care providers, as the scheme can serve to articulate the voice of its members (ibid.).

The differentiation between ex-post and ex-ante mechanisms also relates to another fundamental concept related to CBHI, namely that of risk-sharing. Platteau (1997) has challenged the view forwarded by Evans-Pritchard and others that traditional rural societies have established own, informal mechanisms of risk-sharing. Referring to the process of gift-giving, Platteau claims that "people engage in relationships and condition their continued participation in them on the expectation that net payments will more or less balance out over time" (ibid., p. 768). He holds that often, in traditional rural societies, the concept of risk-sharing often is not properly understood (ibid.). Instead, what has often been taken for risk-sharing by anthropologists needs to be seen as balanced reciprocity. He argues that an ex-ante insurance - the transfer from the lucky to the unlucky – is largely unknown in such societies (ibid.).

The claim of non-familiarity can also be set in relation to the low level of understanding of a CBHI. Checking for the relation between understanding and CBHI participation in India, Platteau and Ontiveros (2013) come to the conclusion that there is indeed a very strong correlation between having an understanding the scheme and participating in it. They argues that low rates of renewal in a CBHI can be explained in particular by a misunderstanding – someone who has paid more in fees than he has gained from the scheme during one year might see the insurance as a loss of money and therefore decides not to renew (ibid.). This view is closely related to Platteau's (1997) argument that there is a tendency to mistake balanced reciprocity for an insurance type of risk sharing.

The considerations on a potential willingness to join a scheme are also influenced by the choice of setup of a newly introduced insurance scheme. Broadly speaking, there are two different options for the introduction of an insurance scheme. One can either rely on an intervention from government or a government-like institution, or develop a bottom-up approach starting at the grass root level. The classical example of a successful introduction of a top-down insurance is Germany under Bismarck, who introduced mandatory health insurances for all wage laborers. This move is typically seen as the start of Germany's state-run model of social security, which – with modifications - exists until today. However, it is questionable in how this system can be employed to introduce an insurance scheme in sub-Saharan Africa. As argued by Wiesmann and Jütting, a mandatory state-run approach to health insurance is not feasible in an environment where the majority of people is either self-employed or works in the informal sector (Wiesmann and Jütting, 2000, p. 2).

In contrast to the German case, the initial British system of health insurance was a bottom-up affair. Only subsequently, it was taken over by the state to develop a universal insurance coverage. Most of the 19th century, the so-called 'friendly societies' were largely responsible for the spread of health insurance in Great Britain. These societies were voluntary organizations of members with of most times the same occupation, but some of them were organizer around other criteria such as ethnicity. They had two primary functions: firstly to provide social security including health insurance to its members, and secondly to organize social events. (Katz and Bender, 1976, p. 271). The function of the friendly societies was thus not exclusively to provide insurance, but also to create a feeling of solidarity amongst its members. The common profession as well as the community-based nature of the friendly societies was crucial in establishing this feeling of solidarity (ibid.).

The setup of most CBHI schemes which are currently executed in Sub-Saharan Africa is largely similar to the setup of the friendly societies: they are run by the members of the schemes and attempt to create a feeling of togetherness amongst their members. Moreover, participation in the schemes is voluntary. However, certain features also resemble the setup of a top-down insurance scheme. Most importantly, they did not emerge as a bottom-up affair. While they were described as 'community-based', they were initiated in a top-down approach from international NGOs and subsequently executed by their local partner NGOs. Likewise, the target population is not defined based on adherence to a particular occupation or affiliation to an ethnic group, but is typically defined on the basis of administrative borders – in the case of Sina Passenang the prefecture.

After having elaborated on the nature of insurance, the next section addresses the issue of social capital.

2.2.2. Social capital

Social capital has been a prominent concept in the social sciences in the last two decades. The start of the discussion is widely acknowledged to Coleman's seminal essay *Social capital in the creation of human capital* (1989). Until now, the concept has continuously been refined and modified in order to widen its scope to new fields. This section provides an overview of different aspects of the concept which are relevant with regard to application to analysis of participation rates in a CBHI. The relevance of social

capital to determine participation in CBHI has been confirmed by two studies (Mladovsky and Mossialos 2006; Zhang et al., 2006) which are elaborated upon subsequently.

The underlying idea of the social capital theory is to carve out the effects which social action can have on group processes (Adler, 2002.). Proponents of this theory assume that through initial interaction, a form of 'capital' emerges which subsequently facilitates further interaction in a society. However, one of the main difficulties when employing the idea of social capital is how to define it. The definitions which have been developed so far differ according to which interactions are included. Roughly, they can be distinguished between what Adler labels 'internal' versus 'external' approaches. 'Internal' definitions deal with social interaction which takes place within a certain group of people, for example a religious community. In contrast, 'external' social capital deals with interaction between members of different groups. (ibid., p. 19 ff.). As a proponent of the internal view of social capital, Fukuyama defines social capital as "the ability of certain people to work together for common purposes in groups and organizations" (1995, p. 10). In contrast, the external view propagates a model which sees social capital as a resource that can be mobilized by an individual. Along these lines, Portes defines social capital as "the ability of actors to secure benefits by virtue of membership in social networks or other social structures" (1998, p. 6). Social capital as defined by Portes is thus not based on affiliation to a certain group. However, next to these two views, a third category of definitions exists which is left broad enough to account for both types of social capital, internal and external. Within this group, Woolcock and Narayan (1999) define social capital as "the norms and networks that enable people to act collectively" (p. 3). This is also the definition which is employed in this paper to make sense of enrolment in the CBHI scheme. Compared to the other types of definitions, Woolcock and Narayan's definition has the advantage of allowing for analysis along internal and external dimensions of interaction. As this project aims at establishing how solidarity influences insurance participation within certain groups as well as between them, such a definition is suited best. Woolcock himself distinguishes between 'bonding' and 'bridging' social capital (1999). These two concepts are closely related to the two dimensions described above. While 'bonding' refers to strengthening of intra-group social capital, 'bridging' is associated with the dimension of interaction between people of different group affiliations.

Social capital can have different sources. Adler sees goodwill in the form of "sympathy, trust and forgiveness offered us by friends and acquaintances" (2002, p. 18). This goodwill can originate on two interrelated levels, one related to governmental structures and another related to customs. For example, shared norms refer to institutions such as family structures or deference to elders (Ostrom, 2000, p. 177). Tracing back the differences in societal organization between Northern and Southern Italy, Putnam (1994) argues that governmental traditions were instrumental in explaining why the two regions. have developed along different paths: Northern Italy with a strong presence of social capital has managed to developed a liberal and well-developed civil society, whereas the establishment of a strong civil society in the South is hindered by the absence of a large stock of social capital (ibid.).

Putnam traces back the decisive period for the differing paths which the development of social capital took in these regions to the late medieval time. In doing so, he suggests that social capital takes centuries to foster. Other scholars have established that social capital is not a form of social capital which can easily be constructed by foreign intervention. As stated by Fukuyama, "states do not have many obvious levers for creating many forms of social capital. Social capital is frequently a byproduct of religion, tradition, shared historical experience and other factors that lie outside the control of any government" (p. 17). Ostrom investigates in how far social capital can be increased as preconditions for successful development projects. She puts the relation between social and physical capital in a nutshell: A donor can provide the funds to hire contractors to build a road or line an irrigation canal. Building sufficient social capital, however, to make an infrastructure operate efficiently, requires knowledge of local practices that may differ radically from place to place…Local knowledge is essential to building effective social capital" (2000, p. 181). Thus, even though this view is less deterministic than Putnam's, also Ostrom and Fukuyama hold that external attempts to create social capital can only be created with an enormous effort.

A large part of the studies on social capital has treated the concept as inherently positive – the more social capital available, the better for the society. For instance, in Putnam's (1994) study, the availability of social capital – as expressed through participation in clubs – is inherently positive. At the same time, it must be stressed that Putnam's theory deals exclusively with the bridging aspect of social capital, whereas intra-group aspects do

not fall under his definition of social capital. However, such a view neglects that social capital has also potentially negative effects on the overall welfare of a society. Woolcock holds that social capital can not only be employed to strengthen the community, but for example also to construct criminal organizations, which would not be possible without a high level of trust and bonding social capital (1999, p. 6). Also Adler it is acknowledged that the norms through which social capital is fostered can likewise " trigger quite destructive and escalating patterns of conflict and violence and thus be destructive of all forms of social capital" (ibid.).

Portes (1998) describes different processes by which social capital can cause negative overall effects. Firstly, he holds that all bonding social capital is positive for those who are in a certain group, but detrimental for those who do not have access to it (1998, p. 15). In case of a considerable 'damage' for those who are left out of the group, it can lead to overall negative consequences. Secondly, in particular in egalitarian societies, high pressure to redistribute income might lead people to keep off from economic activities. (ibid., p. 16). Thirdly, in communities with a large stock of social capital which manifests in conformity, it might be difficult for individuals to behave in a way which runs counter to the established norms, which according to Portes refers back to the classic conflict between individual freedoms and obligations towards the community (ibid., p. 16 ff.). Lastly, Portes holds that in particular groups which oppose mainstream society might have to struggle with eroding norms. He gives the example of a research among Puerto Rican drug dealers in the Bronx (Bourgois in Portes, ibid.), where norms existed which aimed at blocking people from rising to the middle class. Thus overall, numerous paths are possible in which social capital can have overall negative consequences.

Besides the discussions related to the definition of the concept, the introduction of social capital has led to a discussion with regard to the different scientific disciplines. Coleman argues that the introduction of the concept of social capital might be a way to overcome the divide between two of the predominant but seemingly opposing views in the social sciences: a sociological perspective which sees actors as constrained by their social environment and an economic perspective (or rational choice or public choice) which propagates the existence of a purely rational actor (1989, p. 13 ff.). Coleman takes the idea of a rational actor and seeks to insert it into sociological action. According to him, "if we begin with a theory of rational action, in which each actor has control over certain resources and interests in certain resources and events, then social capital constitutes a particular kind

of resource available to an actor" (ibid., p. 16). Thus social capital theory as introduced by Coleman aims at bringing rationality into a sphere which has formerly been explained in 'socialized' or normative terms.

Such a fundamental re-arrangement of disciplines has led to sharp criticism. Amongst others, the proponents of social capital theory are accused of imposing an economic way of thinking on other disciplines, and that as a consequence, "economics is colonizing the other social sciences as never before" (Fine, 2002). Likewise, he claims that social capital does not provide an insight into power-relations. Also Portes (1998) agrees that the term 'social capital' "does not embody any idea really new to sociologists", and can likewise been found in 19th century works from Marx and Durkheim (ibid., p. 2). Still, one of the merits of social capital is to bridge the potential divide between different disciplines. In particular the different approaches of defining the scheme described above provide the researcher with a large range of lenses, which are a useful tool to re-conceptualize the nature of social interaction.

So far, a very limited number of studies has explicitly employed the concept of social capital on participation in a CBHI scheme. Based on a quantitative study from rural China, Zhang et al. (2006) measure how social capital can influence farmer's willingness to join a CBHI. They found that in villages with a high degree of bridging social capital, farmers are more likely to join the scheme than in villages with low social capital (ibid.). In general, in particular a definition which allows for positive and negative effects of social capital is very helpful in showing the different manifestations of social capital. The potential relevance of social capital theory on participation in CBHI has been recognized by Mladovsky and Mossialos. In a theoretical piece, they argue that "a critical engagement with social capital theories could contribute to our understanding of why CBHI schemes do not appear on course to develop according to the 19th century precedent, achieving significant levels of population coverage in a sustainable way" (2006, p. 5). To a certain extent, this echoes Woolcock's recommendation that "development interventions should be viewed through a social capital lens, and assessment of their impact should include the potential effects of the intervention on the social capital of poor communities" (1999, p. 19).

Mladovsky and Mossialos propose to differentiate between two dimensions as a framework for analysis: one dimension distinguishes between bonding and bridging capital,

and another dimension distinguishes between the micro- and macro level. The bonding-bridging dimension refers to the internal-external dimension of social capital described above. The micro-macro dimension deals with an individual's choice as opposed to 'top-down' institutionalized incentives to influence the creation of social capital – typically the level of the state. Macro level bonding refers to a process which treats social capital as "professional ethos committed to pursuing collective goals, fostered by social relations between individual representatives of institutions" (Woolcock in Mladovsky, p. 2006, p. 8).

Based on such a matrix, Mladosky and Mossialos develop four different possible effects. Bridging on a macro level refers to the interaction between citizens and government institutions and addresses the possibilities for government institutions to change the nature of social capital (cf. Putnam, 1994). Bonding social capital addresses the bureaucratic ethos in the promotion of a CBHI scheme. Mladovsky distinguishes between a committed bureaucracy and one where corruption and nepotism prevail (2006, p. 8). Bonding and bridging on the individual level refer to the personal relations individuals have either within a certain group or outsider of the reference group. Mladovsky argues that all four categories can have positive and negative consequences. For example, evidence from CBHI schemes exists that strong bonding social capital on the micro level leads to increased participation in CBHI. Yet, in other schemes, strong intra-community links – coupled with strong informal financial networks – lead to a decreased insurance participation (ibid., p. 9 ff.). The classification introduced by Mladovsky and Mossialos is used as a framework of reference in particular in the discussion part of this paper. While focusing on the micro-level, also the macro-level is of importance for the final claims of this paper.

2.3. Methodological considerations

2.3.1. Case Selection

As stated before, this project is based on Dekker and Leliveld's research project on the same project. For that project, more than 400 extensive interviews have been conducted with household-heads, aiming primarily at a better understanding of what variables contribute to or hinder participation in the CBHI scheme. Their analysis of the data revealed

that variables such as a regularly salaried job or higher education improve the likelihood of buying a micro health insurance. Based on the results of this survey, this thesis emerged as a two-step project: firstly, overall low rates of enrolment are elaborated, before turning towards differences within the village of Aouda.

Towards the beginning of my fieldwork, the study was supposed to be a 'controlled comparative' study between two seemingly similar villages. While the first part dealing with general rates of enrolment would remain the same, the initial focus of the second part would have been on inter-village differences. In collaboration with the organizations executing the CBHI scheme, the villages of Aouda and Nima were chosen for in-depth investigation to carve out differences between the villages. The villages are located two kilometers from each other. In Aouda, approximately 200 families participate in the health insurance scheme, whereas in Nima only four families are member of the insurance. Even though Aouda is approximately eight times bigger than Nima, the difference in terms of insurance take-up remains stark. I started carrying out my research in Aouda, where I was supposed to be settled during my field research. In addition, I started conducting visits to Nima as well. Already during the first weeks of my stay in Aouda, it became clear that it would be a mistake to see the population of Aouda as a homogeneous entity. Also within the village, certain groups participated while others did not. The major cleavages that divide those who participate from those who refrain seemed to run between ethnic and religious lines in both villages. Whereas Nima is almost exclusively inhabited by Muslim Kotokoli, Aouda is heterogeneous, with Christian/Animist Kabye being the biggest ethnic group. As a consequence, I chose to change the initial question of 'why is the participation different *between* villages' towards 'why is participation different between different groups *within* the village'. As a result of the sufficient variation within Aouda, this project now is essentially a single-case study, focusing on the village of Aouda instead of a comparative study between different villages. The within case comparison approach allows to hold several outside factors (geographic location, village size, distance to the clinic etc) constant. Nevertheless, as part of the field work I conducted exploratory visits to other villages in the prefecture of Sotouboua (Nima, Kaza/Kazaboua, Agombio, and Fazao) in order to check whether Aouda is a "special case" or whether the findings are also applicable in other places.

2.3.2. Considerations on a qualitative research paradigm with a single case

This project is organized according to a qualitative, ethnographic paradigm. While quantitative techniques have been very useful to bring to light issues of the individual and household-level on the same CBHI scheme, a qualitative approach is seen appropriate to establish the socio-cultural context. To do so, a single case study was conducted in the village of Aouda. To use Geertz' (1973) expression, it is the aim of this project to establish a "thick description" of the overall low participation rates in SP in Aouda as well as differing participation rates within Aouda. According to Geertz, the the analysis which one needs to embark on "is sorting out the structures of signification…and determining their social ground and import" (ibid., p. 9). Thus, while quantitative analysis has been helpful in *bringing to light* the different participation rates ('thin description'), qualitative, interpretative analysis is now needed in order to *explain* this outcome ('thick description'). As such, the setup of this project is the closest to the method of ethnography, which according to Geertz is a thick description *per se* (Geertz, 1973, p. 9-10).

With the conceptualization of thick vs. thin description, Geertz follows up and refines Weber's differentiation between a '*Verstehen'* (understanding) and a '*Erklären'* (explaining) approach. Similar to a thick description, also *Verstehen* aims at comprehending an act from the actor's point of view (cf. Weber, 2002). The aim of such an approach can also be restated as inquiring about the *emic* meaning of a certain phenomenon. The imperative for ethnographic data collected by trying to understand the emic perspective through fieldwork has most prominently been promoted by Malinowski in the early 20th century (Malinowski, 2007). Malinowski argued that it is indispensible to engage with the population you are conducting research on, stressing the need for participant observation. According to him, the task of the ethnographer is "to grasp the native's point of view, his relation to life, to realize *his* vision of *his* world" (quoted in Lassi, 2006, p. 68). While anthropology and sociology represent the classic disciplines which employ these paradigms, the value of a qualitative *Verstehen* approach has gradually been acknowledged by academics from other disciplines as well. As a part of this process, Coast (1999) has argued that the application of a qualitative methodology can provide very useful results when conducting research on health-related matters.

One occasion on which the need to establish 'thick' descriptions became clear to me occurred during a focus group discussion with local volunteers of the CBHI scheme. I asked them about their motivation to voluntarily work for the health insurance. I received the answer that the sole motivation would be the monetary remuneration which they receive from the insurance (Focus group discussion, 29 November 2012). This surprised me because I knew from prior interviews that the financial compensation for their effort is usually not seen as a major source of motivation. However, I had not chosen my words carefully, because the financial compensation which the volunteers receive from the scheme is called 'motivation'. Because of this link, the volunteers thought that I would be asking about the motivation as defined by the CBHI scheme. Only because I was familiar with the context, I could clarify the confusion around the term. This was crucial because the majority of the volunteers in the group discussion had already been active before the financial compensation had been introduced. If I had not been familiar with the context, I might have accepted the first answer, which would have led to a different picture than the answer which I received when probing further. Thus, a thick description can only be established if the researcher is familiar with the research context.

A major challenge of ethnographic research lies in how to make a 'thick description' of a specific context applicable to a wider context. In this regard, Geertz holds that "the essential task of theory building here is not to codify abstract regularities but to make thick descriptions possible, not to generalize across cases but to generalize within them" (ibid., p. 26). From a social science point of view, this view is likewise supported by George and Bennett (2005), who argue that in a case study research designs, the aim must not be to have a "representative" study. Indeed, they hold that it is "inappropriate and sometimes counterproductive" to extend the 'quest for representativeness' to a case study approach (ibid., p. 31).

In relation to George and Bennett's claim to dismiss representativeness, Geertz further holds that an interpretative approach precludes the possibility of a 'complete' science. In the interpretative approach, "progress is marked less by a perfection of consensus than by a refinement of debate" (ibid., p. 29). There can thus be no ultimate truth. As science is a continuous refinement, a theory only holds true as long as it has not been falsified (cf. Popper, 2002). Thus with regard to theory, rather than coming up with new theoretical evidence, this paper aims first of all at using the case study approach to

confirm or falsify in how far social capital theory is useful to understand CBHI schemes as proposed by Mladovsky (2007). As stated by George and Bennett (2005), the task of theory testing in the case study approach is "to strengthen or reduce support for a theory, narrow or extend the scope conditions of a theory, or determine which of two or more theories best explains a case, type, or general phenomenon" (p. 109). Next to employing and testing social capital theory, this paper aims at furthering the insight into the respective CBHI project, thus to collect empirical data which can be employed by future research as well as practitioners.

2.3.3. Methodology as applied in the field

The first weeks of fieldwork were mainly devoted to observations and in depth conversations with my research assistant as well as open interview with other villagers. This allowed me to approach village relations in general as well as insurance-related matters with a large degree of openness and to redefine my set of questions in order to grasp the most relevant aspects related to participation in CBHI. In order to facilitate the exchange with the inhabitants of Aouda, it was indispensible to work with an assistant. In this role, Noel Pagniou accompanied me in Aouda through the entire stay. Being the local volunteer, he was proposed as my assistant by RADAR, the local supervising organization. He had a tremendous knowledge on insurance-related matters, and was one of the few locals who were fluent in French. During the first weeks, Noel introduced me to all relevant actors in Aouda. Likewise, we had numerous conversations about the proposed setup of my project in Aouda.

Based on information gathered during the first weeks of my stay in Aouda, I established an interview guideline which was first pre-tested with a small sample. After streamlining it, I conducted semi-structured interviews based on the guideline with the wider village population. It should be noted that questions were adjusted to the individual circumstances of interviewees. Some questions were only directed towards insurance members, for example how the experience of illness in a family has changed since the participation in the insurance. The order of the questions was primarily determined during pre-testing, as well as during some first casual conversations on the topic. The final order comes close to an unstructured interview about insurance-related matters, and it was often possible to connect the questions without having a sharp break in the interview. This was

done in order to establish trust between me and the interviewees, but also to pretend that we would be having a casual chat rather than a formal interview so that the interviewee would feel at ease.

In total, I conducted 35 interviews with the help of my research assistant. The interviewees were chosen based on quota sampling in order to have variation on variables which might matter in terms of attitudes on the insurance. The variables which I distinguished were age, ethnicity, gender, and insurance participation. They were developed in the preparatory phase of this project and proved to be salient during the pre-testing period. According to these criteria, a diverse sample was constructed with the help of my informant. After conducting two thirds of the interviews, I switched to haphazard sampling in order to check whether the respondents which were chosen by my assistant held opinions which were different from those of other segments of the society.

Next to interviews conducted as a part of the sample, I conducted a total of 16 individual interviews with persons in different functions[1] in order to gather further information on motives to participate or not to participate in the insurance. While I already spoke to several of the respondents informally during the orientation stage, I revisited them to conduct semi-structured interviews at a later stage. Most of the interviews were conducted to get information on particular topics. For example, interviewing two Imams allowed me to understand the interrelation between Islam and the insurance scheme; and talking to local elders and priests helped to get an insight into how local – in particular animist – traditions might interact with insurance participation.

Furthermore, focus group discussions with volunteers of the insurance were realized in three different villages[2]. However, in relation to the interviews, the data from the focus group discussions proved to be of minor relevance, possibly because it is easier to dig deeper during individual interviews. Therefore, I decided to conduct additional individual interviews with some of the volunteers. These were then treated as a part of the regular sample, where I asked them questions tailored to their work as volunteers in addition to the regular set of questions.

[1] 2 village chiefs, 3 nurses, 1 social worker, 1 village elder, 1 traditional priest, 1 herbalist, 3 salaried promoters of the insurance, the president of SP, 2 Imams, Country Director from Plan Togo, Country Director from Louvain Développement

[2] Aouda, Agombio, Fazao

Next to the interviews and group discussions, a considerable part of the data was gathered during observations or casual chats. Living in the village which was the place of my research provided me with the possibility to get an insight into daily life, leading to 'thicker' data than data gathered solely during interviews. Several times, I accompanied my assistant during his walks in the village, where he sensitized people about the insurance. In addition, I spent hours sitting and chatting in front of the local shop, which served as a kind of meeting point for almost the entire village. Likewise, living with a local family led to a deeper understanding of family-affairs and everyday life. Next to the observations in the village, I participated at several meetings of the insurance in Sotouboua and Sokode, which increased my understanding of the scheme as such, but also the role of different actors within SP.

During the explorative phase of my fieldwork, I attempted to include a pile-sorting exercise. I asked interviewees to assign personal importance to several expenses such as buying food, beer, mobile credit, insurance, schooling fees on and new dresses on a scale from 1-5. I expected that this might uncover patterns of how respondents value certain things, including expenses for heath. However, there seemed to be a consensus that buying food and paying for schooling and insurance were considered to be important, whereas items such as drinks, mobile credit and new dresses were uniformly assigned the least importance. However, this did not coincide with my observations – most of those who stated to prefer spending money for schooling or insurance were ardent consumers of mobile credit and beer, regardless of their low ratings of importance of these expenses in the pile sorting exercise. While the exercise was interesting to show the socially acceptable rating of expenses, it was not helpful in establishing differences within the sample. Being very time-consuming as well, I decided not to include this exercise in the interviews with the sample.

2.3.4. Possible pitfalls and practical limitations

As usually is the case for large research designs, also this design has some possible pitfalls and limitations. Typical for qualitative single case study, one of the possible limitations of this study is the non-applicability to a wider context and low generalizability of the findings. The research uncovers some of the basic mechanisms concerning patterns of insurance participation in Aouda and is able to get behind some of the puzzles of low participation rates in this village. However, the findings should be applied to a wider context

only with caution. In order to provide higher external validity for the hypothesis derived from my case study, the data need to be sustained – possibly by a quantitative follow-up study – in order to be applicable to a wider population of cases. Likewise, due to the qualitative research design, it is difficult to calculate the effect of the variables which were proven to be relevant for insurance participation. In the words of George and Bennett, "case studies remain much stronger at assessing *whether* and *how* a variable mattered to the outcome than at assessing *how much* it mattered" (2005, p. 25). Consequently, there might be omitted variables in this study which could not be identified or quantified during the investigation of this project.

Additionally, the decision to rely on a local assistant has influenced the findings of my fieldwork. In the beginning, it was mainly him who chose the interviewees according to the criteria which I had established. Naturally, he chose mainly interviewees which he was familiar with. In order to control for this effect, I used random sampling in a later stage of the research. This allowed me to check whether the data gathered so far was biased in this respect. While this did not result in major shifts, some minor changes could indeed be observed. However, at the same time, switching to random sampling also lowered the degree of openness with which people were willing to answer. In contrast to the respondents which my informant knew, respondents in the random sample did not know any of the two visitors, which might have led them to answer more cautiously. However, in combining the two sampling methods, I am confident that I was able to minimize or at least balance both problems. Moreover, my assistant's involvement in Sina Passenang might have limited people's openness to express their criticism about SP. However, during several occasions I had the impression that the reluctance to speak out critically about the health insurance was not due to the presence of my assistant, but due to other factors (which will be examined later in this thesis).

The choice to work with an assistant was also due to the language barrier in Aouda. Most of the people I interviewed spoke hardly any French. Consequently, the majority of the interviews was conducted in Kabye and translated on the spot with the help of my assistant, who was fluent in both French and Kabye. When people spoke sufficiently French, I conducted the interviews myself in French. While some of the information in the interviews might have been lost through employing an interpreter during the interviews, it is seen as the possibility leading to the richest data. Limiting the sample to only French speaking

participants would have biased my sample considerably, possibly leading to misguided conclusions.

I used my voice recorder only during the pre-testing phase. I stopped using it after that because I had the impression that it created too much distance between me and the interviewee, limiting the information I could possibly obtain from respondents. During the subsequent interviews, I therefore took notes rather than using voice-taping. I refrained from using a written form for the interviews specifying a consensus for the data to be used for research. In a multilingual environment where not everyone is able to read or write, such a measure appeared to be out of place. Instead, I orally informed people that the data would only be used for the purpose of an academic study and is treated confidentially. However, in some instances this led to a certain distance, because people did not exactly know what is meant by an academic study, which I then explained to them. Ethical consensus proved more challenging for data gathered during informal interviews and observations. Some of this data includes substantial criticism on the scheme, so I decided to use it in an anonymized way and only if it is not too obvious who the respondent was. Again, these decisions involved trade-offs between different pitfalls. However, I am confident that with the choices I made, I have managed to come up with a rich selection of data.

Another problem I encountered during my fieldwork was the fact that I found it largely difficult to come into contact with the Muslim population, which make up a considerable share of the village population. Throughout my stay, I was living with a local Catholic Kabye family in the village of Aouda. Next to my research assistant, the members of my host family were an important point of reference throughout my stay. I learnt a lot about everyday life in the village and local attitudes towards the health insurance scheme by living with my host family. They were of the same denomination as my assistant (Catholic) and were of the same ethnic group. Likewise, the family of the local shopkeeper where I spent a considerable amount of time was Catholic Kabye, as well as many other people I encountered in the field. Also the consumption of the occasional bowl of sorghum beer in the evenings was a Kabye-dominated affair. Thus, while I interacted with the Kaybe population on a daily basis in, I encountered members of the Muslim population only during the interviews. This gave me a better understanding of the attitudes and motivations of the Kaybe population also with respect to the health insurance scheme than of the views of the Muslim population.

In addition, I was confronted with the problem whether people told me their opinions on certain issues, or whether they presented the views which they deemed to be socially acceptable. Clearly this is a common problem for most social science and anthropology research that relied on data collection in cooperation with humans and not special for this particular research project. Nevertheless, it is important to point out that people were reluctant to admit that they themselves did not agree with the tenets of the insurance. Likewise, many were reluctant to admit visiting a healer instead of going to the clinic. This was a serious challenge which I have not completely managed to overcome. To a certain extent, I attempted to circumvent this problem for example by asking whether the interviewees knew *others* who did not like the insurance or who went to the herbalists first. When asked this way, most people knew someone but they remained cautious not to point to themselves. Nevertheless, after several months in the field I had a feeling for such sensitive issues and learned how to interpret certain socially desirable answers.

Lastly, in particular during the sampling phase, many respondents were not able to distinguish clearly between my role as a researcher as opposed to being an employee or representative of SP. In this regard, the role of my assistant might be critical as well, as he was one of the most ardent supporters of the insurance. Thus, people might have been reluctant to share their criticism about the insurance. However, during the interviews included in the sample, I minimized this bias by stressing the fact that I was an outside researcher and not employed by the insurance scheme.

2.4. Summary

This chapter established that in the current literature, three different fields of analysis are present with regard to participation in CBHI schemes. Firstly the individual and household level, secondly aspects related to the setup of the scheme and the health facilities, and thirdly factors which assess the socio-cultural context of a scheme. While this project focuses predominantly on the socio-cultural variables, it is important to elaborate on the first two fields of analysis as well.

Next, this chapter elaborated on the underlying theoretical considerations of this project. It has clarified that there is not a single notion of insurance, but that involves a wide

range of actors. In the context of Central Togo, informal arrangements of risk-sharing are expected to be prevalent. For someone to decide in favor of participation in a CBHI scheme, he must be convinced that the CBHI scheme is either better suited for his needs than the informal mechanisms, or that the CBHI scheme can supplement them. This section has further established that most of the CBHI schemes as executed in Sub-Saharan Africa combine features of a bottom-up and top-down approach to insurance. While they are organized on a voluntary basis and member-run, they have been initiated based on a top-down decision. Likewiese, the schemes are not based on adherence to a common occupation, but on the administrative notion of the prefecture.

Subsequently, considerations on social capital were introduced. Social capital theorists argue that social relations in a society are crucial to understand patterns of action within the society. This is also the assumption which is used to frame the analysis of this project. Social capital can manifest in two different ways, either through strengthening intra-group relations called bonding, or through strengthening relations between different groups called bridging social capital. Moreover, social capital is a concept which can have negative as well as positive consequences on overall welfare. As argued by Mladovsky and Mossialos (2006), social capital is a useful concept to explain participation rates in CBHI. Next to the dimension of bonding and bridging social capital, they introduce a further differentiation of individual action on the micro level as opposed to institutional action on the macro-level.

Lastly, methodological considerations of this paper were presented. This research is based a qualitative methodology which aims at establishing a 'thick description' of patterns of insurance-participation in the village of Aouda. The data has been collected during six months of fieldwork, using the techniques of semi-structured interviews, observations and focus group discussions.

3. Context of the study

This chapter introduces the case and the context of the fieldwork. Subsequently, the local context of the fieldwork, the Togolese health system and the setup of the CBHI scheme in Central Togo are introduced in this order.

3.1. The regional context

The Togolese Central Region is located roughly halfway between the Atlantic Coast in the South and the border with Burkina Faso in the North. Until the early 20th century, the Togolese Central Region was only sparsely populated, serving as a buffer zone between the slave raiding kingdoms in the South and the people of savannah in the North (Piot, 1999, p. 41). Given the fertility of the soils in the region, the colonial rulers – The Germans, followed by the French – established a system of forced temporary labor migration in order to increase agricultural production. The Kabye, whom the colonialists considered the most hard-working ethnic group, had to cultivate the land in the Central Region, which was much more fertile than their mountainous 'homeland' in Northern Togo. From the 1930s onwards, Kabye started to move to the Central Region voluntarily, taking advantage of the fertility of the land. This process has continued until today. Thus, nowadays approximately 200.000 Kabye live in the Central Region, whereas only 120.000 remain in the northern area (ibid., p. 42). The relations between those living in the Central and Northern area are strong, and all 'Southerners' have family members living in the Northern villages. According to Piot (1999), the Central Region is seen as being the Kabye's economic powerhouse, while the North has remained the spiritual centre. The majority of the Kabye now has converted to different forms of Christianity. Nevertheless, traditional elements play a very strong role, and a considerable share of the population considers itself as Animists.

The research for this project has been carried out in the prefecture of Sotouboua, located about 300km north of the Togolese capital Lomé and about 50km south of the regional center Sokodé. The main village and administrative center is called Sotouboua Town. Sotouboua Town is conveniently situated right next to the "Route Nationale No 1", which is one of the few sealed roads in the country and connects the Atlantic coast with the Northern part of Togo and the Sahel countries. The villages in the prefecture of Sotouboua can be distinguished between those located next to the main road and those which are further afield. Those which are not situated next to the 'highway' are more difficult to reach,

as public transport is scarce and the roads are not sealed. Likewise, electricity is restricted to the villages which are located close to the Route Nationale. In addition, proximity to the highway leads to increased economic activity in the form of employment. Overall, subsistence farming is the dominant form of earning a living in all of the villages, the most important agricultural goods being yams, maize, sorghum, beans, and to a lesser extent tomatoes, rice and other vegetable.

Next to the Kabye, the second-biggest ethnic group in Sotouboua is the Kotokoli They are seen as 'Natives' of the Central Area around Sokode, around 50km North of Sotouboua. With 95% being Muslim, they are said to be the ethnic group with the highest percentage of Muslims in Togo (Delval, 1980). Indeed, it is very rare to find a Kotokoli who is either Animist or Christian. Unlike the Kabye, the Kotokoli have a reputation for being skilled traders. However, in particular due to the rural setting, a large share of the Kotokoli is likewise active in agriculture. Besides the Kabye and the Kotokoli, several minorities are present in Sotouboua, most notably the Peul, a semi-nomadic cattle breeding ethnic group which originally stems from the Sahel Zone. Some of the Peul have come to live in Sotouboua permanently, while others who have maintained the nomadic lifestyle. The latter group of Peul visit Central Togo only between October and January. Also amongst the Peul, Islam is the dominant religion.

Besides the religious and ethnic differences, the different ethnicities are also divided along linguistic lines. Each group has its own language. The two predominant local languages - Kotokoli and Kabye – are closely related, and people from the two groups can understand each other without difficulties. Given the prominent position of the Kabye, their language is considered the lingua franca in the prefecture. French, Togo's official language, is in general not widely spoken. Especially amongst the older generation, one hardly finds someone who speaks French. However, as French is spoken at school, this situation is canging with the advance of the younger generation.

3.2. Aouda – the location of fieldwork

Except for the introductory weeks, I was based in the village of Aouda throughout my entire stay in Togo. The village is located approximately 20km north of Sotouboua Town next to the Route Nationale. With several thousand inhabitants, Aouda is a relatively big village. In spite of its size and location next to the highway, Aouda feels like a very small place: not a

single two-store-building exists; and most houses are surrounded by fields connected by a seemingly endless network of footpaths. Besides farming and small-scale commerce, economic activities are largely absent. In terms of economics, wealth in the village is distributed relatively equally. The people with the highest incomes were local teachers (with an income ranging between 100-200 €/month). The only person with a private car is the traditional chief. However, he lends out the car during the day to be used as a shared taxi. Aouda takes advantage of its location next to the Highway. A big permanent market exists, selling yams, oranges, avocados and bananas to people travelling on the highway to Lomé or the Sahel respectively. Even though international remittances are often described as one of the major sources of poverty alleviation[3], they hardly play a role in Aouda. While many of the younger men search for employment in Nigeria, none of the inhabitants of Aouda has relatives or acquaintances in Europe or the USA.

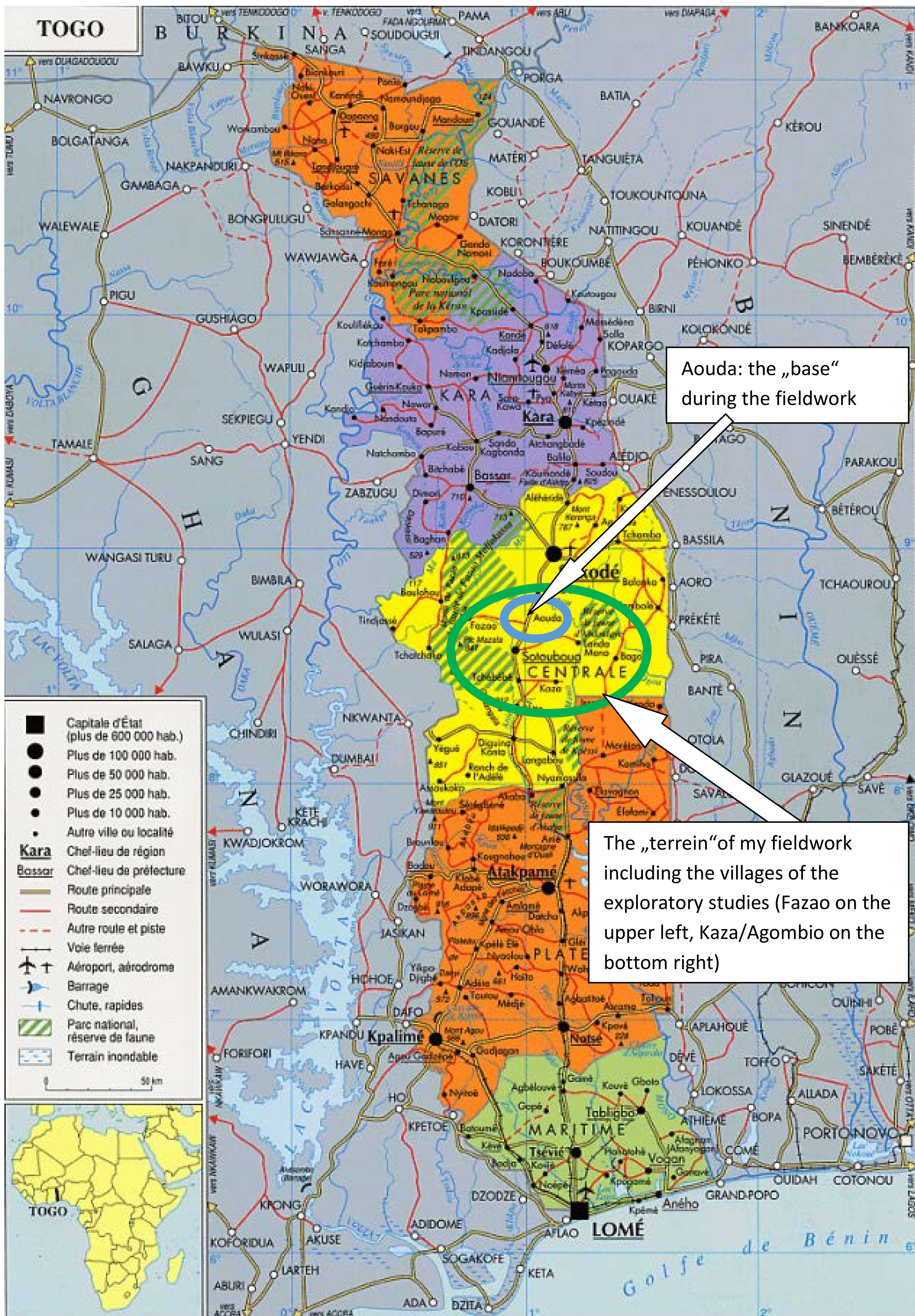
Picture 1: The village of Aouda

[3] For a discussion of the role of remittences in Ghana, see Adams (2006)

In Aouda, the Kabye are the largest ethnic group. Next to them, a considerable number of Kotokoli lives in the village, too, as well as Peul and individuals from other ethnic groups. However, in most quarters one of the ethnicities predominates, and the Peuls had constructed their hamlet about 5km from Aouda. Also in terms of religion, Aouda is heterogeneous. Numerous Christian denominations are present, most notably the Catholic Church and the Assembly of God. Likewise, several mosques exist. In addition, animist rituals are common and can be observed frequently. In spite of the heterogeneity, in particular interaction between the different ethnic groups is limited: they live in largely separate quarters, are active in different religious communities and tend to have somewhat separate economic networks. Overall, in terms of religious and ethnic composition, Aouda can be seen as a microcosm of the province of Sotouboua, which was also one of the reasons to choose this place for an in-depth study on insurance participation.

Aouda and the surrounding villages constitute the “Canton de Aouda”. The canton is the next level of governmental organization after the prefecture. The highest representative of Aouda is Samke Babadou, the “Chef Canton”. He is the hereditary chief of Aouda, and has taken over the office from his father some 30 years ago. His approval is essential for most activities to be conducted in the Canton, and he was also the first person where I had to introduce myself during my stay in Aouda. As most affairs in the village are dealt with according to customary law, the Chef Canton is likewise responsible for legal matters where he serves as a judge once a week. Even though the position of the chief is a very prestigious one, he is not necessarily much wealthier than other people in the village and relied on agriculture for an income. Besides the Chef Canton, there are numerous ‘Chef de village’ and ‘Chef de Quartier’. Besides the Chef Canton, the only visible governmental structures in the village were the public schools, health facilities and the office of the Togolese Social Service. However, the latter was not staffed during my stay in Aouda.

As part of the research, I conducted exploratory visits to several other villages, notably Nima, Kaza/Kazaboua and Fazao. These villages are located in the prefecture of Sotouboua as well. While in Nima and Fazao are dominated by Kotokoli, in Kaza/Kazaboua the Kabye were the biggest ethnic group. Nima is located about two kilometers South of Aouda, whereas Fazao and Kaza/Kazaboua are rather remotely located. They are situated at about 20 kilometers west respectively east of the highway and only accessible via a dirt road, whose condition varies with the season (see Map 1).



Map 1: Geographical map of Togo. Source: http://www.vidiani.com/maps/maps_of_africa/maps_of_togo/detailed_administrative_map_of_togo.jpg

3.3. The health system in Central Togo

The state-supported health system in Central Togo consists of different levels. In the rural areas, the most frequently used facility is the village clinic called Unité des Soins Peripherique (USP). This institution caters for basic health needs in the villages. The treatments which can be received there include vaccinations, treatment against Malaria, consultations and birth-related health including giving birth. The USPs are staffed by a nurse and a midwife, which are often accompanied by assistants. In addition, a pharmacy is attached to each USP which sells basic and often subsidized drugs. In the prefecture of Sotouboua, there is a total of 17 USP, and the majority of the population is located within 10km of the next USP. The financial situation of these clinics is often in a state of limbo. The majority of the buildings have been constructed with the help of foreign donors, and the Togolese government pays the salaries of some of the employees. However, in many cases, additional employees need to be recruited in order to satisfy the health-related needs of the population. This staff is recruited on the village level and receives its salary from the user fees which are collected at the clinic. This system leads to the situation that patients complain about steep prices, while the clinic personnel is frustrated about the patchwork-financing and the scarce resources which are at their disposal. The equipment of the clinics is very simple, and in some cases the possibilities of treatment are reduced because equipment is broken and cannot be replaced due to financial constraints. Some of the clinics are situated in areas without access to electricity, further limiting their possibilities, particularly when it comes to emergency treatment at night or cooling vaccinations.

Attached to the USPs are the Agents de Santé Communautaire (ASC). These individuals have received training in health-related matters. They are typically employed in villages which are distant from the next USP. There, they are entitled to treat diseases such as simple malaria and diarrhea. Furthermore, the ASC are involved in a number of socio-medical matters such as family planning and encouraging parents to vaccinate their children. If a USP receives a case whose treatment is beyond their scope, this case can be referred to the provincial hospital in Sotouboua. If the disease cannot be treated by the provincial hospital either, cases can be referred to the Regional Hospital at Sokodé. This is where

surgeries are carried out, as well as treatments which require rarely demanded medicine such as antivenoms against snake bites.

Next to the facilities which are part of the state-supported health system, a wide range of alternative choice exists when it comes to medical treatment. Those who prefer auto-medication can buy pills against different diseases on the daily and weekly market. In addition, 'local' medicine made from herbs can be bought at the market and at people's private houses where it is produced.

In addition, numerous healers were offering their services. In Aouda, they had their specific location on the weekly market, where people could consult them. In general, these healers operate independently and are not recognized by the state-supported health system. Two healers stated that they had participated at a workshop in Lomé and Sotouboua, where the healing practices were intended to be integrated into the state-supported health system. However, no immediate action has resulted from this workshop, and there are hardly signs of official cooperation between the two systems of healing. Also the CBHI schemes collaborate exclusively with the state-supported health system. As the healers work outside the regulated framework, their reputation plays a crucial role. Healers with outstanding records of past healings could demand very high fees and were asked to travel as far as Lomé to carry out healings.

The local healing practices can broadly be divided into two categories. The first category is the herbalist, whose treatment is based on the application of locally grown herbs, plants and roots. The second one is locally called "le charlatan", but this notion does not have the negative connotation attached to it in Western Europe. It is rather used in a neutral way, referring to someone who possesses an inexplicable knowledge. The charlatans offer services which aim at resolving the metaphysical context of an illness. This paper uses the more neutral term 'healer' for this profession. For that kind of healing, rituals and sacrifice are frequently employed mechanisms to please whoever was displeased by a certain behavior. The source of knowledge of healers and herbalists is relatively similar – it is either transmitted through one's parents, or through one's own personal experiences. One herbalist explained to me: "Some year ago, I was very sick, and even in coma. When I woke up, I saw some plants, which I then used to treat my illness, and I became better. Afterwards, I started to treat other people" (Interview, 29 November, 2012). Given the

existence of different methods of healing, the population needs to make a choice which treatment they prefer. SP has taken the decision on behalf of its members, collaborating solely with the state-supported facilities. The next part sheds more light on the institution of the Central Togolese SP, describing its structures and responsibilities.

3.4. The setup of Sina Passenang

The community-based health insurances in the Central Region were initiated by Plan Togo and Louvain Developpement in 2008. Already in 2006, Louvain Développement conducted feasibility studies in five different prefectures. In 2008, the project was launched in the prefectures of Sotouboua and Tchaudjo. In 2012, it was extended to the three provinces of Est-Mono, Blitta and Tchamba.

The institutional setup of the insurance schemes on the ground is rather complex. Plan Netherlands and the European Union being the main donors. Plan Togo is responsible for channeling the funds in Togo. Also in the village, the project is largely perceived as an initiative by Plan. This is crucial, because due to prior engagement, Plan has an excellent reputation. When passing the province of Sotouboua on the highway, one can see numerous signs of Plan's engagement in form of street signs which post the way to offices of sponsored organizations or in the form of Plan's logo on co-financed buildings such as school and latrines. Moreover, Plan executes child sponsoring program in the prefecture of Sotouboua, which aims at improving the living conditions for children from poor families. Besides, numerous small NGOs provide support in different fields.

Plan delegated the task of supervision Louvain Développement. Louvain is a Belgian-based development organization, which has expertise in the field of health care. From Louvain Développement's office in Sokodé, the schemes in the different prefectures are monitored, and visits are conducted in case of special occurences. Louvain Développement also employs a doctor who checks whether the prescriptions in the clinics paid by the insurances are justified. The day-to-day supervision in the prefectures is carried out by different partner organizations: RADAR is responsible for the supervision in Blitta and Sotouboua, ADESCO in Tchamba and Tchaudjo, and SOS Vita in Est-Mono. Working on the scheme in Sotouboua, I was mainly in contact with RADAR and Louvain Développement.

The insurance schemes themselves are organized as non-for profit entities and are recognized by the Togolese government. They are legally independent from the consulting

organizations and also from each other. Each of the schemes in the five provinces has different names and they have also different terms of participation. Each of the insurance schemes possesses an office in the respective capital of the prefecture. There, the director of the scheme is responsible for the execution of the administrative day-to-day work of the insurance as well as accounting tasks. The directors typically hold a university degree in accounting or management, and have undergone an application process set up by the consulting organizations. As the term ‘community-based health insurance’ implies, the schemes are supposed to be run by the community. Therefore, an administrative advisory board (*conseil d’administration*) is responsible for checking the work of the director and for taking decisions concerning the course of the insurance. The members of the advisory council are directly elected by all participants of the insurance. The highest representative of the insurance is the president, who is also the chairman of the advisory board. Next to the president, the board consists of a secretary general and an accounts auditor as well as their deputies. The members of the advisory board are also present in most workshops and discussions which are organized by the partner organizations.

Picture 2: The Office of Sina Passenang in Sotouboua Town

Next to the advisory board, the volunteers of the insurance in the different villages are crucial in its setup. They are elected by the insurance's members on the village level and are primarily responsible for the collection of the fees. Likewise, they are responsible for sensitizing people about insurance-related matters. In villages with a well-functioning volunteer system, the volunteers are the primary point of contact and information for the participants in the insurance. However, since the start of the CBHI in the Central regions, the schemes are struggling to achieve a sufficient level of voluntary involvement at the village level. Several minor reforms were conducted aiming at improving the incentives to become a local volunteer. One of the measures by which volunteers are encouraged to become active was a 10% commission which they received on all annual membership fees which they collected.

In addition, the local partner organizations employ several 'animators'. The function of the animators is to animate people to participate in the insurance in cooperation with the local volunteers. They come from different backgrounds which were not directly related to the health insurance. Before working as animators, they receive training by the partner organizations. In Sotouboua, three animators were employed by RADAR, who were then responsible for different villages within the prefecture. The animators frequently assisted at workshops or accompanied the local representatives of the insurance in the villages.

In line with the aim of providing insurance for the poor, the fees of SP are modest. In 2012, the annual fee per person was at 2.600 CFA[4], and rose to 2850 CFA after SP struggled to break even in 2012. As a general consequence of the low premiums, also the benefits are limited: not all illnesses are covered, and a co-payment of 30-40% of the total amount is in place for almost all consultations. Besides general consultations and minor surgeries in the USPs, the insurance also covers treatment against snake bites and birth-related health: pre-natal consultations for woman are included, as well as midwife-assistance at birth. In addition, consultations and blood analysis for children are included in the insurance. Due to the comparatively high benefits in the case of pregnancy and child birth, participants of the scheme and nurses have stated that it is in particular woman and children who benefit the most from the insurance. Participants of the insurance have the right to be treated at all

[4] 656CFA (West African Franc) = 1 EUR

levels of the healthcare system: the USP, the provincial and the regional hospitals. However, in practice it rarely occurs to have a case transferred to one of the hospitals.

To overcome the challenges for insurances described in the previous chapter such as moral hazard, several measures were introduced by the supervising NGOs. In order to combat the problem of adverse selection, the household was set as the unit of insurance. The definition of the household focuses on the woman and her children. In particular in polygamous marriages, a wife and her children are treated as separate households, and it is possible for the wife to become member of the insurance with her children without having to insure the husband. There are indeed numerous families in which the wife or wives and the children are insured but the `husband is not. To a lesser extent, this also occurs in monogamous marriages. It is more difficult for the husband to insure his children without insuring the wife. This is based on the insurance's strong focus on birth-related health, and it is thus seen as problematic when the wife is excluded. Nevertheless, in the majority of the cases, the husband as the household head pays the insurance for the entire family.

Additionally, a waiting period has been introduced to prevent adverse selection. This means that an adherent of the insurance can only benefit three months after having paid the fees. Further actions have been undertaken to sensitize the population about behavior that contributes to good health. For example, mosquito nets were distributed in order to minimize the risk of malaria. To prevent cases of fraught, the insurance has handed out individual booklets to each insured household. These booklets are furnished with photos of each person and include personal details. To make the insurance more attractive for bigger families, households receive a 10% discount if they insure a family with nine or more members.

Concerning the collection of premiums, SP has adopted a flexible approach: adherents can pay in installments, but only receive care once the full amount has been paid. The fee is collected once a year, and the collection is started in September or October of the previous year. After making the experience that a considerable share of adherents did not finish paying the fees until the end of the previous year, the CBHI schemes allow the adherents to finish to pay the fee until the end of March. In case people fail to pay the remaining amount until the end of March, the insurance keeps the money as first installment for the coming year.

Most of the meetings between the director and the advisory board of SP are also attended by staff from either Louvain Développement or RADAR. Unlike foreseen at the beginning of the scheme, the insurances are not yet able to operate independently: in terms of finances, the schemes still depend on contributions from external actors, and the organizations struggle with low participation rates as well as low levels of voluntary engagement for the insurance in the villages. For now, the aim of SP is to break even excluding administrative costs. However, in mid-2012, it became clear that this objective would not be met unless additional measures were taken. As a consequence, the administrative council decided to increase the co-payment. In order to avoid this problem in the coming year, the premiums increased from 2650 CFA to 2800 CFA for 2013, while returning to the lower co-payments. However, a structural problem of the insurance remains: The project is limited to six years, and the CBHI schemes were supposed to be self-sufficient after that. Being started in 2008, it means that the funds are running out in 2013. At the time of fieldwork, it did not seem likely that the schemes manage to be self-sufficient by the end of 2013. It is however, unclear whether new funds can be liberated for the project. Therefore, the future of the project is was uncertain.

3.5. Summary

This chapter has introduced the context of this study. Aouda, the place of fieldwork, is located in the Togolese Central Region, which is ethnically dominated by the Kabye. Also in Aouda itself, the Christian and Animist Kabye are dominant, while a sizeable minority of Muslim Kotokoli is present as well. The USP is the primary point of reference for the inhabitants of Aouda. However, there is a wide range of choice when it comes to treatment, which next to the state-supported institutions includes healers and herbalists. While the healers deal with the supranational causes of illness, herbalists treat the bodily causes.

Sina Passenang has been introduced in 2008 by different international and local development organizations. As the scheme is member-based, the highest institution of the scheme is the admininstrative council, which consists of elected voluntary members of SP. Several measures are in place to avoid the insurance-related risks of adverse selection and fraught. Amongst others, the family has been defined as the unit of insurance, and waiting periods were introduced.

4. Low Rates of Enrolment I: Testing for the importance of solidarity and risk-sharing

4.1. Introduction

Officially, the rate of SP lies between 5-6% of the target population. However, it is more realistic to speak of 3%. The data of the participation rates is distorted by the fact that the activities of the insurance have been extended to additional villages beyond the official target group of villages. The participants of the additional villages are simply included in the overall participation rate without adjusting the data to the overall extension of the scheme to additional villages. Likewise, the demographic change in the area since the beginning of the scheme has not been taken into account, even though the population is growing by an estimated 2,8% per annum (Programme de Développement Local 2009 – 2011, 2009). Thus, while the number of participants is slowly increasing, the overall enrolment rate is not necessarily increasing. A participation rate of 3% of the target population thus means that in its fifth year, roughly 97% of the population decided not to enroll in the scheme.

This chapter aims at embedding the issue of low enrolment rates in different perceptions of solidarity and risk-sharing. It presumes that different connotations of these two concepts are predominantly responsible for the low rates of enrolment in SP. This analysis is guided by the theoretical considerations on social capital. The chapter aims at showing under what circumstances people are willing to change their pre-existing focus on the family with regard to healthcare. This chapter is structured as follows. First of all, this chapter inquires into the prevalent mode of cooperation and solidarity which is present in Aouda. The next section continues by comparing the solidarity as executed in customary relations with that promoted by SP. Subsequently, the chapter addresses sheds light on the role of the local volunteers, inquiring to what extent their activities can lead to a change of patterns of participation. In relation to the different arrangement of solidarity in the case of illness, this chapter then examines whether insurance participation has an impact on pre-existing, family-bound networks of solidarity. After that, a section tests whether Platteau's hypothesis of a mis-understood risk-sharing is also true for Aouda. Lastly, SP is compared to a local savings scheme. The section intends to test in how far the concepts of this chapter – solidarity and risk-sharing – are responsible for low rates of enrolment.

4.2. Reliance on personalized relations

When I bought peanuts next to the road in Aouda, I was told by my assistant afterwards that I should have told him that I intend to buy peanuts, because he would have shown me his trusted peanut seller. Because he knew her personally, he trusted her that she would not cheat on him with the price and that the quality of the product was good. At the same time, having a 'trusted' seller means that you would not be surprised to receive an inferior product when buying it from someone you would not know. To a certain extent, distinguishing between someone you know and someone you do not know seems to be an acceptable act. For example, merchants whom one knew personally might be able to give you a discount on a product, while taking the regular price from unknown customers. Thus overall, a large part of economic transactions in Aouda is taking place within a group of people which one knows.

Personalization is the norm for basically all transactions which are carried out in Aouda, regardless of being groceries, washing powder, millet beer or mobile credit. Frequently it was not a problem to pay the bill at a later stage when sellers new me or if I used to be a customer for a while. An interrelation of trust and social control resulted in a mutual moral obligation to repay the debt. Moreover, these personalized transactions also led to a high degree of social interaction. Typically, a market transaction was not confined to the transaction itself, but was accompanied by some small talk. In contrast, reliance on impersonal institutions is almost absent. Of cause this was also partly related to the absence of well-functioning abstract institutions. The focal point for a vast amount of transactions was the face-to-face community in the village, whereas higher-ranking institutions such as national companies or government-related institutions were barely present. This seems to be at least partly related to the performance of government-related institutions. As explained by one villager: "Here in Aouda, I know the people, and I know that I will not be cheated. If you are waiting for the government to fulfill a promise, you can wait forever, but if someone you know promises something, it is normally much easier" (personal conversation, 24 September).

The positive connotation which is assigned to personalized relations in particular in the field of economic transactions vice versa indicates that impersonal relations are seen critically. Overall, levels of trust outside the realm of the personalized seem to be relatively low. As stated during a casual conversation: “Many people here are too much interested in themselves. They do not care about other people. That’s also why we have big problems of theft here. Often, if you want to harvest, you see that there has already been someone who took some of your maize. Also, in the hot period in March and April, many people leave their door open at night because otherwise it would be much too warm. It often happens that people come into your room and take everything which they can get: radio, mobile phones, and even your cloths!” (Conversation, 30 November, 2012). On one occasion, I witnessed a similar situation. The woman of the family I was staying at lost her purse and mobile phone on the way to the weekly market in Aouda – a way which takes approximately 5-10 minutes to walk. Back at the house, she called her number from another phone and explained that she would be the owner, but the effort was in vain. The person who had found the phone and the money did not reveal his identity nor did he or she return it. These stories and stories about theft in the village – including theft of motorcycles – are common to hear in Aouda. It seems that while moral obligations exist to be honest towards the people who you are close to, different standards for other people are accepted.

The cases elaborated upon here are crucial to understand patterns of social capital within the village. Overall, personal relations are a guarantee for the availability of bonding social capital for economic transactions. Bridging social capital by extending mutual trust to those whom one did not know is not wide spread. Living in the same village seems to lead only to a certain degree of feeling of togetherness. Within the village, a high degree of mistrust exists, which is regularly confirmed by frequent cases of theft.

Next to the transaction itself as being a social and personalized, also the nature of most products which are regularly consumed have a personalized nature. On Christmas and New Year’s Day, each family in the village produced large quantities of millet beer. On Christmas day, I was walking around in the village with my assistant to visit some of his friends. At each house, we stopped to have a bowl of millet beer and a chat, during which we wished each other a merry Christmas Day regardless of one’s religion. Later that day, I was sitting in front of my room in the courtyard, which I shared with the family I was living with. Also the family had prepared an enormous pot of millet beer. Throughout the whole

day, all people which were either friends or relatives of the family came by and repeated the ritual. Naturally, such an occasion not only served to greet people, but also to exchange news about what has happened in the village. The availability of millet beer was a strong motivation for people to stay at least for the length of a bowl of beer. Also during other occasions, the consumption of millet beer had much more a social function rather than being confined to the consumption of alcohol. It was hardly ever consumed alone, but always in a round of people – either friends or strangers. Each evening, the market place turns into a large, well-visited bar, where beer is consumed and chats are taking place

Not only the millet beer serves a social function but also the importance of mobile phones is interesting in this context. Regardless of a person's wealth, he seemed to possess a mobile phone. Even though the majority of the people hardly ever has credit on their phones, it is very important to be accessible. In Aouda, mobile phones facilitate communication with people in other places considerably. Given that most families had relatives in other parts of the country, the mobile phone is indispensible to stay in contact with them. The importance of mobile telephony in Africa has been increasingly recognized (i.e. De Bruin, Nyamnjoh and Brinkman, 2009). By now, the mobile network in Togo has a more extensive coverage than the electricity grid. During a meeting with the local volunteers of the insurance in Sotouboua, all electricity plugs were constantly occupied. Those volunteers who came from remote villages took advantage of being at a place with electricity to charge their mobiles. The 'need' to buy mobile credit was aggravated by Togocel, the state-related mobile network and former monopolist. Togocel had a policy which required frequent recharging (with the smallest amount once a week) in order to prevent the SIM-card to be deactivated. Likewise, mobile telephony is considerably more expensive than in the neighboring countries. Given the limited availability of financial capital, also small amounts quickly accumulate. In spite of the costliness of mobile telephony, almost all people in Aouda are willing to make the effort to possess a mobile phone. In a way, the consumption of mobile credit – similar to the consumption of millet beer – serves to strengthen social, personal relations.

Interestingly, when proponents of the insurance argued that people would spend too much money on consumption, it was exactly these two items – mobile phone credit and millet beer – which were central. Most of the time, such expenses were perceived as a 'useless' investment, because it was seen as a purely consumption-based expense without

any added value coming out of the consumption. However, it would be more appropriate to see particularly mobile credit and millet beer as integral aspects of a ‘personalized’ society.

4.3. Ideas of solidarity and people’s unwillingness to join

Like for other fields of interaction, the personalized level is also crucial in the case of an illness. Before the introduction of SP, financing in a case of illness took place exclusively within a personalized face-to-face group. However, in the case of illness, the group within which solidarity is executed is limited even further towards the family, only occasionally including non-family members. However, within this network of support, further differentiations can be made according to the seriousness of the disease and the position of the respective family member. If the illness is not grave, it is primarily up to the nuclear family to find the money. In case other family members are living at the same compound, they may be obliged to help, too. Only if the illness becomes more serious, help from other family members such as brothers living at other places is considered[5].

Overall, solidarity in the case of sickness is primarily based on bonds of kinship which create a moral obligation exists to help a family member in the case of an illness (cf. Criel, 1998, p. 67). The head of the household of the family I was staying with explained to me: “If someone falls sick it is the family who is primarily responsible for finding the money to cure. Firstly, only the nuclear family is concerned, so maybe they have to sell some livestock or other foodstuff. If the family does not have any money at all or if the illness is getting more serious and the person has to be hospitalized, sometimes also other family members – brothers or the parents – feel obliged to help him. It is very unlikely that you will receive help from someone who is not member of your family. Even your neighbor – if he is not a member of your extended family, you would not help him” (Personal conversation, 28 September, 2012).

To a certain extent also non-family members can be included in the network of solidarity in the case of illness. However, unlike members of the family, they do not have the moral obligation to help. From the perspective of the sick, their help is therefore highly appreciated, whereas it is taken for granted from family members. Having a moral obligation to help in the case of illness for a family member likewise means that one day, the other family members will help you in a case of illness. Such an arrangement does not seem to

[5] See Bossart (2010) for a description of solidarity networks in a case of illness in Cote d’Ivoire

exist with regard to non-family members. Helping a friend in the case of illness thus does not morally oblige him to contribute to the cost of your treatment in case you fall ill one day. Help which comes from outside the family is thus rather an act of generosity rather than being part of a balanced reciprocity. Yet, while financial contributions are not expected from non-family members, an elaborate culture of visiting the sick exists. If someone hears that another person which he knows has fallen sick, he is likely to visit this person to wish him all the best, thus to provide emotional support.

In particular during one occasion, the relations of solidarity in the case of illness became very clear to me. Shortly after I arrived in Central Togo, the mother of a friend in Sokodé was hospitalized with a combination of different grave illnesses[6]. The family was a 'middle class' family, with the father working as the driver at the local diocese and with their children either working or going to school. The family was not covered under a formalized insurance scheme. The CBHI is executed in the province, but is not present in the city of Sokode. Other formal insurance schemes do not exist. During my two week's stay in Sokode, the mother of my friend was in hospital. Even though I visited her on two occasions, the status of her health – in particular when the health deteriorated – was largely concealed from me. As it was obvious that the family was struggling with the cost of her treatment, I decided to support the family with what is a considerable sum of money in the local context. In spite of my rather close relationship with the family, my help was neither demanded nor anticipated, but it was very much appreciated. I also witnessed the giving of small tokens of appreciation of other distant family members, which was mainly constrained to local medicines rather than money. It seemed that being unable to contribute an amount of money they used this as a way to show their support.

Tragically, my friend's mother died shortly after I left Sokode to start my fieldwork in Aouda. In the subsequent week, the funeral ceremony took place in Sokode and Aledjo, her village of origin. When I walked through the area of town where my friend and his deceased mother were living, I encountered several people who were family members of the deceased and had known her for a very long time. I was perplexed when they offered me their condolences. In contrast to them I barely knew her. Likewise, I was uncomfortably treated like a special guest during the ceremonies. When I handed over the money to the family, I

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was unaware of the possible implications. Only at a later stage I understood the bond which I had created between me and my friend's family.

Even though my contribution could not prevent the death, this act lastingly changed the relationship between me and the family. In the subsequent months, I was received like a close friend of the family. Each time I visited the family, the sister of the deceased arranged a proper meal for me and was upset if I would not eat it. Likewise, the widower of the deceased continuously expressed his gratitude for the financial help and the other family members continued to offer me their condolences. While people in Central Togo are in general very welcoming towards foreigners, my relationship with this family had achieved another quality, so I am certain that this 'special treatment' was not primarily due to my special status as a foreigner. Even after I returned from my fieldwork, the communication with the family has continued, and my role during the disease of the mother is highlighted.

My contribution in the case of illness made me once more aware that in case of a grave illness, the immediate and extended family is by far the most important point of reference. However, while this case likewise indicates that the division between family and non-family members is relatively fluid. As a non-family member, I was not expected to contribute to the disease. Still, they accepted the amount which I handed over. Their behavior in the subsequent months – preparing food and continuing to show gratitude – showed me that the family tried to at least somewhat provide me with a compensation for my contribution.

In contrast to the personalized patterns of solidarity elaborated upon so far, SP is based on the assumption of an abstract of solidarity. It means that in the case of illness, the ill and the one who finances the cost of treatment are detached from each other. More precisely, participation in a CBHI scheme requires the willingness to share the cost of healthcare with someone who is not a member of your face-to-face community. During interviews with non-participants, they were overall reluctant to state that they are unwilling to participate in the insurance because they would not agree with the abstract solidarity. Arguably, this is due to the fact that it is socially no longer accepted to openly embrace a personalized view of solidarity in the case of healthcare. However, when asking the interviewee whether *other* people do not participate in the CBHI because they would not agree with the lines of solidarity as propagated by SP, the majority of the respondents

confirms this. A frequent statement is that "I do not participate because I do not have the money, but there are other people who do not participate because they do not like the idea of paying for the health of someone who is not member of their own family" (interview, 15 October, 2012). The wish to keep money in the family is relatively universal. Health and illness is something personal which is not openly shared with strangers. This is also reflected by the attitude of my friend's family described above. While I was aware that the mother was ill, the family rather played down the role of the illness. Until a few days before the mother died, my friend assured me that her illness was slowly getting better, even though it apparently had deteriorated during that time.

To a certain extent, non-participation also seems to be related to a refusal of questioning the existing mechanisms of healthcare financing based on kinship. Given the relevance of the concepts which stand behind these different risk-coping strategies – strengthening kinship-ties as opposed to abstract solidarity - considering participation in SP also forces people to rethink the mode of social interaction. The barrier to do so seems to be relatively high, which might also explain why a considerable number of people so far have not considered participating in the insurance. During several interviews as well as during casual walks with my assistant, I encountered people stating that SP would not be 'their' business. They reasoned that insurance participation would be something that had to be decided by the spouse. Interestingly, this argumentation was applied by both sexes. Often, women saw it as the responsibility of the husband to deal with finance-related matters. Men, in contrast, did not see the health of their children to be within their margin of discretion and therefore did not see the need to think about participation in SP. The reasoning of not being responsible can be used to erect a barrier which shields the person from having to consider the advantages and disadvantages of insurance participation, which would likewise mean questioning customary patterns of action. Similarly, I was frequently met with surprise when I wanted to know why illness is predominantly a family affair, and a frequent answer was: 'That's the way in which things work here'. It seems that the 'power of tradition' is a strong barrier which can lead to unwillingness to consider alternative mechanisms.

To convince people of solidarity outside the realm of the personalized, two different paths can be taken. One possibility would be to embrace a universal solidarity which sees everybody as a potential partner in risk-sharing. This would presuppose a considerable

readiness of bridging social capital. Alternatively, given the prefectural scope of SP, one could Attempt to rely on the bonding social capital which is based on the affiliation to the prefecture of Sotouboua. This means that someone living in village A is paying the costs of hospitalization of someone in village B, acting on the assumption that someone from village C will cover the cost of his treatment one day. However, the prefecture seems to be a rather abstract point of reference, and is to a large extent seen only an administrative entity. While it would already be a challenge to establish a feeling of solidarity on the village level, this difficulty is multiplied on the level of the prefecture. While inhabitants of Aouda would consider themselves as inhabitants of Aouda, only rarely would they refer to their place of origin as the prefecture of Sotouboua.

Consequently, those who have decided to participate in SP do not refer to the possible bonding factor of the prefecture. Rather, they refer to a universal solidarity as a reason for participation. As proclaimed by one participant: “It is good to know that the money which I have contributed is used for another ill person who can now receive treatment. You never know when you fall ill, maybe already tomorrow, I will need to receive treatment.” (11 September, 2012). Often, they evoke the meaning of the name ‘SP’ – Help others before you are helped.

According to one participant, a self-selection is taking place in Aouda, which distinguished the people who are willing to overcome the customary pattern of risk-coping. She stated that “All those who participate in the insurance have shown a willingness to share solidarity with others. SP has created a new bond amongst people who have the will to support each other. It is inside of persons’ heart whether they accept the insurance or not. Those with a good heart will participate“(personal conversation, 29 November, 2012). As such, the creation of SP might lead to a new layer of feeling of solidarity – thus bonding social capital - on insurance participation, which in turn might lead to a new network of social relations. However, so far, this bonding factor seems to be in its infancy, if it exists at all. Besides their affiliation to SP, insurance participation does not establish common bonds of solidarity amongst its members. Currently, it is therefore not seen as a project which creates a large stock of social capital.

This chapter has demonstrated that prior to the introduction of SP, risk-sharing in a case of illness has been predominantly a family-affair. A case of illness in the family creates a

moral obligation to help. In contrast, those outside of the family are not obliged to help, even though their contributions are accepted. In contrast, SP requires its participants to develop an abstract form of solidarity. Besides the affiliation to the same prefecture, no bonding factor is visible, it can consequently be described as bridging social capital. Being accustomed to solidarity on the family level, a large amount of people seems reluctant to engage in risk-sharing which goes beyond the scope of the existing, personalized level of solidarity. So far, the insurance is not seen as a project which creates large amounts of social capital. The next chapter examines the other side of this line of reasoning by examining the existing degree of social capital which is employed to convince people of participation in SP.

4.4. Personalized aspects of the insurance: the engagement of local volunteers

In the prefecture of Sotouboua, approximately 6000 people have been covered by the insurance in 2012. Amongst these, the canton of Aouda is represented over-proportionately with about 800 participants. Given a population of approximately 15300 in 2012 (Programme de Développement Local, 2009), this amounts to an enrollment rate of approximately 5,1%. Likewise, the villages south-west of Sotouboua in the canton of Tchebebe have a participation rate which is higher than average. Overall, approximately 2000 adhere to the insurance in the canton of Tchebebe, which amounts to a participation rate of approximately 8%. Taken together, the cantons of Aouda and Tchebebe amount to half of all insurance enrolments even though they constitute only 26% of the overall population of the province (ibid.). While the enrolment rates are modest in these cantons as well, they are about twice as high when compared to the rates of other parts of the prefecture.

As Aouda has a relatively big number of adherents of SP, the insurance is very present in the village. One can frequently see someone wearing a T-Shirt which was distributed to all adherents. They advertise participation in SP with proclamations such as “Micro health insurance=health at a lower price”[7] or “I am a participant of the health insurance, the health of my household is secure”[8]. Relatively many people in Aouda are

[7] Mutuelle de Sante=santé à moindre cout
[8] Je suis Mutualiste, la santé de mon ménage est assuré

aware of SP and have spent thoughts on the insurance. Likewise, the insurance is subject to a considerable number of discussions. In this regard, it differes from villages with low participation rates, where a considerable share of the population is unaware of the scheme.

The most striking factor which sets these two cantons apart from others is the level of engagement of the elected volunteers. Noel Pagniou, the elected secretary general of the insurance lives in Aouda. Mr. Pana, the president of SP, lives in Agombio, which is situated in the canton of Tchebebe. These two persons are by far the most active local volunteers of the insurance scheme. As a consequence, their engagement has led to clusters of insurance participation in the areas where they are active. This section thus addresses the question under which conditions, social capital as manifested through personalized relations can manage to overcome the focus on face-to-face relations in the case of illness.

As Noel was the research assistant throughout my stay at Aouda, we interacted almost on a daily basis. We were frequently walking through Aouda, and at each of our tours Noel was dealing with insurance-related matters at some point. For example he was asking where 'his' money was in order to remind people that they have not yet paid the fee for the coming year, or people would approach him with issues such as cases of illness or questions about the modalities of participation. The importance of his role in the village for insurance-participation is acknowledged by those whom he has managed to convince to participate: "Without him, many of the people here in Aouda would not have joined. He talks to the people about the insurance one, two three times. He only stops bothering you if you agree that you participate and have paid the fees for the coming year (laughing)." (Interview, 16 September, 2012).

Noel's engagement is not restricted to SP: he is very well integrated into village affairs, and is a sought volunteer for several other development initiatives from Plan Togo and RADAR. He is likewise active in several local initiatives such as a cleaning the village-committee and is managing a student's football team. Being an agriculturalist, he was chosen in a competitive process to receive a prestigious training on entrepreneurship in agriculture and could briefly be seen on TV with the Minister of Agriculture. Participation in that training has further increased his status in the village. Noel is very aware of his integrative role. When accompanying him in the village, he was constantly approached by other people, either concerning some of his project, or just to have a casual chat. One time,

he jokingly proclaimed: “All these people who want to talk to me… I am too popular”. In that sense, he is a much respected member of his community, and he is often asked for advice. During my stay in Aouda, he was additionally approached from people who wanted to know what I was doing in the village. He claims that it was very important to be polite and open to everyone, regardless of age, ethnicity and religion. While having a very integrative personality, he is also speaking up if someone behaves in a rude ways. Likewise, he is openly critical about the (child) labor migration to Nigeria, because, according to him, it would be better or the children to receive a proper education before starting to work.

Asking about his motivation to be active for SP, Noel claims that it has the potential to improve the quality of life in the region, and that it is very important to invest time and effort in it. He was enthusiastic about an improved access to healthcare, as it diminishes the risks in the case of illness. “Before, many people only went to the hospital when it was almost too late. But now, I often see that they go earlier, which is much better for their health. It is also a progress that pregnant woman now receive support during pregnancy and giving birth” (11 September, 2012). Like other proponents of the scheme, also he sees it as a way to improve living conditions by replacing customary patterns – in this case mechanisms in the field of healthcare-financing – with what he perceives as more effective, ‘modern’ mechanisms.

The supervising organizations had introduced to hand over 10% of the fees which each volunteers manages do collect throughout the year for them. This measure is intended to increase the volunteer’s motivation to become and remain active for SP. Asking Noel about the 10% commission which he receives, he denies its importance. “For all the work I do all year long, the amount which I receive is very, very small. And often, I use a lot of this money to make phone calls for the insurance or to buy gasoline to make trips for the insurance with my motorcycle. No, I am not active for the insurance to earn money, but to help improving the living conditions in our village”. I had the feeling that indeed the 10% payment to the volunteers did not make a huge difference. While it definitely is an additional motivation or reward for their efforts, the main motives seem to lie elsewhere.

Next to the philanthropic and the financial motivation to be active for the insurance, also a gain of reputation is of importance. Noel’s activities as a volunteer for the insurance lead to a considerable prestige in the village. It also helps him to establish personal relations

with people in different functions such as the village chief or the head nurse of the USP. Likewise, it offers access to the personnel of local, national and international development organizations. Being himself a prospective chicken breeder, Noel activated his contacts in particular to RADAR to logistically help him with applications for funding for his project. A multi-dimensional symbiotic relationship exists between him and the personnel of the development organizations, which was not only constrained to the professional level. During my stay in Aouda, he was asked several times by different staff members to buy either meat or yams on their behalf in Aouda, which they would later come and pick up. While he was somewhat complaining that he had to do everything which they wanted in return for nothing, he was not in the position to say 'no' to such demands. Given the importance of personalized relations coupled with the relatively high ranks of those who asked him favors, he could benefit from these relations in the long run.

Noel meets up once a week with the animator who is responsible for Aouda once a week to carry out awareness-raising events and to discuss current matters of the scheme. In this role, he is an intermediary between the personnel of the scheme and the needs of the adherents. The importance of such intermediaries is crucial in case of extraordinary problems. In 2012, SP had major issues with its expenditures. Half way through the year, it became clear that without counter-measures, the scheme would not manage to break even in that year. In order to ensure the financial viability of SP, the scheme's General Assembly comprised of elected voluntary members took the decision to increase the co-payment from 30% to 40% from July 2012 onwards for most treatments covered by SP. The General Assembly further decided to increase the annual fee from 2600 CFA to 2800 CFA in 2013, while at the same time reducing the co-payment to the old level from 2013 onwards. The local volunteers then had the task to mediate this information to the adherents of the insurance in the villages. In particular the increase in annual fees was received critically by many of the adherents. However, most of them accepted the increase because of the way in which it had come into being and was mediated to them. As Noel was present during that meeting, he could explain that the decision had been taken by their representatives. Further, he was able to show to the adherents that the scheme could not be continued without the proposed modifications. In this case, the existence of a trusted and well-informed local representative of the insurance was very helpful to mediate a decision which could easily have caused major discontent amongst the participants.

Noel knows that the enrolment rates in Aouda would probably be very different without his engagement in SP. "Normally, the participants are supposed to come to me to hand over the annual fee. But it does not work that way. Instead, I have to visit them three, maybe four times, and sometimes they do not give anything, sometimes they just pay a little bit. If no one constantly reminds them of paying the fees, many people would not renew their participation and the number of participants in Aouda would be much lower" (conversation, 15 October, 2012). In particular during the market days of November and December, he regularly circulates to make people pay the fees for the next year. "Now it is the season to force people to pay because the people have harvested. In October, they did not have money for the insurance because they had to buy schooling material and pay the school fees for their children. But now, they have money for the insurance, especially on the market days when they have sold some of their goods." (Conversation, 10 November, 2012).

In his immediate surroundings, the effect of Noel on the insurance participation is tremendous. As proclaimed by him: "By now, I have managed to convince all whom I call friends to become members of SP". This indicates that a gradual relationship exists between the level of trust to a proponent of the insurance and insurance participation: the closer one is to a proponent, the more likely he gets to participate in the insurance. As a consequence, it shows that within a very narrowly defined target group – in this case the target group would be called 'friends of Noel' – very high rates of participation are possible. The engagement of the volunteers such as Noel can be seen as a possibility to partly overcome the bonding factor on kinship and close friends. Through personalized relationships, especially people close to the volunteer have a strong incentive to insure themselves and their families in SP. They no longer perceive it as entirely abstract, but as a project in which their trusted friend has a say. For the friends of Noel, participation in the insurance is thus something in between personalized and abstract solidarity, which makes it easier to decide in favor of participation. In a way, this can be seen as the effect of social capital which manifests through interpersonal trust, leading to increased rates of participation.

Given the overall reluctance of people to participate in arrangements of solidarity which are beyond the scope of the family, it requires an enormous amount of time, effort and existing trust to achieve such levels. However, as stated in the previous section, often, those who have decided to participate in the insurance are now convinced that the project is something which can be beneficial for their village. It seems that to a certain extent,

engagement of a trusted volunteer such as Noel is the starting point for rising levels of insurance participation in a village. Afterwards, an increase in participation rates becomes self-sustaining, as those who have decided to participate promote the insurance within their circle of personalized contacts. This can also be seen on the change in the insurance-related discourse, which is elaborated upon in the next Chapter. In villages without an initiator of such a process, it seems difficult to achieve a self-sustaining growth of insurance participation.

The existence of an active volunteer is not only of importance in Aouda itself, but also in neighboring villages. In particular in places without active volunteers, people who want to participate in SP prefer to discuss these matters directly with Noel. Also when it comes to paying the fees, most turn over the fees to him rather than to inactive volunteers from their village or barely known animators. Especially the weekly market in Aouda has developed into a place where not only fees from adherents from Aouda are collected, but also from other participants in other villages. Because these adherents prefer to deal with the volunteer who is officially designated to deal with insurance-related matters in Aouda, they then are officially treated as adherents from the village of Aouda. This means that the official number of participants of villages with a well-functioning system of volunteers such as in Aouda is somewhat higher than the number of adherents living in the place, whereas the contrary is true about villages without well-established volunteer structures. By now, Noel has developed quite a reputation for being a specialist in insurance-related matters. In most cases, people from other villages have either known him personally before they decided to participate in the insurance, or they have been referred to them by personal contacts.

The trust towards Noel can also be measured in the amount of money which he collects in Aouda. In November and December, he frequently managed to collect fees of about 30.000-40.000 CFA on a market day, which is enormous amount of money for the local context. All these transactions are based on personal trust: the persons who hand over the money do not receive any proof of payment immediately. Noel writes down the name of the adherents and the amount which they contributed in his notebook, and forwards this information to the animators, who then issue a proof of payment. Thus in the first instance, Noel's integrity plays an important role in the collection of the fees.

I was assured that the presence of Noel made a big difference. On some occasions, the animators of schemes carry out the collection of the insurance fees. However, in such cases many people would come up with excuses if they were visited by the animator alone. They would only pay if the animator was accompanied by a local volunteer whom they knew personally. Thus even though the animator is employed by the scheme and had been visiting the village for years many people feel more comfortable to hand over the fees to their 'trusted volunteer'. During the vast majority of the interviews – stratified and randomly sampled – people throughout Aouda and Nima claimed that they knew about the insurance because Noel has told them about it. This came as a surprise to some of the functionaries of the scheme, who thought that the majority of the people would have acquired knowledge on the scheme during the awareness-raising events which were carried out by the animators and the participating institutions.

In spite of the low rates of enrolment, a large number of people show interest in the insurance when approached by one of the local volunteers. One voluntary member of the insurance stated: "If I sensitize other people about Sina Passenang, those who are really interested pose a lot of questions. Others say immediately that they have understood, but you know that they will not participate" (interview, 29 November, 2012). I was surprised to see how often casual talks with participants and non-participants turned into detailed discussions about the health insurance when Noel was present – partly also during the interviews which I conducted as part of my sample. Due to the reputation which Noel has managed to build up, many people are relatively open to discuss insurance-related matters with him. However, also here, it is necessary to establish personalized bonds between the volunteer and the person who might be interested. Throughout my stay, Noel wanted to visit a mess of the Assembly of God to sensitize people about the insurance. Being a Catholic, he did not know many people there. However, the family of the preacher was member of SP and agreed to let Noel explain the scheme. Before Noel started to explain the scheme, he pointed out that the preacher himself was a member and asked all other members of SP to stand up, so that the rest of the congregation could see who else trusts the scheme already.

Picture: Noel Pagniou sensitizing for SP after a service of the Assembly of God

As reported in the literature review, prior research on other schemes has established that the understanding of CBHI of many prospective participants is inadequate. Also in Aouda, these aspects are crucial. The level of detailed knowledge about the insurance is deficient in different ways amongst members as well as non-members. In Aouda, many participants did not exactly know what illnesses are covered by the insurance and which ones are not. Also, they could not exactly recall to how many percent the co-payment amounts. It seems that what matters for many people to participate in the insurance is not only a mathematic calculation of how often they need to get sick in order to financially benefit from the insurance.

What rather matters is the *feeling* that the insurance is beneficial for them[9]. Many entrust the decision on the insurance on the local volunteers – provided that they trust them. In the case of Aouda, Noel has become a kind of 'risk-manager' for those who have decided to participate in the insurance. Several respondents claimed: "I know that it is a good project because I know Noel very well. He would not try to convince us to participate if

[9] This is not meant as an Orientalist statement. Adherents in Europe would probably behave similarly. Still, to elaborate on this aspect in this context is crucial to better understand patterns of enrolment.

it was not a good project" (interview, 19 September). As such, he is also the primary contact person if problems with the health insurance occur, either administratively or when it comes to treatment in the hospital. For many participants, it is crucial to have a trusted person who takes action on their behalf, and to whom they can turn to in the case of problems.

However, it would be misleading to attribute the difference in participation rates solely to the engagement of a single volunteer. IN this respect, it is helpful to compare the case of Aouda with the case of Agombio, where the president of the scheme lives whose impact on insurance participation is similar to Noel's in Aouda. While the engagement of these individuals is absolutely crucial for the high participation rates in these villages, their local support structures need to be taken into account as well. In the case of the President, he can rely on a solid network of very active volunteers in Agombio and the surrounding villages. This means that the responsibility is shared amongst many, with the President coordinating the volunteers' work. In contrast, in Aouda, the volunteers are only modestly active. Even though the volunteers' structure exists, most of them do not feel an urgent need to promote the insurance, so it is up to Noel to be the first and foremost contact person for insurance-related matters. When I was asking Noel who would be the most active volunteers of the insurance next to him, he told me that some of them had convinced one family to insure, while the engagement of the other volunteers has not led to any visible results. This stands in stark contrast to the engagement of Noel, who –as described before – is very active for the insurance and has managed to convince a considerable number of people to participate.

Picture 3: Lunch at the President of the insurance (left) at Agombio with Noel Pagniou (second from left), René (Animator from RADAR) and the wife of the President

The Chef Canton plays a crucial role in Aouda. Since the launch of SP, he is very supportive of the project. During a meeting of all Chef Cantons of Sotouboua in the preparatory phase of the project, he raised the word to speak out his support for the scheme, whereas the majority of the chiefs preferred a 'wait-and-see' attitude. He and his family are members of the insurance as well, and the chief is also frequently present during insurance-related meetings. Frequently, Noel and the Chef de Canton collaborate when it comes to the insurance. As proclaimed by Noel: "When I go to the villages, I always get a signature from him before to make sure that people will listen to me "(personal conversation, 18 September, 2012). Given the prominence of the Chef Canton, his backing is probably a relevant factor for the spread of the insurance in Aouda. In sum, while there is no 'standard formula' for the environment where local volunteers can be most effective, it seems that at least some kind supportive structures needs to exist for effective promotion of the scheme.

This section has shown how personalized relations as manifested through engagement of the volunteers is one possible to overcome the issue of abstract solidarity. While this does not mean a profound change of abstract risk-sharing, the majority of the people feels more comfortable when such a scheme is promoted by a trusted member of their community. These multipliers are crucial to understand how patterns of social capital are changing in Aouda. It seems that Noel's engagement has enabled an environment which is conductive of high participation rates. In villages without active volunteer structures, such self-sustaining engagement is difficult to establish. The start of the process which was bound to set the participation rates of Aouda apart from that of other villages was Noel's recognition that promotion of SP would be beneficial for the community and for him. Supported by the Chef Canton, he lobbies heavily in favor of SP. His esteemed position in the village enabled him to convince a large share of people of participation in SP. In doing so, he has become a kind of 'risk manager' of those people, which was again only possible due to his role in the village.

4.5. Interaction between the solidarity of SP and customary patterns of solidarity

Those who participate in SP have established an additional layer of risk-sharing. Next to the kinship-based solidarity, they are now also entitled to help from SP in the case of illness. However, in contrast to kin-based solidarity, they do not have moral obligations towards Sina Passenag. While the family-bound solidarity is mainly characterized by the social interaction in the case of illness, participation in SP is more individualized. Indirectly, SP has thus the potential to favor an individualistic culture by partly replacing family-bound networks with an abstract, individualistic notion of solidarity. Also other institutions related to a 'modern' lifestyle have proven to have such an effect in similar contexts. In particular, Pentecostalism is an a influential way to break with obligations towards family and the community, holding that instead of relying on personalized relations, one only has to justify in front of God (for the effect of Pentecostalism amongst the Kabye see Piot, 2010, p. 103 ff.). At its core, also a project such as SP has the potential to lead to a weakening of the customary relations within society. This section examines in how far those who participate in SP use this option to 'escape' from kinship-based notions of solidarity. In order to verify or

falsify this hypothesis, this section compares the effect of insurance participation on the health seeking behavior and the structures of payment in the case of an illness between the two models of solidarity.

A frequently stated reason for insurance participation was the possibility to visit a health facility without having to fear a high amount on the bill. As stated by one of the participants, “now I no longer fear going to the hospital. Before, I was hesitant because I knew that it would be very difficult for me to pay the bills, but I was ashamed to admit this to the doctors. If they prescribed three kinds of medicine, I had to make the choice which one I would like to have, because I could not afford to have all of them. Now with the insurance, I can afford all the medicine I need, because I only have to pay a fraction of the entire price” (interview, 29 November, 2013). Likewise, the relatively low cost of treatment in the USP leads to adherents seeking treatment earlier than non-adherents. It seems that the insurance has indeed contributed to a fundamental change in the health-seeking behavior of the adherents. Receiving healthcare at the USP has become much more affordable for adherents. Also the nurses are cautiously positive about these aspects. While they sometimes struggle with overconsumption of the adherents, the positive aspects – seeking treatment earlier and being able to afford all prescribed drugs – prevail.

For non-adherents, finding money for treatment at the clinic is more difficult. As only very few families have larger cash reserves, they frequently have to sell some of their assets even for minor treatments. As explained by one non-participant: “If I or one of my children gets sick, I try to go to the hospital, but it is very expensive. Maybe I sell some of the food we stock so that I can pay the bills. But sometimes, it is very difficult to find the money, so first, I try to cure the disease with herbs” (13 September, 2013). According to the nurses, those who are not member of the health insurance tend to visit the clinic at a later stage, often after they have relied on other kinds of treatment such as auto-medication or medicine from the herbalists.

Interestingly, the importance of family members was only rarely mentioned when inquiring into the sources of healthcare-financing. For the vast majority of illnesses, the point of reference is not the extended, but the nuclear family – father, mother and the children. First and foremost, they themselves are responsible for seeking money for treatment. As stated by one respondent: “I cannot ask my father or brother for help each time one of my

children is sick. I will find money myself" (interview, 12 October, 2012). It seems that for having to ask the family, the illness has to be very grave. Such a measure is only taken as a last resort. Next to the seriousness of a disease, another precondition for the extended family to help is a certain level of wealth. For members of the family who are not particularly wealthy, it is more common to show one's support through the provision of low-cost items, such as for example small quantities of (traditional) medicine. However, even if there are family members who are relatively wealthy – in particular when talking about distant relatives - it is common that they have to be approached several times before they provide help.

Being intended as a micro insurance mainly for farmers, the annual fees as well as the benefits which can be derived from SP are very basic. Most grave diseases are excluded, which is also a recurrent criticism on the insurance. The insurance covers almost entirely 'high probability/low cost' events as opposed to 'low probability/high cost' events. Besides certain pediatric consultations and cases of difficult birth which are carried out in the regional hospitals, the only high-cost event which is covered by the insurance is snake bites. Likewise, treatment for chronic diseases such as HIV/AIDS is excluded. The insurance focuses thus rather on diseases such as Malaria which can be treated cost-efficiently at the local USP. However, in combination with the tendency to pay one's own expenses for minor treatments this also means that the insurance has the potential to prevent the members from extreme expenditures only in very rare occasions. Indeed, it frequently occurs that those who are insured still face major risks in the case of grave illnesses.

Six months before I arrived in Aouda, the wife of Noel had experienced difficulties during childbirth. Even though childbirth is generally included in the insurance, the coverage is confined to the actual process of giving birth. Subsequently, the wife was hospitalized in the regional hospital of Sokodé, where one of the most reputable gynecologists of the region works. In order to provide food and mental support to her, my assistant camped in the corridor of the hospital for several weeks. At the end, she tragically died several weeks after having been hospitalized. As such a case was not foreseen to be covered by the insurance the costs of the hospitalization were to be taken over by my assistant and the family of the wife. At that time, Noel had launched a business in the field of chicken breeding. However, as the period of hospitalization of his wife grew longer and the cost of treatment rose, he had to sell the chicken and parts of the equipment to pay the bills. During the time of my

stay in Aouda, he still had not financially recovered. As he proclaimed: “I have no mone lefty, no chicken, and my wife could not be saved” (personal conversation, 25 November). He explained that next to him, the burden to pay for the hospitalization was mainly on the family of his wife. There were no clear rules on who had to pay what share of the hospital bills. It was clear that both sides would go until the limit to cover the costs of hospitalization, even though the main burden of it was on my assistant. In spite of his participation in and engagement in the insurance, the death of his wife left him financially ruined for at least an entire year.

This example provides an interesting case to see how one’s personal situation is gravely effected in the case of an illness notwithstanding participation in SP. SP’s focus on low-expenditure high-occurrence events does favor seeking earlier and more effective treatment at the clinic, but it is not an institution which can typically be relied on in the case of hospitalization. For the events which are covered by the insurance, the financial burden is usually borne by the nuclear family. While non-participants are often forced to rely on substandard-treatment for minor diseases which would be included in the health insurance, there is hardly any difference between insured and non-insured when it comes to grave illnesses which require financial contributions from the entire family.

In turn, this indicates that unlike other mechanisms such as Pentacostalism, insurance participation does not lead to a fundamental altering of customary networks of solidarity. However, one needs to exercise caution not to oversimplify matters. This section does not exclude the general possibility of altering family-based networks of solidarity as a result of insurance-participation. In individual cases where adherents of SP are entitled to a major treatment at the hospital, it can indeed be the case that they are less dependent on bonds of kinship. However, given the small number of these cases, so far they do not seem to have the potential to alter the overall kinship-relations in a case of illness.

4.6. Unfamiliarity with risk-sharing

So far, this chapter has shed light on how different aspects and ideas of solidarity can influence the decision to participate in SP and the potential of SP to change existing perceptions of solidarity However, next to issues related to solidarity, the perceptions of the concept of ‘risk-sharing’ is likewise crucial to better understand enrolment rates. Risk-sharing is one of the fundamental concepts of insurance. Formalized insurances presuppose

that all those who are willing to share the risk pay into one account, and during the assigned period those who are hit by the risk get reimbursed. Those who are not hit by the particular risk have made a financial loss in that particular time, but they do have the certainty that they will be covered in case the insured event takes place. In contrast, those who are hit by the risk are likely to get more than the amount which they contributed before the assigned period has started. Participation in a formalized risk-sharing scheme creates winners and losers in terms of financial capital.

In Aouda, the idea of an abstract institution which formally regulates risk-sharing is uncommon. Up to now, the idea of contributing something and possibly receive something back at some point is restricted to informal risk-sharing arrangements such as kinship-based arrangements. However, also here, risk-sharing is only active to a certain extent, and a large amount of risks is to be borne by each nuclear family. Before the execution of the scheme, a feasibility study has elaborated on several insurance-related aspects with regard to CBHI. Amongst others, it has shed light on forms of cooperation in the region. The report has established that numerous work-related associations exist such as agricultural work groups or similar arrangements in the field of commerce (Al Khourdi, 2005, p. 45).

One of the most visible forms of cooperation in Aouda are agricultural workgroups amongst Kabye men. During different periods throughout the year, they come together for different tasks, depending on the season. They are particularly active during harvesting and planting season, when labor is very high in demand. These work groups consist of 10-20 men, who work on the field of one farmer for one day, and switch fields on the next occasion they come together. In this way each farmer can rely on the help of the whole group if he himself contributes to the fieldwork of others. After the day on the field, the men participating in the group gather and enjoy one or two bowls of millet beer provided by that day's field host.

The question thus emerges in how far such kinds of arrangements could be seen as a precondition for schemes such as the CBHI. SP as well as the workgroups requires the participant to contribute something at an early stage to benefit from it at a later point – in the case of the CBHI with money, in the case of the workgroups with labor. However, in contrast to the CBHI schemes, the workgroups do not produce winners and losers: everyone's field is worked once – there is thus no risk involved to be worse off by

participating. Rather than being labeled risk-sharing arrangements, these workgroups resemble more a balanced reciprocity of personalized solidarity. In contrast, SP can lead to a financial loss if one does not fall ill. Also other institutions of cooperation which were described in the feasibility study resemble balanced reciprocity rather than risk-sharing arrangements. Similarly, arrangements are in place for a case of illness. As stated before, a person has the moral obligation to support another family member who has fallen sick, acting on the assumption that during one's next case of illness, he will contribute to your health. The idea is that in the long run, the benefits equal out.

The evidence presented is close to Platteau's argument introduced in the theoretical chapter that the idea of risk-sharing is not common in many societies. As stated by one of the non-participants of the insurance: "You never know if you get sick, and I know that you do not get the money back if you do not get sick. I am a farmer, so for now, I prefer not to participate in the insurance, but to stock foodstuff with the money I have. If I get sick and if I have to go to the clinic I can still sell some of my foodstuff"[10] (personal conversation, 29 November, 2012). It thus seems to be the case that at least partly, risk-sharing is a concept which is not well understood. In particular at the beginning of the schemes, the vast majority of people were unfamiliar how the insurance would work. A frequent question was whether a person who would not get ill during the entire year would get his money back. Given the previous experience with balanced reciprocity and unfamiliarity with risk-sharing, such a question makes perfect sense. In its fifth year, especially those who have not come into contact with the insurance still pose this kind of questions. However, it needs to be questions whether unfamiliarity with risk-sharing is a factor in its own right. Rather, it is useful to connect it to the patterns of solidarity. As established above, overall levels of trust in Aouda are relatively low. In this case, it seems that the low levels of trust result in an environment which is not conductive to the establishment of a culture of risk-sharing.

However, also amongst those who have already been told about the insurance, a general skepticism seemed to exist about a project where the benefit is only potential. As explained by one respondent: "If someone decides to contribute and does not get sick, he

[10] The respondent was amongst the only ones to openly spoke about his disliking of paying something while not knowing whether you get anything in return. He and my assistant were Business partners, and I suppose that it was their level of trust which made him feel at ease to share this thought with me. However, even he was reluctant to state this reason, stating first of all that he would not participate because he does not have the money

will say that the insurance has cheated on them" (interview, 9 October). Moreover, according to one volunteer, some argue that the insurance makes them sick: "If someone buys the insurance for him and his family, it can occur that they get sick with a disease which is not covered under Sina Passenang. Then they say that they lack the money to treat that disease because they have already invested very much in the insurance. These people fail to understand that Sina Passenang does not include everything and that other diseases are not included" (interview, 29 November). Especially given that SP focuses mainly on treatment of high-frequency low-expenditure illnesses, if a serious condition occurs which is not covered by SP, money which has been paid to the insurance can turn out to be missing to pay the cost of treatment in the hospital.

This section has established that unfamiliarity with risk-sharing can be an important aspect which deters people from insurance participation. As so far, arrangements of balanced reciprocity are prevalent in Aouda, the idea of solidarity as involving winners and losers is not well established. This is true about arrangements such as rotating work groups, but also about the line of reasoning in customary solidarity arrangements in the case of illness. As this kind of solidarity is propagated by SP, this might increase people's reluctance to join.

4.7. Comparison between SP and the Groupes Gvec

Next to the CBHI project, another development-related initiative is very present in rural Sotouboua, namely a local savings scheme called "Groupes Gvec" (GG). Several aspects of the GG are similar to the CBHI scheme, while others are different. In contrast to SP, overall participation in these groups is relatively high, also in villages where SP has difficulties to achieve a satisfactory level of enrolment. The GG are generally considered as a successful development project, also because it is considerably less costly than the elaborate setup of the CBHI schemes (interview with Fritz Foster, Director of Plan Togo, 2 October, 2012). A comparison between SP and the GG is useful to work out which aspects of the schemes lead to different participation rates which in turn has the potential to stress the claims of this chapter.

In variations, the idea of local savings schemes has existed for a considerable time in different contexts outside of Central Togo (cf. Rutherford, 2000). The core idea is to create

self-governed micro financial institutions in areas where financial institutions do not operate. The aim is to provide access to financial services which provide them an opportunity to save money. Due to the success of the project, the idea of local savings groups has been replicated by different NGOs in numerous contexts (Anyango et al., 2007)

Like SP, also the GG are financed and coordinated by Plan Togo. Similarly, they are executed in several provinces and executed by local partner organizations. In the prefecture of Sotouboua, RADAR is responsible for the execution of the GG as well as SP. For both projects, animators are employed by RADAR. However, in the villages, the animators for the GG operate largely independent from each other, and the institutional cooperation between the schemes is still in its infancy. Only in late 2012, synergy between the two schemes has emerged as a major field of activity, aiming at improved participation rates – in particular in the CBHI schemes – from cooperation with the GG.

In contrast to the CBHI, the GG do not have a central office where the project is coordinated. Instead, the project is executed in a decentralized manner with the groups operating independently from each other and largely autonomous from RADAR. Each of the savings groups comprises 15-20 members, mostly originating from the same neighborhood. As the GG program has a strong focus on the empowerment of woman, the majority of the participants in each group have to be woman to ensure that they have the say in the financial affairs of their group. Each week, the members meet on specific day, time and place to make a financial contribution. The groups have target contributions which in most groups either amount to 750 CFA or to 1000 CFA. Members can also contribute less than the full amount, even though a certain social pressure does exist to contribute as much as possible. The contributions are made publicly, and no one wants to be the person who is contributing the lowest sum. Moreover, each member has a personalized booklet, where he receives stamps according to the contribution made during the meeting. Next to the regular contribution, each member has to pay a weekly solidarity-payment of 50 CFA. Money from the solidarity fund is used to provide support the sick. In the case of sickness of a group member, he/she is then provided with 1.000 CFA.

Picture 4: Meeting of a Gvec Group in Nima

Each group possesses a cash box where the money is kept. After each meeting, this box is locked with three keys, which are then handed over to three members of the group to ensure that no one can take money from the box[11]. Once a year, the content of the box is cashed and member receives what they have contributed throughout the year. Given the weekly payments of up to 1.000 CF, the individual amount frequently surpasses 30.000 CFA - an enormous amount in an environment where money is scarce. Most of the groups split the savings in June or July, the time before the harvest, when money is chronically short. However, other groups have different times of cashing their saving. There, the money is frequently used to stock grains in advance, to invest in petty commerce, or to buy schooling material for their children. Recently, the supporting NGOs are now attempting to convince more people to use the money from the GG to enroll in the health insurance.

Each GG is steered by a board, which in turn is led by a president. These positions are filled based on elections from the group's members. In addition, each group has an own

[11] This system has originally been developed in the 19th century British "Friendly Societies" and has proliferated since then

name which is chosen by the group. The groups possess an elaborate code and rules for penalties, for example for coming too late to one of the meetings. This code is a written document, which has been signed by all members. At the beginning of each meeting, some of the rules and regulations are red out in order to remind members of their rights, duties and obligations. The statutes of the GG have been drafted by the Plan, and the groups have to fill in details such as the name of the group, the contributions, the office-holders and the location. The individual groups thus have only limited possibilities to influence their statutes.

As part of these statutes, also the solidarity payment must be accepted by all groups. In particular in the beginning, this caused some stir amongst members of the groups. As one woman explained who was a member of the GG since the launch of the project: "in the beginning, some people complained about having to pay 50 CFA extra each week because they saw it as an unnecessary expense. By now we have been accustomed to the payment, and we have realized that it is very helpful, so there is no more opposition to it. But we would not have come up with this ourselves" (Interview, 19 September, 2012). The reservation concerning the solidarity payment seems to be similar to the one which SP has to face – after all, both are similar forms of risk-sharing.

Next to being entitled to 1.000 CFA from the solidarity fund, members of the GG can also borrow money without interest from the group in case they become ill. In case a family member gets ill, they can likewise borrow money, but with interest. This interrelation between the GG and healthcare financing leads to a potential influence on insurance participation. However, it has not been possible for me to reveal whether the participation in the GG is a positive or a negative factor for enrolment in SP. On the one hand, SP could profit from people who save money and then use it to buy the health insurance. Likewise, the increase in cooperation between the two schemes can lead to increased enrolment rates in SP, in particular given a rule introduced in 2013 that members of newly founded GG have to become a member of SP as well. Thirdly, familiarity and satisfaction with the work of RADAR and Plan might increase the willingness to participate in another of their schemes. On the other hand, participants of the GG might decide that they do not need to buy a health insurance when they are entitled to money from the solidarity fund and have access to credit via the GG in the case of illness. During my stay, I encountered both evidence for both hypotheses.

As this section so far has established, SP and the GG share several characteristics. First of all, the two projects are executed by the same organizations, Plan and RADAR. Even though different animators are responsible for the supervision and animation in the villages, people are aware that RADAR and Plan are the organizations which stand behind the schemes. The success of the GG supports the data collected in Aouda that a lack of trust towards the organizations executing the scheme is not relevant for the low enrolment rates of SP. Moreover, the GG as well as SP require their adherents to invest money now and to benefit from it at a later stage. This indicates that the concept of saving money for a later point in time is not problematic as such, and the low enrolment rates are not primarily due to an unwillingness to spend money for a future benefit. Nevertheless, it must be noted that 'health' is a special case in this regard, and that the experiences from the GG are not indirectly applicable to SP in this regard.

For participation both in the GG and in SP, prospective members need to have a certain amount of money readily available to invest. The GG are successful in villages where there are hardly any participants. Likewise, a considerable number of people in Aouda is member of the GG are not a member of SP. Also in groups who split the money between October and December – the period when the fees for the insurance are due – the majority prefers to invest the money in foodstuff rather than in the health insurance. Even though this is bound to change with the compulsory link between the two schemes, the strong participation in the GG suggests that a lack of money is not the primary reason for low enrolment rates in SP.

Next to the similarities, several conceptual differences in the setup of the schemes can be observed which relate back to the arguments put forward in this chapter. Firstly, the solidarity which is required by the GG is a different one than the one asked for by the insurance. In contrast to SP, the GG are based on a personalized notion of solidarity. The participants have known each other personally before the introduction of the scheme. While this setup has the potential to strengthen solidarity within the group, already the creation of a new GG presupposes mutual trust amongst its members. The groups are built on at least one common denominator amongst its members, in most cases the know each other either through neighborhood. Interestingly though, in Aouda it is not uncommon for groups to be ethnically and religiously heterogeneous. This could indicate that in the case of the GG, personal relationships are valued higher than trust established around lineage, ethnicity or

religion. As established before, a personalized nature of interaction is prevalent in Aouda, whereas an abstract concept of solidarity is seen critically. Therefore, it seems likely that higher participation rates in the GG are at least partly due to the notion of solidarity being more in line with pre-existing ideas.

In relation to the difference with regard to solidarity, the different fields of action of the two projects seems to be relevant. In contrast to SP, the GG are not seen as an institution which is primarily concerned with health care, but is situated rather in the realm of commerce. However, as demonstrated above, the realm of commerce and the realm of healthcare operate according to different paradigms. Whereas healthcare financing is exclusively a family affair, commerce is based on personalized relations. Health can thus be seen as a 'special field' in this respect. As a consequence, while the GG is in line with the local ideas in the realm of commerce, the pre-existing patterns of interaction differ in the case of SP.

Moreover, the personalized nature of the GG drastically reduces the incentive of cheating the group. As the members of the GG choose with whom to create the group, a certain level of trust is a prerequisite for the launch of a new group. In addition, continuing social control is very strong. As explained by one participant: "We have never had a case where somebody did not repay money which he had taken from our group. If someone does not pay it back, it will be very difficult for him to find a new group to participate, because everyone knows that he is not a honest person" (interview, 10 December, 2012). Especially in a rural area where most people who live in the same village know each other, such an effect is crucial. In contrast, the personal trust in combination with social control is not very well developed in SP. As it is based on an abstract form of solidarity, diminishing fraught cannot be executed by a reliance on social control. Instead, the participating institutions had to come up with an elaborate system of checks and balances described in Chapter 3.

The divergence in performance between the GG and SP can also be seen as a confirmation of Platteau's (1997) hypothesis of the unfamiliarity of risk-sharing in 'traditional rural communities'. Unlike in the case of the CBHI, participants of the GG know that they will receive the same amount which they have contributed. Consequently, there can be no winners and losers. When participating in the GG, the members not only have the certainty to receive the amount which they contributed, they further have the possibility to access

credit in the case of urgent needs. In other words, it is perceived as an institution which is producing money, as opposed to the image of the CBHI as consuming money. The only risk-sharing element which is present in the GG is the weekly solidarity payment. The initial skepticism against this measure needs to be seen in this light as well – risk sharing as introduced by the development NGOs has a difficult position in Aouda.

To conclude, this section compares the CBHI with a local savings scheme which is executed by the same set of NGOs. It is established that considerations of solidarity and risk-sharing are central in determining enrolment rates in development projects. In contrast to SP, the GG scheme is largely in line with local perceptions on these matters. The savings groups do not require an abstract idea of solidarity, but are executed amongst a small group of people which normally have known each other before. Moreover, the GG do not require risk-sharing. As all members are entitled to the amount which they have contributed, there are no winners and losers.

4.8. Summary

This chapter has shed light on how aspects of solidarity and risk-sharing have contributed to low rates of enrolment in SP. So far, almost all transactions are based on personalized relations. In the case of an illness, solidarity is executed first and foremost in the circle of the family. In contrast, SP requires adherents to favor an abstract, impersonal solidarity. Many people in Aouda do not feel at ease with an abstract concept of solidarity, in which they are obliged to share the risks with strangers.

In a next step, this chapter has shown that the engagement of local volunteers can make a big difference for participation. In villages with active volunteers, the enrolment rates are considerably higher. For many, personalized contact to a trusted volunteer seems to be a possibility to overcome the impersonal risk-sharing of SP. In particular amongst people close to volunteers, participation rates are very high. Social capital as manifested through personalized relations to a volunteer seems to be responsible for a large part of the rates of enrolment in SP.

Furthermore the chapter examined to what extent the SP scheme has the potential to change conceptions of solidarity in the village. Even though participation in SP has the potential to favor an individualistic concept of solidarity, it is unlikely that it has the effect of diminishing kinship-bound networks of solidarity. The insurance focuses mainly on low-

expense diseases, whereas the extended family is only supposed to help in grave cases of illness. Therefore, both participants and non-participants are similarly dependent on the extended family in the case of major diseases.

In addition, the chapter has established that the prevailing conception of risk-sharing is a major detrimental factor for participation in SP. So far, cooperation has been taking place based on balanced reciprocity, whereas risk-sharing which produces winners and losers is seen as a new concept. The importance of abstract solidarity and risk-sharing has lastly been exemplified by a comparison with a local savings scheme. In contrast to SP, the savings groups rely on small, personalized groups in which the saving takes place. Moreover, the savings groups are not based on risk-sharing, thus all members know what to financially expect from participation.

5. Low Rates of Enrolment II: alternative explanations to social capital and risk-sharing

5.1. Introduction

The previous chapter has shown how aspects related to social capital and risk-sharing are crucial to understand low enrolment rates in SP. This chapter seeks to confirm or refute the centrality of the previous chapter by elaborating on alternative explanations for participation in SP. This chapter elaborates on additional aspects from the three fields of research on participation in CBHI schemes: the individual- and household level, the supply side (e.g. setup of the scheme and the health facilities), and the socio-cultural context.

More precisely, this chapter deals with the following issues. First, the image and perception which people have about health, insurance and healthcare prevention are elaborated upon. Next, the relevance of the supply side is examined, first testing the satisfaction with the health care providers and second with regard to possible constraints based on the setup of the scheme. After that, insurance participation in relation to income is studied, first in relation to 'higher than average' income, and then concerning 'lower than average' incomes. With regard to participation amongst people with a higher than average income, in particular the introduction of a new nationwide compulsory health insurance for

government workers is relevant. In relation to lower incomes, the most frequently stated answer for non-participation “I don’t have money to participate” is investigated in more detail.

5.2. Perceptions of health, healthcare and illness

One of the possible explanations for low participation rates could be that being ill is not perceived as a situation which must be overcome by all means. As argued in the cultural theory of risk perception, risks are not perceived in the same everywhere. As a consequence, risk coping strategies such as insurance are not universal either (Douglas, 1982; Ewald, 1991). Only once something is constituted as a risk, there need to be coping strategies. A plausible hypothesis is that in a notoriously risky environment where insecurity abounds, health and illness is taken as being normal. Indeed, many behaviors which would be seen as risky by most people in other countries are not considered to be overly risky in Togo. For example, helmets for motorbikes are something which hardly anyone uses, even if they are available. As explained by an informant: “I know that I am at risk when I do not use a helmet, but I do not have the habit, so I do not use it” (personal conversation, 20 November, 2012). This small anecdote shows that in some cases, risks and risk-coping strategies are indeed perceived differently, and thus can be context-dependent.

However, inquiring into health-related matters, it seems that the contrary is true: being ill is perceived as a major risk by most interviewees. Being healthy is indeed of utmost importance, which is also reflected in a range of institutionalized rituals. On the first of January, people greeted me and each other with “Happy New Year, it’s health above all” People reason that if you are not healthy, you cannot work either, so all effort should be invested in being in a state of good health. As not being able to work easily leads to financial problems – possibly followed by a shortage of food – being healthy is absolutely necessary. Also in relation to SP, this argumentation was frequently employed to highlight the importance of being insured. Given the relative absence of high-level medical treatment, an illness can easily lead to severe conditions. Also diseases which would be curable in other parts of the world can turn out to be very dangerous to one’s life in Central Togo, so it is imperative either not to fall ill in the first place, or to have the capacity to react quickly in a

case of illness. Thus, the general significance of falling sick would rather speak in favor of strong participation rates in the CBHI scheme.

While the fear of falling sick seems to be universal, different systems of healing exist in Aouda to which one can turn to in a case of illness. More specifically, the predominant healing practices are difficult to understand without being set in the proper context. As argued by proponents of medical anthropology, “healing…is obviously rooted in the social and cultural order” (Feierman and Janzen 1992, p. 1)[12]. These different perceptions of healing in relation to the social and cultural order became clear during the insurance’s attempt to reduce the average cost of treatment, which was seen as a prerequisite for the financial viability of SP. The main point of contestation was whether a sick person has a right to choose his/her own form of treatment or whether he has to accept the treatment prescribed by the nurses at the clini. Often, this conflict culminated in the question whether the sick person receives pills or whether he is entitled to an injection. An injection – typically a shot of penicillin - is the form of treatment which is by far the most prestigious one. Regardless of the disease, many people are convinced that only an injection can heal them properly[13].

The preference for injections does not seem to be necessarily related to the purely medical achievements of injections, but rather to the belief of injections as being the *ultima ratio* of modern medicine. The reasoning was that everyone can give you a pill to swallow, but if you get the medicine pumped right into your blood, than it must by definition be a more effective treatment. As one of the animators from RADAR stated: “People who are prescribed *Paracetamol* will be disappointed. In contrast, someone who gets an injection will consider the treatment to be good, regardless of whether it cures the disease better than the pills.” (Interview, 21 November, 2012). Whenever possible, the insurance preferred the application of pills instead of injections because they were cheaper. The most widely prescribed drugs were Guatem and Paracetamol: Guatem is the state-subsidized standard treatment against Malaria, and Paracetamol a very affordable painkiller (approx. 1 Eurocent

[12] For a discussion about the interaction of different paradigms of healthcare see Marsland (2007), Hampshire and Owusu (2013); for a general discussion about medical anthropology in Africa see Feierman and Janzen (1992).
[13] The ‘cultural appropriation’ of injection practices has also been established in other regional context. For an overview about a discussion about the preference for injections based on field studies in Uganda and Indonesia see: Van Staa & Hardon (n.d.), pp. 18-28

per tablet). The preference for these pills led to the insurance's nickname 'Assurance ParaGuatem' (Dieudonné, presentation in Sokode, November, 2012).

The nurses at the clinics told me about frequent cases where the patients demanded an injection instead of being prescribed pills. They were critical about this attitude: "They do not respect what I prescribe, even though it is me who is the professional. I know what drugs can cure their illnesses better than they do. Regardless of that, they think that they know better and demand me to give them an injection" (interview with the nurse in-chief, USP Agombio, 21 November, 2012). Cases in which people perceive pills as equal are rare. The president of SP told me: "A while ago, I was feeling a pain in my hip, so I went to the clinic. There, I received a shot of penicillin, but the pain did not get better – on the contrary! I could still feel the spot where I received the injection weeks later, and it was difficult for me to walk. So now, if I have the choice between an injection and a pill, I say: Never again an injection" (interview, 21 November, 2012). Up to now, it seems that only in cases where people have made negative experiences with the application of injections, they refrain from preferring them.

The demand for one's treatment of choice must also be seen in relation to pre-existing nurse-patient relations. Before the introduction of SP, everybody had the habit of being his/her own doctor to a certain extent. Most people are used to making decisions on what kind of treatment they wishes to receive and how much they are willing or able to pay for this service. Depending on one's choice, several options exist. One could rely on auto-medication by buying local medicines or imported pills on the market, or collect herbs, visit healers, or seek treatment in the hospital. Likewise, one could visit the pharmacies which are attached to the USPs and demand a certain medicine. In addition, it was common to seek treatment from more than one healthcare provider. While the majority of the population relied on auto-medication first, they tended to switch to another health care provider if they were not cured. In doing so, it is also frequent to switch between the different systems – thus those who visit the healer first would visit the USP at a later stage or vice versa (Dekker et al., 2010). Moreover, as explained above, it is common to demand a certain type of treatment in the hospital.

The introduction of SP has led to limitation of one's agency concerning the choice of healthcare. Neither alternative providers of healthcare are included in the insurance, nor do

the adherents have the right to the treatment of their choice in the clinic. The difference between participants of SP and non-participants with regard to the choices of treatment is also confirmed by the nurse at the clinic of Agombio: “There is a difference between those who participate in SP and those who do not. Those who are not member of the insurance can choose their treatment freely. If there is a disease where pills and injection have the same effect, we advise them to take the pills, because they are cheaper. But if they want to have the injection, we will give it to them, but of course they need to pay for it. If there is a similar situation with a participant of the insurance, we tell him that under the coverage of the insurance, he is only entitled to pills, because an injection is not required from a medical point of view. If he wants to have an injection, he has to pay the full amount himself” (interview, 21 November, 2012). From a patient’s point of view, the insurance is expected to include the whole range of treatment from which the patient can choose. Even though it does make sense from an economic and medical point of view for the insurance scheme to opt for cheaper but equal treatments, it creates the unintended consequences of disappointed adherents if the treatment which they are prescribed is seen as being substandard.

However, not only the choice of treatment matters with regard to participation rates in SP, but also how the scheme is perceived. In other CBHI schemes in West Africa, a frequent concern which has been raised was people’s unwillingness to join because of the meaning attached to saving money for the case of an illness. In Burkina Faso, de Allegri (2006a) has encountered numerous people who did not participate in the health insurance because saving money for a case of illness was perceived like wishing oneself a disease. In addition, the act of saving money for healthcare-related aspects could also attract an illness (ibid.).

The supernatural sphere of meaning is very present also in the interpretation of SP. In particular in the first years of the insurance, many people were very skeptical about participating in the insurance because they feared to fall ill. I was told by an early adherent of the insurance: “Many people told me that it would not be good to participate. It would bring me bad luck and could make me ill, so I should leave SP as soon as possible” (interview, 28 November, 2012). According to some participants and personnel of the scheme, these negative connotations between CBHI and one’s health are a reason why enrolment rates of so low. As testified by one of the animators: “Last week, I tried to sensitize a woman about

participation in SP, and when I talked about the insurance covering snakebites, she forbade me to speak any further. She feared that by talking about taking preventive measures, the snake bite would materialize“(Personal conversation, 16 October, 2012).

However, the belief of a health insurance making you ill does not go unrivalled. In particular in villages with relatively high participation rates such as Aouda, the hypothesis that insurance-participation makes you ill has been largely reversed. Numerous people have now started to reason that being a member of SP prevents you from being sick. As argued by one adherent: “The children are much less sick than before since we became member of SP. It is the insurance which helps you not to fall sick” (interview, 11 September, 2012). Not only are people convinced that the insurance helps to protect them from diseases, most also know cases or have heard stories in which people have fallen seriously ill after they have decided to withdraw. My assistant told me a frequently repeated story: “One man had insured his whole family for three years, but then he left because they never got sick. On the 4th of January, he was working on a field and was bitten by a snake. His family came to us and asked us to help with the cost of the antivenom. They even offered to pay the insurance fee of the whole family for the entire year on the spot. But we had to turn their request down because it was not in line with the rules of the insurance.”

Unfortunately, it was not possible to trace the root of the change in perception that the health insurance is now seen as a guarantee for being healthier. Still, it seems that such a change of perspective has occurred relatively recently. In the beginning, also in Aouda the opinion was prevalent that the insurance has a negative effect on your health. As stated by my assistant: “In the beginning, people were very skeptical about the effect of the insurance. But now, in its fifth year, many people have seen enough cases where the insurance has saved people from falling ill, so now, people are less reluctant to participate” (14 November, 2012). Potentially, the belief of the insurance being good for your health is fuelled by an overall improved health of those who are a member of SP, which relates back to the previous chapter that participants visit the clinic earlier and can afford to buy all prescribed products.

Whereas the insurance was initially introduced based on the assumption that people would engage into strictly rational a cost-benefit analysis to reduce the effects of falling ill, SP additionally has become filled with metaphysical meaning. In particular the connection

between the insurance and the supranational leads to a certain ‘fetishization’ of the scheme, which then becomes a fetish in its own right – either a positive or a negative one, depending on one’s point of view. This process is an interesting example of how a formerly ‘foreign’ concept such as health insurance has been appropriated by local discourses on health, illness and healing. While SP has contributed to a change of these discourses, it has likewise become part of it and is internalized into local discourses. The outcome of this process is a CBHI scheme which has been re-interpreted based on local context, and to a certain extent resembles what Homi Bhabha has termed a ‘cultural hybrid’ (1994).

Also the general mood towards SP in Aouda seems to have changed towards being better accepted than before. The canton chief told me that in the beginning, he frequently faced criticism for his involvement in the health insurance: “In the beginning many people told me that I should not be active for SP. By now, I have managed to convince most of those who were critical. Even if they do not participate in the insurance, they now accept that participation in SP is a good thing. Now, each case of illness is another point in favor of the insurance: If a family member falls sick who is not insured, of course I have the obligation to help him. But afterwards, I will tell him that his behavior cannot be tolerated. If people see that someone spends a lot of money on food and drinks, but does not contribute to the insurance, they will help him one time, but if he does not change his behavior, they will not help him a second time” (Interview, 28 November, 2012). Also one of the animators for the insurance confirms this change in perception. “Many people have preferred to wait and see whether SP is useful. Now, each time someone falls sick people see that it is good to be insured because they can receive treatment which otherwise might be too expensive” (Interview, 21 November, 2011).

Summarizing this section, it seems that local perceptions of illness and healing do seem to play a potentially big role in the decision to participate or not to participate in the insurance. Risk-awareness towards being healthy is given, and the danger of falling sick is seen as a major risk for which coping mechanisms should be in place. In addition, local healing preferences – as exemplified through the preference for injections – can contribute in determining to the acceptance of the insurance. Instead of the previous freedom with regard to medical treatment, participants of SP are supposed to accept the nurse’s choice of treatment. Consequently, this might lead to disappointment with the scheme. This chapter has further established that a change of perception of SP has taken place in Aouda. In the

early phase of the project, many people in Aouda feared that participation in SP would make them ill. In the last years, the image has become considerably more positive, particularly due to a “positive fetishization” of the insurance. This means that insurance is no longer seen as attracting diseases, but that it protects you from sickness.

5.3. The Togolese health system – positive or negative factor for insurance participation?

As established in the literature review, satisfaction with the health care provider is a major criterion for people to enroll, which vice versa means that dissatisfaction with the health care provider is likely to be a strong motive for not joining the scheme. This section examines in how far this is true about CBHI participation in the province of Sotouboua.

The USP is the most relevant health care institution in the prefecture of Sotouboua which serves as a first resort in the case of an illness. The overall situation of the USPs is somewhat mediocre, and challenges in terms of finance and personnel exist. The government only pays two of the employees, whereas the head nurse in Aouda holds that in order to work properly, the clinic needs at least eight employees. The remaining six are paid by user-fees. However, the nurse stated that “this is sometimes not enough, and sometimes the overall situation at the USP can be insufficient to rapidly take care of all those who fall ill. This becomes difficult in the weekend, when only half of the staff works. For patients who have government jobs, Sunday is the only day off, so it is the only day when they can come and seek treatment for someone from their family. This can easily lead to waiting hours.” (22 October, 2012).

In contrast to the nurse’s harsh description of the USP’s situation, the majority of the interviewed claim to be satisfied with the level of services which are provided at the hospital in general. As one respondent states: “If one of my children or I get sick, we go to the clinic because I know that I will receive good treatment there” (interview, 16 September, 2012). Next to the USPs, also the communal health agents were perceived as having a positive impact on the overall access to healthcare. However, as I was mainly interacting and conducting interviews with people living in the village of Aouda itself, I had limited access to testimonials about these agents.

Next to the general levels of satisfaction with the health care facilities, one needs to distinguish between satisfactions of the adherents of SP with regard to equal treatment at the clinic. Here, the answers were more varied. While some claimed to be treated equally, others claimed that CBHI adherents were treated worse than non-members. Mostly, longer waiting hours or the alleged unavailability of drugs were stated as points of contestation. However, within these findings, a temporal dimension seems to be crucial. As explained by several voluntary members of SP, at the beginning the nurses at the USP were critical about SP, fearing large amounts of bureaucracy. In addition, the unfamiliarity with the insurance sometimes led to confusion between the nurses and those who were insured, for example with regard to what illnesses are covered by the insurance to what extent. As one respondent claims who used to be insured: "In the beginning, there were some problems in the USP with regard to the insurance, because the nurses did not have much knowledge of the insurance. However, this might have changed. I am no longer a member, so I do not know how the situation is now" (interview, 13 September, 2012).

The shift from a problematic start towards routine is also reflected in the answers of the nurses. As the head nurse in Aouda explained: "In the beginning there were some problems, because the clinic personnel did not exactly know the proceedings of the insurance. We tried our best, but it is not true that we did not like the insurance because we think it is too much work. Our job is to make people healthier, so if there is an initiative to improve people's health, of course we are very happy about it" (22 October, 2012). However, the nurses also criticized the behavior of the adherents. According to the nurse in Aouda, sometimes the members of the health insurance would not bring their personal insurance booklet. However, in order to receive treatment, it is mandatory to have the booklet so that the nurse can check whether the person is indeed insured and in order to keep track of the patient's history of treatment. Still, even though disagreements exist with regard to the choice of treatment, the nurse at Aouda is positive about the introduction of SP.

In particular the introduction of the INAM[14] seems to have demonstrated the nurses that insurance schemes can be considerably more time-consuming than SP. As the head nurse at the USP in Aouda stated: "I cannot say that Sina Passenang causes too much work

[14] Nationwide compulsory health insurance for government workers, see below.

for us. If you compare it with the INAM, it becomes clear that the INAM is much more time-consuming. There, you have to fill out four documents for each case you treat. For adherents of Sina Passenang, there is only one form on carbon copy paper which you have to fill in once. Then you can give one sheet to the patient, one to the insurance, and one is kept for the records of the clinic" (interview, 21 November, 2012). While the overall situation in the clinics of Aouda is far from perfect, the treatment and reception of CBHI participants causes only little problems now.

Compared to the USP in Aouda, the situation in other clinics is more difficult, as exemplified by the USP in Fazao. The data gathered by Dekker and Leliveld (2011) show that enrolment rates in Fazao are above average. When I confronted the volunteers and functionaries of SP with these findings, I was met with disbelief. The level of enrolment in the scheme in Fazao used to be relatively high, but has then dropped and now stagnates at a relatively low level (see Fig. 4). Now, Fazao is seen as one of the villages where mobilization is extremely difficult. During a visit to Fazao, I conducted interviews with insured, non-insured, the clinic personnel and the local volunteers of the insurance. It emerged that in the case of Fazao, the issue of low enrolment rates was closely related to problems at the local USP.

In spite of the relatively small population of Fazao (about 2000 inhabitants), the local USP is bigger than the one in Aouda, even though the USP in Aouda serves more than double the population. Still, the USP in Fazao has almost the same number of employees. The building has been financed by an international development organization, but due to a lack of patients it is underused. When I visited the clinic in early December, there was no patient anywhere, while three of the employees were present. This stood in stark contrast to the USP in Aouda, where the waiting hall was crowded each time I visited the clinic. According to the head nurse in Fazao, the biggest problem which keeps sick people from visiting the clinic is the lack of drugs. As the clinic is chronically short on money, drugs are frequently not available. As a consequence, the majority of the population tends to seek alternative forms of healthcare provision either from one of the numerous local healers in the village or from the USP in another village approximately 10km from Fazao. Now, if drugs are available, they are sometimes already expired because demand is erratic.

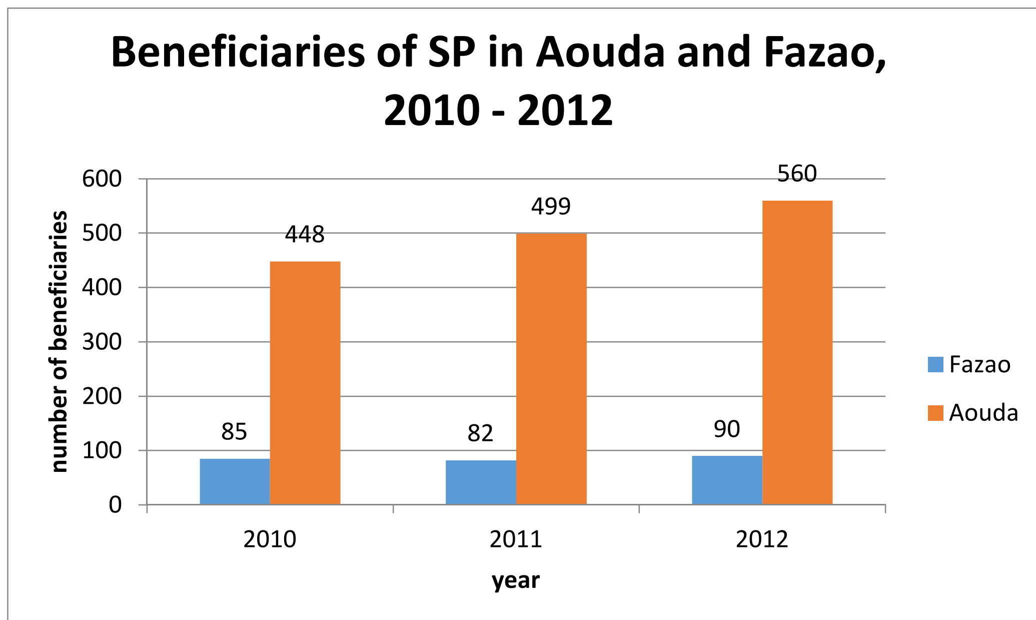

Fig. 4: Beneficiaries of Sina Passenand in Aouda and Fazao, 2010 – 2012

At the start of SP in 2008, Louvain Développement singled out USPs with financial problems, amongst others the USP in Fazao. These clinics were then provided with a stock of drugs. The idea was to break the circle of under-utilization, non-availability of drugs and lack of financial capital. The sale of these drugs was supposed to allow the USPs to generate income to buy further stocks, so that subsequently, drugs would also be readily available. Contrary to the expectations, the USP in Fazao has not managed to convert the donation of drugs into the availability of a lasting stock of medication.

The financial problems at the clinic are aggravated by logistic and administrative expenses. The head nurse described the problem as follows: “Before, we used to have a fridge, but since it is broken, we need to get vaccinations from Adjingre, which is about 25km from here, and it is very expensive to get there. We also have to make a lot of photocopies from documents, which is expensive as well. In addition, we are supposed to give 5% of our revenue to the Prefectural Health Service for supervision, but we have refused, because there is simply no money left for that... Sometimes there is a whole week in which we do not have a single admission, in particular in November and December“ (interview, 5 December, 2012). Next to these constraints and expenses, another major expense of the USP is the salary of the employees, and one of my informants posed the question whether the current number of employees was justified given the scarceness of patients.

The local volunteers in Fazao confirm that over the last year, the number of participants in Fazao has dropped from more than 100 to currently 77, which is mainly due to the problems at the clinic. As a consequence, most of the remaining participants of the insurance prefer to receive treatment in USPs from other villages. However, often this leads to frustration because in the clinics of these villages, the equal reception of participants of SP is not always given and complaints from the adherents are frequent. As stated by a local volunteer: "Members of SP do not receive good treatment in other clinics. Sometimes, there are no products for them, whereas for those who do not participate in the insurance, there are products." (Interview, 5 December, 2013). Access to treatment to which they are entitled is thus a double challenge for adherents in Fazao: first they need to circumvent the mal-functioning clinic in their own village, and then they have to hope for adequate treatment in distant clinics.

Overall, the case of Fazao shows how the conditions of health facilities can be relevant for the success of the scheme. In Fazao, several detrimental aspects occur at the same time: a low target population, a remote location and high expenditures of the clinic. While this might be an extreme example, it shows how the level of services provided at the USPs to make a difference in certain villages in determining the participation rates.

This section has demonstrated how different levels of satisfaction with the local USPs can lead to different levels of participation. In particular in Aouda, the USP is functioning relatively well, given the limitations in terms of personnel and treatment. This is also reflected in the patient's satisfaction, both insured and non-insured. In contrast, the case of Fazao has exemplified that mal-functioning USPs can lead to a decrease in enrolment rates. While the state of the health system cannot explain overall high or low enrolment rates, it contributes to an understanding of why seemingly similar villages have different rates of enrolment.

Picture 5: Noel Pagniou in front of the USP at Fazao

5.4. Aspects related to the setup of the scheme

In personalized groups, most insurance-related problems such as adverse selection and fraud can be dealt with informally. For example, in many cases, people are less inclined to cheat someone they know than someone they do not know. Also, in personalized communities, a system of 'naming and shaming' is very effective, leading to a partial exclusion of someone who has turned out not to be honest before. Most of these mechanisms are largely ineffective when it comes to abstract obligations. As elaborated upon in Chapter 3, SP needs to employ elaborate checks against fraught and adverse seletion.

Another major problem of the insurance is the issue of over-consumption. Earlier in this chapter, over-consumption has already been dealt with concerning the choice of treatment. However, over-consumption is taking place not only when it comes to the quality of treatment, but also concerning its quantity, thus the number of visits to the clinic. During the period of fieldwork, quantitative overconsumption was a much contested issue. The

most basic form of preventing over-consumption is co-payment, which requires those who are insured to pay a certain amount of the costs of the treatment. As stated before, people have to pay 30-40% of the bill themselves for most forms of treatment. However, during my stay, the volunteers of the scheme and employees of the supporting NGOs claimed that quantitative overconsumption was still a problem. As explained by the president of SP: "There are frequent problems with people who go to the clinics too often. People are just not used to getting something almost for free, so they do not understand that they are only supposed to go to the USP when they are really ill. Cases exist where people drink too much beer in the evening, so the next morning they go to the clinic. They have a consultation with the nurse and would like to get medicine, even though the only problem is the amount of drinks from the night before" (interview, 21 November, 2012).

Since 2012, a system of 'consumption vouchers' has been introduced, aiming at minimizing over-consumption. Under that system, each family which participates in the insurance receives one voucher per person per year, which needs to be handed over to the doctor in case of a consultation. These vouchers are distributed per year, and the color of the vouchers is changed annually in order to prevent the usage of old but unused vouchers in the next year. If all vouchers have been used, the family can ask for additional ones from their local volunteer. If the second round of vouchers is used, one of the animators visits the family to discuss why all vouchers have been used, and to determine whether the consumption of health services has been reasonable.

Being in an early stage, the voucher system is subject to considerable criticism on different levels. During a high-level meeting of the insurance's executive staff from five provinces, a passionate debate arose about how many vouchers families should be entitled to. At its core, the debate dealt with the issue whether the adherents of the scheme should be controlled or whether they could be trusted. In particular the issue how to deal with pregnant women turned out to be a point of contestation. Being covered by the insurance, they are entitled to four antenatal consultations. However, some argued that handing over four additional vouchers to families with a pregnant woman would only lead to an increase in over-consumption, as these vouchers would be used for other purposes. Others stated that a basic level of trust should be granted, arguing in favor of a more relaxed approach towards the limitation of the vouchers.

At the village level, other concerns were more prominent. While potentially limiting overconsumption, the introduction of the voucher system likewise has the potential to complicate access to healthcare. New vouchers can be difficult to obtain, in particular when the local volunteer did not have any more vouchers left to distribute and had to wait for the animator to provide him with additional ones. This aspect has been aggravated in villages without active volunteers, where often the animators are the only source of new vouchers. In addition, in the beginning of 2013, vouchers were distributed only in the second week of January, while the nurses had been briefed to no longer accept the 'old' vouchers from 2012. On 1 January, one of the animators as well as the secretary general of SP claimed that they had already received several calls from adherents who experienced a case of illness and had no vouchers to be treated at the hospital, even though they had already paid the fee for 2013. It seemed that the introduction of this system of vouchers was intended to readjust the balance between the financial viability of the scheme on the one side and the right to receive treatment on the other side. At the same time, the checks as introduced by the voucher system are an interesting way to use personalization as a means against overconsumption: the participants have to justify themselves personally in front of volunteers and possibly animators.

This section has shown how aspects related to the setup of the scheme can influence participation rates. While measures against overconsumption help to ensure the financial viability of SP, they have the potential to limit the number of adherents. In particular the introduction of a system of consumption vouchers has led to a considerable stir amongst the supporting NGOs as well as the participants.

5.5. More likely participation amongst the 'Rich'?

The survey by Dekker and Leliveld (2011) has established that households which have at least one salaried worker are more likely to participate than those without a salaried worker, whereas household wealth does not make a difference. This stands in contrast to results from other studies, in which income is positively correlated with insurance participation (Aladji Boni, 2011; Cole, 2011). Matul (2012, see Fig. 3 p. 11) argues that the relation between participation in CBHI and income is reversely U-shaped. Neither the

destitute nor the rich participate, whereas those with a median income are more likely to insure. This section and the subsequent one aim at assessing the question in what sense wealth has the potential to influence insurance participation. While this section deals with those who are richer than average, the next section addresses those who are poorer than average.

As stated in Chapter 3, wealth in Central Togo is distributed relatively equally, and it would be misleading to talk about 'the rich' in this context. Regardless of that, several people live in Aouda who could afford the insurance comparatively easily. Families which can rely on some commercial or other economic activities (e.g. shopkeepers) besides their agricultural activities do not face the same financial constraints as the majority of the families in the area. That means that they do not have to struggle to find money for schooling fees, visits to health facilities, mobile credit, meat and new dresses. Overall openness towards SP seems to be higher than average amongst the richer and a large group of people seems to have considered participation in the health insurance. Still, there are many who do not participate. According to some of the 'richer' people, the insurance is too basic. As explained by the owner of the largest shop in Aouda:

"Before, I used to be member of the insurance because it seemed to be a good initiative, but then I left. If I get sick, I need to seek treatment in the regional hospital in Sokodé because the service at the USP is deficient, and they can only treat minor diseases. One of my daughters has a chronic disease for which she often needs to receive treatment at the regional hospital in Sokodé. This treatment is not covered by SP either. I prefer to guard the money for analyses and special medicines, which are not available in at the USP. This might also be the reason why many people do not participate in the insurance. Each time I visit the hospital in Sokodé I see people from Aouda there who are not member of the insurance. The insurance is a good thing for the poorer families, but for me to be interesting, it should also include treatment for other illnesses and a wider range of medicine. I would be willing to pay higher fees if this means that I can get quality-healthcare." (Personal Interview, 14 September, 2012).

Within the richer share of the population, government employees have a special position. In Aouda, they were amongst the only ones having a regularly salaried job, and consequently are also prominently represented in the group of 'the rich'. A large degree of

them has a high level of education – often university degrees – so in line with Dekker and Leliveld's finding of a positive correlation between education and insurance participation (2011), civil servants should be highly likely to participate. Most of the government employees were indeed very interested in the insurance, and several used to participate in SP in the past. However, the rules of the game have changed with the creation of a nationwide compulsory health insurance for civil servants. The *Institut National de l'Assurance Maladie* (INAM)[15] was founded in 2011, and has become an important player in the field of healthcare. The INAM is modeled after a European-style state-run compulsory health insurance and is based on a model of shared the responsibilities between the employer and the employee. This means that the Togolese Government pays 50% of the healthcare expenses of its employees, which has attracted considerable criticism. The employee's contribution for the INAM amounts to 3,5% of the monthly salary, which is automatically deducted. The fee covers the spouse as well as a maximum of four children. The amount which needs to be paid for the INAM surpasses the one from SP by far, but also includes much more varied treatment such as laboratory analysis and dental care. In addition, also the co-payment is smaller than at SP, typically being 20% of the total.

Also amongst government employees, the introduction of the INAM has led to criticism. In particular the decision to make the insurance compulsory is criticized. "They should leave everybody the choice whether he wants to participate in the INAM or not. They do not care whether there is already a health insurance in place in certain areas. Here for example, we have Sina Passenang. If someone wants to be a member of the INAM, be it so, but if someone wants to be a member of SP instead, the government should not force him to participate in INAM." (Interview, 25 September, 2012).

During my stay, I encountered numerous active and retired government workers who had left SP because they were now members of the INAM . However, this does not mean that all government workers have left the CBHI scheme. In one case, a retired government worker was apparently forgotten to be included in the insurance, so he kept being member of SP. As he expressed, he does not feel any wish to change this situation:"I would have to pay much more for the INAM, so why should I be forced to give them the money if I can also get health care for much less money at Sina Passenang?" (25 September, 2012). This reflects

[15] While the INAM officially refers to the institute, it is also used as the name of the health insurance issued by the institute. In this paper, INAM is used as the name of the insurance.

a dominant view amongst the government workers – if they had the choice, most would opt for SP rather than the INAM. Several government employees who have more than four children decided to become member with the remaining children in Sina Passinang. However, this causes problems whether the four children covered under the INAM need to be insured again under SP, or whether an exception to the requirement to have the whole family insured can be made. In yet other cases, government workers insure the whole family twice – in the INAM as well as in SP, so that they are able to retrieve the benefits from both insurance schemes. The headmaster of a local school who was insured in both insurances stated: "In case of an illness, I prefer to use SP it instead of the INAM, because the INAM is very complicated. Also, I like to be in SP, because in contrast to the INAM, it is a local initiative. In case of an illness which is not covered by SP, I will use the INAM" (18 September, 2012).

Overall, it seems that the positive correlation between regular incomes and insurance which has been found in Dekker and Leliveld's study (2011) should not be mistaken for necessarily higher participation rates amongst 'rich'. While some of them argue that the insurance is tailored for the needs of poor peasants and therefore not interesting to them, in particular the introduction of the INAM has led to a weakening of the hypothesis that richer people tend to participate in SP more frequently.

5.6. Community-based health insurance: too expensive?

A liquidity constrain is one of the widely cited factors for non-participation in the literature on CBHI (cf. Cole, 2011; Matul, 2013; Aladji Boni, 2011). Also in Aouda, one of the most frequent answers for non-participation in SP is "I do not have enough money to participate". This section investigates to what extent poverty can be seen as *the* determining factor for low rates of enrolment in Aouda.

Having grown up in Western Europe, it could be a challenge to detect differences within the village of Aouda with regard to poverty. Even though the homestead of the family I was living with did not look much different than other ones in the village, they were considered to be one of the families in the village which was better off than others. However, after some time, differences in wealth levels became clearer to me, which was partly due to conversations on that matter with different people. I was assured that in June and July, many people would have serious problems finding enough to eat. In particular

when family members who were supposed to provide food die or can no longer work, the situation becomes difficult. This also holds true about divorces. I was told about one villager in Aouda: “This man has been left by his wife. She left with the children to live with another man in Kara. Now, he is all alone, he does not have any other family members here, and he is too old to work. This is a very precarious situation. Normally, it is his family which provides him with something to eat, but now it is up to the neighbors to provide him with food” (conversation, 20 September, 2012). Likewise, families with a high number of children seem to struggle to find money to sustain the whole family. In this regard, not only income as such matters, but particularly income in relation to the size of the family.

Given that the vast majority of the population of Aouda is employed in subsistence farming, the situation of most villagers quickly turns to be precarious when difficulties in the agricultural cycle occur. Even though the farmers attempt to reduce the risk by planting different crops on the same field[16], farmers are amongst those who are the most prone to risk. Also the patterns of purchase and sale of agricultural goods seem to favor those agriculturalists that are not amongst the poorest. As explained to me in late October: “In the harvesting period, prices for agricultural goods drop, for example now with the Yams. You can already get three yams for 1500 CFA. Now, only those who are desperate try to get some money. Those who are able to wait a little longer can get much better prices. In a month the prices for three yams are easily already 3000 CFA ” (conversation, 30 October, 2012). Money is thus indeed an issue for many people, and those who struggle to have enough to eat have probably other worries than participating in a CBHI scheme. It therefore seems that a considerable share of the population should be considered to be below the threshold of poverty which effectively excludes them from participating in SP. However, it would be mistaken to perceive the majority of the inhabitants of Aouda as too poor to participate.

Insurance participation in Aouda is not constrained to those who are well-off, and the scheme is not perceived as project which is driven by the affluent. For the majority of non-participants in Aouda though, a lack of money does not seem to be the primary reason for non-participation. While there are some members in SP who are affluent, the majority of the participants are subsistence farmers who are not visible better off than many other people in the village who presumably do not find the money to participate. Even though the vast

[16] Typically one which needs a lot of rain and another which requires little rain

majority of the inhabitants of Aouda would probably be classified as 'extremely poor' according to World Bank standards, the village must not be mistaken as a desperate place where absolute poorness prevails and people think about nothing but surviving.

Walking through the village of Aouda on a regular night, I was struck by the amount of transactions taking place at the market place. There, the best-selling item was not necessarily groceries, but millet beer, which is produced by various women in the village. Likewise, it is very rare to encounter anyone who does not possess a mobile phone. Due to Togocel's tricky mandatory weekly recharges mentioned in the previous chapter, possessing a mobile is relatively costly. Additionally, particularly amongst women, it is almost obligatory to have a new tailor-made dress for the festivities around Christmas and New Year[17]. These activities are not constrained to the 'rich', but are very present in most segments of society.

Overall, the vast majority of the population does possess a certain amount of financial capital about which they can decide relatively freely. While a 'typical middle class villager' faces grave challenges in everyday life, it has the financial means to partake in the activities just mentioned. Therefore, it seems fair to say that potentially, a large share of the population of Aouda would also be able to buy a health insurance. Taken the insights from the rich, the poor and the average, the overall distribution seems to resemble Matul's (2012) distribution which leaves the majority of the population being neither too rich nor too poor to be in the target group of SP.

Nevertheless, the most frequent answer for not buying health insurance was the lack of money. With the pile-sorting exercise described in chapter 2, I attempted to understand people's preferences in spending money. As indicated before, health and education always scored very highly, while 'consumption-related expenses such as mobile credit, meat and millet beer were low on people's list of priorities. Given the partly reversed reality, this exercise was presumably not able to show people's preferences, but the socially acceptable version of the preferences. Still, it revealed that there is a very strong image on how money is supposed to be spent: rather than spending it on consumption, it is better to be used for investments in schooling and health insurance. This is also reflected in the answer of what people think about the health insurance – hardly anyone comments negatively on SP. Rather, a typical answer of a non-insured was: "SP is a good thing, because it improves the

[17] The amount which is spent on a dress – about 5000 CFA roughly equals the annual insurance fee for two people

health in our village. However, I do not have the money to participate in it. Maybe next year, I will find enough money" (interview, 19 September, 2012). A large share of the population indeed is more inclined to spend money either on items referred to above or different forms of investment such as livestock or grains rather than buying a health insurance.

Statements such as "I don't have the money to participate in Sina Passenang" are difficult if not impossible to assess objectively. Given people's preference for other items, such a statement can be more appropriately restated as: 'Given the financial limitations, I derive more utility in investing in other items than in buying a health insurance.' It seems that in direct comparison with other expenses, buying a health insurance is frequently not seen as a top priority. The Chef de Canton of Aouda summarizes this conflict of interest in relation to participation rates: "Many people like too much to drink and to eat meat, so there's no money left for the insurance" (interview, 18 September 2012). While this contrast does not necessarily capture the full complexity of participation rates in SP, it exemplifies the competition with other expenses which the health insurance faces. Thus when compared with other expenses, SP is not attractive enough for people to purchase it.

5.7. Summary

This chapter has shown the possible explanatory power of 'alternative explanations' as opposed to the importance of aspects related to the theory of social capital. While being healthy as such is of utmost importance, differing opinions exist with regard to the 'proper' treatment, which culminates in the question whether the patient has the right to choose his/her own treatment and health care provider. Whereas this used to be the case prior to the introduction of SP, adherents are now expected to respect the choice of treatment of the nurses. Moreover, with regard to perceptions of SP, this chapter has established that in Aouda, the predominant view of insurance making you ill has been at least partly reversed. Insurance participation is now seen as a fetish which protects you from falling ill.

Next, this chapter has dealt with the question whether the Togolese Health System is a positive or negative factor for participation. As shown by the example of Fazao, the local state of the health care facility can have a detrimental effect on insurance participation. However, in villages such as Aouda, the clinics work relatively well, and their nurses appreciate the introduction of SP, even though the overall situation of the health care

system is somewhat mediocre. However, with regard to Aouda, the state of the health care facility as a detrimental factor for enrolment can be ruled out.

Subsequently, the impact of wealth levels has been examined. Amongst the 'richer-than-average', participation has suffered with the recent introduction of the INAM, the compulsory insurance for civil servants. Even though participation in INAM and SP is not mutually exclusive, those with a salaried income do not seem to be more likely to participate than those without. Turning towards 'the poor', this chapter has established that poverty can indeed be a factor for non-participation. Nevertheless, it might be mistaken to see it as *the* defining reason for non-participation. Numerous non-participants who say that they would not have money for the insurance do have money to spend on other items such as millet beer or mobile credit. Rather, it seems that spending money on the insurance is not a top priority for many, because compared to other possibilities of spending, the insurance is not attractive enough. This however relates back to the aspects elaborated upon in the previous chapter: in order to be more attractive, the scheme would have to be in line with people's perceptions on risk-sharing and solidarity.

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6. Explaining intra-village differences in participation

6.1. Introduction

In the early phase of this research project, the idea was to compare two villages. However, as explained in Chapter 2, I decided to drop this idea in favor of an intra-village comparison. Comparing two villages might have led to 'easy explanations'. For example, the malfunctioning of the USP in one village or the involvement of a local volunteer in another village might have explained certain differences between villages. However, such an approach would potentially neglect the fact that there are entire segments of the society in the prefecture of Sotouboua as such, but also within all bigger villages, which barely participate. Therefore I decided to focus also on differences in participation within the village of Aouda. This chapter aims at establishing whether factors related to different variables are significant for determining the differing intra-village enrolment rates in SP. The variables which are investigated for are age and religion/ethnicity. This chapter hypothesizes that the insurance is more popular amongst the younger generation than the older one. The variables of religion and ethnicity are dealt with in combination as these variables are strongly linked in Aouda and largely coincide with each other.

After dealing with the variable of age, firstly, this chapter elaborates on the Christian/Animist Kabye group. It aims to show why the rate of enrolment is relatively high in relation to adherence to pre-existing, supranatural explanations of illness. In a next step, this chapter turns towards the predominantly Muslims minority group of the Kotokoli, which are underrepresented in SP. The study seeks to contextualize the low enrolment rates both in religion and in their role as an ethnic minority.

6.2. A generational approach to explain differing participation rates?

In the exploratory phase of the project, I assumed that generational aspects might constitute a crucial cleavage for insurance participation. The hypothesis was that a difference might exist between older and younger people. The older generation was seen to be less ready to embrace a new form of solidarity because of skepticism about a change of

personalized arrangements into an abstract form of solidarity[18]. At the same time, the younger ones were expected to be more likely to join. It was suspected that they have developed a higher willingness to break with prior arrangements of solidarity. This was hypothesized to lead to a conflict between the older ones who might be reluctant to join and the younger ones who might be more willing to test new arrangements of solidarity.

In Aouda, old age is seen as a very respectful state of life. Having lived for a long time is equated with being knowledgeable and wise. Consequently, the elderly have a considerable influence on large number of affairs in the village as well as in the families, legitimating their influence through the 'power of tradition', or to use Bourdieu's (2008) term, symbolic capital. However, the conditions of live have changed considerably in Togo over the last decades with regard to education, religion, infrastructure, political systems and discourses. As a consequence, those who are at a younger age now have grown up in an environment which is fundamentally different from that in which their parents and grandparents have grown up. This has the potential to lead to differing opinions on a wide range of issues.

Such a generational conflict is even dealt with in the school books: one educational text for the purpose of English teaching in the local high school exemplified this conflict on the issue of cropping techniques. Whereas the elder ones – who had the say – insisted to keep the system the way it used to be, the younger ones wanted to employ different methods but had to accept what the elder ones said. Thus, the school book tried to take up a real live scenario and a common conflict in most Togolese villages. Theoretically, the introduction of SP has the potential to lead to a similar process: the younger ones embracing 'modern' mechanisms, while the older generation prefers to keep relying on the old mechanisms.

However, this hypothesis did not correlate with the findings of my fieldwork. Instead, it confirmed the findings of Dekker and Leliveld (2011). Insurance participation does not seem to be linked to the variable of age – there are heads of the household of different ages who decide to insure their family. While the wish for a materially improved situation of living is very present amongst the young, many of them do not see the insurance as providing the

[18] Talking about 'the elderly' in relation to decision-making is somewhat ambiguous – in most cases, predominantly men are concerned. Also the decision about the health insurance is mainly a male affair. As long as a man is present in the household, women are overall subordinate in the process of decision-making.

desired result. The immediate wish lies on breaking out of the income-structures of rural Togo, aiming at establishing a life in other places rather than seeking to improve life in the village by relying on programs of development organizations. However, most of the men only marry at a relatively late age when they are able to financially support a family, typically around 30. Given the insurance's focus on maternal and children's health, most of these younger people are not fully part of the target group of SP as long as they are solitary.

Amongst the elder ones, a considerable number has agreed to insure their family. However, it is necessary to briefly elaborate on intra-household decision-making to show the scope of decision-making power of the elder. Being a 'household head' is a somewhat ambiguous term. The household head is typically male. With marriage, he is financially responsible for his wife(s) and later his children. However, his role of the household head undergoes a profound change when he is no longer able to financially support the family. No longer being the 'breadwinner' means in most cases that also his say in monetary affairs is diminished. However, the extent by which his powers are taken over by the younger generation depends on the family. Whereas they have the say on a wide range of aspects in one family, they only have some advisory power but can be overruled by the breadwinners. In both types of arrangements, insurance participation is frequently discussed amongst the two generations. One participant of SP explained to me that "when I first heard about the insurance, I thought that it was a very good idea. I then discussed it with my father, who agreed that it was a good idea. Then I bought the insurance for our entire family" (interview, 10 November, 2012). In these cases, the 'old' household head had the final say.

In other cases, the two generations do not agree with each other whether a health insurance is bought or not. In some cases, it ends with the breadwinner insuring himself and his children, but not his parents. In one isolated case, a young household head had decided to insure his wife, children and his mother. However, the mother refused to be insured, explaining that she would be too old for SP – also because she feared that participating in a health insurance might lead to a sickness. However, in this situation she was overruled by her son, who argued that it was him who had the power to decide to have her insured, because in a case of illness, it was also he who had to pay for the cost of her treatment. In this case, the son saw it as advantageous for himself to have his mother insured.

The family dispute led to a follow up conflict when the animator wanted to take the picture for the family's individualized booklet of the mother who opposed the insurance, but eventually also this problem was resolved. However, it is not clear whether the same situation could have also occurred if this was a conflict between a son and his father. My assistant explained that "in this case, this conflict would have been much more difficult to resolve, maybe he would have had to leave his father outside of the insurance" (conversation, 8 September, 2012). However, overall, (muted) opposition towards the insurance does not seem to be more wide-spread amongst the elder ones than amongst the younger ones.

6.3. Socio-religious explanations - Kabye

This section tackles the question in how far the complex field of religion, tradition and ethnicity can influence participation in the insurance. This chapter on the Kabye focuses predominantly on an interaction between a 'traditional belief system' and adherence to the health insurance. Moreover, the interrelation between Christianity amongst the Kabye and the health insurance is examined. Most of the mechanisms elaborated upon concerning 'tradition' might also hold true for other ethnic groups in the region. However, as I was in a village dominated by the Kabye and likewise happened to be surrounded by almost exclusively Kabye, it was difficult for me to establish these aspects for other ethnic groups, particularly as this section relies on observations rather than data from interviews.

In the prefecture of Sotouboua as well as in the village of Aouda, the Kabye are the biggest ethnic group. Their longstanding dominance is also reflected in the offices which are held by them. Almost all decisive public offices have been filled with Kabye. This is true about the Prefect, but also the village chiefs, as well as the Canton Chief in Aouda. According to Piot (1999), the land of the Kabye "is a place that has all the earmarks of a pristine African culture: subsistence farming, gift-exchange, straw-roofed houses, rituals to the spirits and ancestors. Moreover, many of these elements of "tradition"… have flourished and intensified over the last thirty years" (p. 1). However, Piot argues that the 'traditions' of the Kabye "were forged during the long encounter with Europe over the last three hundred years and thus owe their meaning and shape to that encounter as much as to anything "indigenous"" (ibid.) . The notion of 'tradition' and is thus not used to establish an

essentializing notion of tradition as opposed to modernity. In contrast to Piot, this section does not attempt to contextualize the events in notions of ‘modern’ or ‘indigenous ‘events, but sets these institutions in relation to the behavior in cases of illness.

Even though the majority of the Kabye now have converted to Christianity, a relatively large share considers themselves as Animists[19]. However, also those who consider themselves Christians treat the Kabye traditions as an integral part of their identity which is dealt with independent from their Christian faith. As stated in Chapter 3, Blaese (2012) holds that pre-existing beliefs of health and illness can be a detrimental factor for the success of CBHI schemes. Seemingly in contrast to Blaese’s argumentation, Dekker and Leliveld’s study (2011) indicates that being an animist does not have an influence on the propensity to participate in the CBHI. This chapter intends to make sense of these claims. It is crucial to distinguish between the ‘adherence of traditional views’ forwarded by Blaese and the ‘adherence to animism’ as defined by Dekker and Leliveld. ‘Adherence to Animism’ is a self-definition, proclaiming that someone sees himself as an Animist. It indicates that they would worship ‘local’ deities as opposed to going to church or the mosque.

In Aouda, a considerable number of Kabye considers themselves as being Animists. They were frequent adherents of SP, confirming Dekker and Leliveld’s results (2011) that adherence to animism does not have a positive or negative effect on insurance participation. In contrast to that, Blaese’s claim is more difficult to assess. It does not only deal with self-proclamations, but assumes pre-existing beliefs are wide-spread in the entire society. However, during the discussion about these beliefs, Piot’s claim that non-local influences have considerably contributed to the shaping of these beliefs must be kept in mind (1999).

Adherence to a certain religion is something which contributes to structure your life in Aouda. In particular amongst adherences of different mosques and churches, belief is not confined to a weekly service and personal prayers, but also serves to embed you in a social structure. As a result, the ties amongst members of the same congregation are typically very strong, leading so frequent social interaction also outside of the religious field. Nevertheless, in spite of differing religions amongst the Kabye, interaction between animist and Christian

[19] The ambiguity of the term animism is acknowledged. Still, it is used in this paper for two reasons. Firstly, people in Aouda considered themselves animists. Secondly, this paper conducts research partly based on Dekker and Leliveld’s (2011) study, which uses this classification as well. In order to have the same ‘basis of argumentation’, this classification is maintained.

Kabye is almost as common as interaction within one's 'own' religious community. Interaction is much rarer between Kabye (regardless of religion) and Kotokoli, indicating that in this case, belonging to the same ethnic group - and sharing a common language and heritage – is more relevant than sharing the same religion (cf. Piot, 2010). Therefore, it would be misleading to speak about adherents of animism as opposed to adherents of Christianity. It is widely accepted that those who convert from Animism to Christianity do not break with all prior beliefs, leading to an increase in a two-sided exchange between the faiths. The frequent interaction between adherents of different faiths as well as the role of those who converted from one religion to another leads to a fusion of elements of these faiths, which manifest on specific occasions.

Prior to the introduction of Christianity, the most important celebration of the year amongst the Kabye was the Yam Harvesting festival, which is celebrated in August during the rainy season. It marks the end of the period of hardship and the beginning of a period where food is available in abundance. For such special occasions, large dances which are supposed to bring good luck are performed. However, since Christian holidays have replaced the Yam Festival as the spiritual peak of the year, these dances are now taking place also on occasions such as Christmas and New Year. With the occasion being based on Christian faith and the form of the celebration rooted in Christian tradition, this seems to be an acceptable solution for adherents of both faiths. It preserves the strong interaction amongst the Kabye.

When it comes to the issue of healthcare, the difference between the different belief systems is potentially relevant. As described before, the sick must make a choice between different healthcare providers. One can either decide to seek treatment at the healer, or at the herbalist, or at the clinic. Between them, a struggle is taking place with regard to who is the primary point of reference in a case of illness. One of the villagers who still remembered the time before the USP explained: "When I was young, the clinic here did not yet exist. Receiving treatment at a clinic would have required us to go to Sokode. We relied on healers and herbalists; there were no other options for the people in the village" (interview, 29 November, 2012). Healers are crucial to treat diseases which are seen as being related to supranational forces such as witchcraft. In contrast, when it comes to the treatment of diseases which are related to mal-functioning of your body, the USPs and herbalists are important actors. These two institutions stand in direct competition – one seeks treatment either at the USP or at the herbalist. During the interviews, respondents claimed that they

would prefer to receive treatment at the hospital because the treatment there would be superior. However, they also acknowledged that the service is more costly than visiting an herbalist, so seeking treatment at the herbalist is something for those who cannot afford treatment at the USP.

The relation between the USPs and the herbalists forwarding bodily explanations of an illness on the one side and that of healers forwarding supranational explanations of illness seems to be changing. More precisely, the scope of illnesses is seen as having supranational causes is shrinking. All of the respondents claimed to seek treatment for bodily explanations for illnesses first. Only if the treatment of these health care institutions could not improve their health, they would seek advice from a healer. The number of people who seek treatment at the healer before visiting the USP or an herbalist seems to be decreasing- partly also related to the advance of Christianity amongst the Kabye. Most Christians were quick to point out that they would not visit the healers, because having converted to Christianity, supranational explanations of illness as advanced by the healers were ruled out as a source of illness. The healers, on the other side, claimed that they would treat both Animists and Christians. While there seem to be Christians who stick to the bodily explanations of illness, others secretly ask for advice at the healers. Animists were more open concerning this matter – it was normal to visit a healer if the illness did not get any better, sometimes also parallel to the treatment at the clinic.

For illnesses which cannot be treated or diagnosed at the clinic, witchcraft frequently serves as an explanation. Cases of witchcraft need to be revealed by the healer, and rituals are then carried out to heal the bewitched. In addition, also the witch is subject to rituals. As witches are seen as being possessed by an evil spirit rather than being an evil person as such, these rituals intend to free the person from these evil spirits. One day in November, I was invited by the Chef Canton to a trial because he wanted me to see how the local justice system works. Coincidently, that day a man was accused of having bewitched his daughter who had died. The trial did not intend to find out whether the potential witch was guilty or not, because he had already pleaded guilty at the start of the trial. Apparently the accused had faced similar accusations a few years earlier, but healers were engaged who were supposed to heal him from the influence of witchcraft. Now, the healers who claimed to have healed him were accused of not having done a proper job, so the trial dealt with their wrongdoings. Because the former wife of the accused (and mother of the dead child) and

her family swore to kill the accused as revenge, the Chef de Canton allowed him to live at his compound for a certain period to show that he was protected by him.

All of the participants considered themselves to be Animists: the chief, the accused and the healers. The trial allowed me to get a rare insight into the supranational sphere of such matters which are normally rather concealed to non-locals. Even though supranational explanations for illnesses are diminishing, cases of witchcraft have a tremendous capability to explain certain occurrences with regard to health and illness. The presence of witches seems to lead to low levels of trust within the village. If everyone could be a witch, the willingness to engage in risk-sharing with him might suffer. Moreover, the belief in predominantly supranational explanations of illnesses can lead to a general unwillingness to engage in risk-sharing for an insurance which is based on bodily explanations of a disease. While cases of witchcraft remain confined to Animists, the lasting effect of it seems to be similar for members of Christians and Animists alike. Even though some segments of the Kabye are no longer directly involved in accusations of witchcraft, the effect of it shaping images of health, illness and trust should not be underestimated.

In order to get further insight into witchcraft affairs, I had scheduled a meeting with a village elder who supposedly was familiar with such matters. However, during the meeting, it turned out that he had converted to Christianity and stated that he would no longer possess knowledge on supranational explanations of illnesses. This was not an isolated case – several of those who had converted to Christianity were reluctant to share their knowledge on ‘animist’ affairs. It seemed some of them attempted to convince themselves and me that their conversion to Christianity meant a radical break with supranational beliefs propagated by Animism. My assistant (being a Catholic) told me that “Witchcraft accusations are not as abundant as they used to be before because now, people go to church. Going to church does not mean that everyone stops practicing the tradition immediately, but those who accept that Jesus Christ has come to rescue them no longer sacrifice to the tradition. There is a popular song in Kabye, which says that the tradition adheres to stones, but that the same stones have been made by god. So that shows that god is superior to the tradition“(personal conversation, 10 November, 2012). Overall, witchcraft is a very sensitive topic. Due to my lack of theoretical knowledge and practical experience with the topic I was hesitant to engage in discussions about it. Still, it seems that local beliefs of witchcraft help

to foster an environment which is not entirely supportive of a high willingness to participate in SP.

Arguably, elements of Christianity are also relevant in the acceptance and promotion of SP amongst the Kabye. Frequently, such connotations were made during interviews with Christians who are member of SP. In many cases, those ideas are led by a universal solidarity which is rooted in a Christian belief: "All of us are children of God". For them, the insurance is a way to 'live the word of God'. I was told by one respondent that the Bible would tell to love your enemies, so the insurance would be a way to realize an improvement of one's life in line with the word of god. Indeed, the insurance does resemble the discourse of a religion to a certain extent, which arguably makes it easier for Christians to accept participation in SP. It creates a dividing line between those who believe and those who could not have been converted. In particular at one workshop which was organized by the animators for the elected members of the insurance, a religious element was very present. Participation in the insurance was described as a possibility to improve one's life, as opposed to those who have not understood the benefits of such insurance. Asking one of the animators whether he could see a parallel between the insurance and a church he stated: „Yes, our health insurance can also be seen as a church. Before, there had not been something like that. Now we are evangelizing the people in the field of health" (16 October, 2013). Overall, the strong interrelation and evoked parallels between a Christian belief and the health insurance seems to favor participation amongst Christian Kabye.

As established in this section, frequent contact and shared institutions and rituals amongst Christian and Animist Kabye make it difficult to distinguish between these groups with regard to their beliefs. This is also true about healthcare, where treatment at the clinic is preferred to treatment at healers or herbalists. While herbalists are seen as a possibility for poorer people, the treatment related to the supranational offered by the healers is often perceived as a last resort. In spite of the preference for hospitals and numerous conversions to Christianity, supranational explanations for illness seem to be indirectly related to overall low participation in the scheme by leading to low levels of tust rather than leading to low enrolment solely amongst Animists.

6.4. Socio-religious explanations: The Kotokoli

As stated above, Islam in Sotouboua is largely synonymous with the ethnic group of the Kotokoli. While their homeland is situated in the North of Sotouboua around Sokodé, they are a sizeable minority in the entire prefecture of Sotouboua. In many instances, the different ethnic groups live in the same village, but have separate neighborhoods, being either predominantly Christian/Animist-Kabye or being Muslim-Kotokoli. The survey which Dekker and Leliveld (2011) executed in Sotouboua and a neighboring prefecture shows that Muslims have a lower likelihood of participation in the CBHI schemes. However, as this finding has not been set in relation to other variables, this leads to the question why being Muslim' leads to a lower probability of participation and which aspects are hidden in the variable of 'Islam'. Also during my stay in Togo, the difference in participation in the health insurance between Muslims and non-Muslims was striking: as a rule of thumb, hardly any participants in SP can be found in the villages which are dominated by Muslim Kotokoli, whereas participants in Christian/Animist Kabye villages are very present in the scheme.

Also the villages which were initially chosen for a comparison between two villages could be situated along this line: the one with higher participation rates was Christian/Animist, the other one was almost exclusively Muslim. However, the same distribution of participation can also be observed within the village of Aouda. Even though it is dominated by Kabye, it also has a large Muslim community of at least several hundred members. Regardless of that, from roughly 250 families which participate in the insurance, only three were Muslim-Kotokoli, whereas almost all other families were Christian/Animist Kabye. During numerous interviews in Aouda as well as Nima – the neighboring village which is almost exclusively Muslim - I attempted to establish why the rates of enrolment are lower than average amongst Kotokoli Muslims.

In some of the Arab countries, lively discussions are taking place whether the Quran allows for participation in a health-insurance or whether it is against the principles of Islam. More precisely the question whether the aspect of 'gambling' is seen as permissible is discussed (cf. Shayk Muhammad S. Al-Munajjid, n.d.). However, the position is more relaxed when it comes to the establishment of a community-based insurance, as it excludes the possibility of economic profit (ibib.). Still, insurance in general and health insurance in particular is a topic which is fiercely debated in Muslim communities in other countries. In

Sotouboua, the introduction of SP was relatively uncontroversial amongst Muslim leaders. Muslim as well as Christian and traditional dignitaries were incorporated into the process of setting up the insurance, and were all present at the official opening of the insurance's office in Sotouboua. As explained by the leading Imam in Sotouboua, "SP is very good, because it helps people in the case of illness. There is no reason to believe that the religion would forbid us to participate" (interview, 24 January, 2013). Likewise, several local religious dignitaries have confirmed that they endorse the health insurance and the related concepts of health financing. The wife of the former Imam of Aouda is one of the few Muslim adherents in Aouda and very positive about the scheme. Her husband does not oppose her engagement. As she explained: I pay the fees for me and my five children. I sell oranges, in this way I manage to pay the tuition fee for the children and the contribution for the insurance. My husband is old and too sick to work. But as the insurance helps to save the family, he always says that it is a good thing" (interview, 16 September, 2012). It seems that with regard to overall compatibility, there are no major conflicts between Islam and insurance participation.

Another important aspect where Islam could contribute to shaping an opinion about SP concerns the arrangements of solidarity as propagated by the religion. During an interview with the local Imam in Aouda, he told me about numerous examples where he or the Muslim community of Aouda exercised different forms of solidarity, for example by providing shelter and food for poor travelers from the Sahel countries. According to him, to help the needy is essential to be a 'good Muslim: "To do something good is much more important than visiting Mecca. If someone is found to have saved money for a journey to Mecca while not sharing money with the poor, he will have a bad reputation. Also, if you are in Mecca, you need to bath in a river. If you have not given to the poor, the river will make a sound, and everyone will know what kind of person you are" (interview, 19 November, 2012).

Next to individual solidarity, the local mosque possesses a fund from which money can be distributed to needy locals as well as strangers. In a way, such form of solidarity represents an abstract mutuality which is not very different from the solidarity as required from the health insurance. Abstract solidarity in the form of alms-giving (Zakat) is enshrined in the Quran as one of the five pillars of Islam. Everyone who is able to do so is supposed to give a certain percentage of his income (typically 2,5%) in order to decrease inequalities and

the burden of hardship for others (Jawad, 2009). However, in contrast to the abstract solidarity established by SP, the group of solidarity as defined in the Quran is confined to the religious community - thus Muslims helping other Muslims. Jawad (ibid., p. 60) argues that it particularly serves to achieve a closer feeling of togetherness amongst the followers of Islam.

In this case, Islam constitutes the basis for solidarity amongst believers and creates a social bonding which is restricted to belonging to a certain religion. In Aouda, being a Muslim seems to be an important factor for bonding people. In the winter months, nomadic herders from the Sahel countries come to the village with their cattle herds. Being Muslims, they are treated as brothers of faith, facilitating their integration into the village. However, given the importance of religion, it seemed that the willingness to show solidarity based on religious affiliation decreases one's willingness to become part of another risk-sharing network such as SP which is not faith-based.

In order to find out why participation differed between Muslims and non-Muslims, I therefore asked for reasons for low participation rates during my interviews. However, when confronting a Muslims with this question, it was somewhat difficult to establish reasons for low rates of enrollment. 'I do not know why participation is lower amongst Muslims' was a frequent response. Others argued that participation amongst Muslims is lower because they have more children than non-Muslims. Already the survey from Dekker and Leliveld (2011) has shown that bigger families are negatively correlated with insurance participation. As established in Chapter 2, this finding is in line with the literature on determinants for participation in CBHI and is thus relatively uncontroversial as such.

While it is rare to have less than three children per family in Aouda, the number of children seems to be higher amongst Muslims. Also widespread polygamy is relevant in this context. In particular for men with a higher-than-average income, it is not uncommon to have more than one wife. However, while many people already struggle to pay the insurance fee for a relatively small number of adherents, paying the insurance fee for ten or more members would be tremendously difficult. As stated by one of the few Muslim adherents in Aouda: "If someone has less than five children, you can assume a lack of willingness for non-participation. However, if you have five or more, it is very likely that you do not participate because it is too expensive for you to pay for the entire family" (interview, 9 October, 2012).

SP has recognized this difficulty and has consequently introduced a 10% discount for bigger families. Nevertheless, it remains a major burden for bigger families to insure the household, in particular if the husband is willing to insure all children and wives. Therefore, several respondents have forwarded the wish to allow for insurance-subscriptions which do not require participation of the entire family. However, given the problems related to that with regard to moral hazard and fraught, this is not seen as an option by the supporting institutions. Family size is therefore seen a relevant factor which needs to be taken into account to understand lower enrolment rates amongst Muslims.

Next to the big families, another repeated answer for differences in participation rates was a lack of money. However, this answer was mostly seen either in relation to the big family sizes, or was given as a reason for overall low rates of enrolment. While it might be true that Muslims have less financial capital available per family member, when taking income as an indicator, Muslims did not seem to be poorer than non-Muslims. This was also acknowledges during the interviews.

The third frequent answer for comparatively low enrolment rates amongst Muslims was that they have only now started to understand the benefits of the scheme. As stated during a meeting with local representatives in Aouda: “It is only now that we have properly understood why we need to join. I am sure that very soon there will be more Muslims who participate in the insurance” (group discussion, 10 December, 2012). Inquiring into why the level of understanding amongst Muslims was lower than the level of understanding amongst non-Muslims, the respondents proclaimed that they would not know.

The reasons were very different when asking non-Muslims about differing rates of participation in the village. They confirmed that bigger families and a low level of understanding contribute to the low enrolment rates amongst Muslims. However, often, they went a step further and claimed to know why the knowledge amongst Muslims is lower than amongst non-Muslims. Such answers were mostly influenced by strong prejudices about the other ethnic group as the quote by one respondent indicates: “Participation amongst Muslims is lower because it sometimes takes them longer time to understand things (…) They are more traditional and sometimes ignorant; they don’t know that they are not doing themselves a favor in this way’ (personal conversation, 18 September, 2012). Moreover, non-Muslims frequently argue that Muslims prefer to seek treatment at the

herbalist rather than going to the hospital in the case of illness (Interview, 19 September, 2012). Possibly, this might also be related to the high costs of treatment at the clinic.

Next to that, Muslims were also described as “liking their money too much”. As claimed by one respondent: “A Muslim would not tell you that he likes money a lot. But when you ask a thief whether he has just stolen something, will he tell you the truth?” (interview, 28 November, 2012) . These answers are at least as telling when it comes to inter-ethnic relations in Aouda, which seem to be to a certain extent based at least partly on mistrust and a feeling of superiority of one’s own religious and ethnic group.

Curiously, such claims coincided at least partly with my observations. I had indeed the impression that a lack of understanding of the CBHI was more wide-spread amongst the Kotokoli than amongst the Kabye. I experienced expressions such as ”do we get the money back in case we do no tget sick?” to occur more frequently. Still, a large share of the Muslims who I interviewed showed a considerable interest in SP. On several occasions, would interviews would drift off because the interviewee would pose detailed question about technical matters of SP. Nevertheless, so far the whole idea of the health insurance was far less present amongst the Muslim community.

So far, this section has focused on religion as the primary variable for lower participation rate. As indicated in the beginning, religion and ethnicity strongly coincide in Aouda. To come to a more precise picture of the situation, the level of religion needs to be complemented by the dimension of ethnicity. As established in the literature review, differences in participation between the ethnic groups are common, but the explanations for these differences vary. While some studies attribute differing enrolment rates to the general openness of certain ethnicities towards novelties, Batiano (2012) holds that minority groups do not participate because they do not feel represented by the scheme.

Also in the case of the Muslim Kotokoli in Sotouboua, their role as a ethnic minority seems to be crucial. As stated above, the Kabye are dominant in the prefecture of Sotouboua as well as in the village of Aouda with regard to language, offices and customs. While there are no open conflicts between the different groups, they do not tend to intermingle and also tend to have rather negative views about the other ethnic groups. As described by Batiano in a similar context, the separation between the different groups “is the result of common mechanisms of mutual help and solidarity that are normally based

partly on lineage and inheritance and partly on social networks, special alliance relations and religious affiliation" (ibid., p. 418).

The predominance of the Kabye is also present in SP: the animators of the scheme as well as most other employees of the institutions which support the scheme are Christian – mainly Catholic - Kabye. Likewise, the elected members of SP are Christian. As a promotional activity of the insurance, an annual calendar is printed which is then distributed to all adherents. Shortly before I left in late January, the calendar for the running year was distributed. However, in spite of the multi-religious environment, the calendar shows exclusively Christian holidays[20]. Even though the supporting background organizations – Plan and Louvain Développement – enjoy wide popularity in the region, they are identified as organizations which are promoting 'Christian-Western values'. Also the idea of an abstract solidarity which is detached from kinship or faith can be seen in this light.

The Christian-dominated setup of the insurance with regard to the local volunteers is bound to reinforce itself: as demonstrated in the previous chapter, personalized relations are crucial in promoting the scheme. Given that the vast majority of the active volunteers are Christian Kabye and taking into account the low level of interaction between the ethnic groups, it is relatively difficult for Kotokoli to have a trusted contact person for the insurance. This, in turn, can also explain their comparatively low understanding of aspects related to the setup of the insurance. Consequently, one important explanation for low enrolment rates amongst the Kotokoli can be found in their underrepresentation in the scheme.

Even Kabye who are very critical about the Kotokoli acknowledge that they have an extremely high level of internal solidarity. As stated by the head nurse in Aouda: "The Kotokoli are very efficient in supporting each other. If an outsider comes and wants to buy three Yam, they might refuse to sell them for 1000CFA, but if someone from the village comes, they might sell it for even 600 CFA. Also when someone gets sick, it is easier for them to borrow money from someone else. People from Aouda are struggling to find 2000 CFA for a treatment. In contrast, people from Nima (the village strongly associated with Kotokoli) sometimes even come and pay with a 10.000 CFA note for a treatment of 2.000 CFA." It seems that the situation of the Kotokoli as a minority also seems to have strengthened their

[20] The Calenders were distributed in Aouda the day before I left, so I did not have the chance to discuss that matter with any of the Muslim respondents.

level of intra-group solidarity. As they do not feel represented by public institutions, they have consequently intensified intra-group mechanisms. Religiously-bound solidarity as propagated by Islam further increases this tendency. It would be misleading to argue that low enrolment rates amongst the Kotokoli could be attributed predominantly to religion, or that the Kotokoli – as opposed to the Kabye – are generally less open towards new ideas. The experiences of the CBHI scheme in the neighboring prefecture of Tchaudjo (around Sokode) contributes to these findings. Here the Kotokoli are a majority group. In contrast to Sotouboua, the Kotokoli are holding the majority of the elected offices as well as participating in the insurance in relatively large numbers. The non-participation in SP can therefore rather be linked to the role as an ethnic and religious minority rather than related to being Muslim or being Kotokoli as such.

6.5. Summary

This chapter has focused on possible cleavages for insurance-participation within the village of Aouda. It has established to what extent the variables of age, religion and ethnicity contribute to determining enrolment rates. The first section has established that age is not a decisive variable to explain differences in the enrolment rates. While opposition exists amongst generations, it is not stronger or towards a certain direction in a particular age cohort. Unlike expected, the younger generation is not more likely to participate than the older one, which is also related to the insurance's focus on reproductive and pediatric care. Next, this chapter has shed light on the effect of religion and ethnicity. Due to the strong correlation between these two variables, they have been combined. Firstly the case of the Chriastian-'Animist' Kabye was elaborated upon. Due to the strong interaction between Animist and Christian Kabye, also their health-seeking behavior is very similar. As a rule of thumb, visiting a healer is seen as a last resort, whereas the local USP is the preferred healthcare-facility. However, the longstanding belief in witchcraft seems to impede people from preferring solidarity which is not bound by family ties. The interaction between Christianity and the insurance might contribute to higher enrolment rates amongst Christian Kabye.

Next, this chapter examined the effect of being Muslim Kotokoli on buying a health insurance. This enrolment rate of this group is considerably lower than average. Part of the explanation is the family size – given the acceptance of polygamy, families are bigger while

incomes are not, which increases the difficulty of buying the insurance. In addition, solidarity as propagated by Islam is restricted to solidarity within the religious group, which has the potential to keep them from joining the scheme. However, the Kotokoli's position as an ethnic minority seems to be more relevant in this context. As they do not feel represented by SP, they rather resort to strengthening intra-ethnic networks of solidarity. Also the low level of understanding of SP amongst the Kotokoli can be understood in this regard. As most of the volunteers are Kabye, it is difficult for them to discuss SP with someone within their trusted face-to-face community.

7. Conclusion

The aim of this chapter is to synthesize this information and to set it in relation to the theoretical section. In this way, the most relevant findings of this project are discussed. This thesis is based on research on the CBHI scheme SP in the Togolese Prefecture of Sotouboua. Like the vast majority of CBHI schemes in West Africa, also SP has to deal with the problem of low rates of enrolment. Currently, arount 3,5% of the population is enrolled. The aim of this thesis is to establish why overall participation is that low by conducting a single case study in the village of Aouda. Moreover, it aims to establish why different segments within the village have different rates of enrolment. In line with the article of Mladovsky and Mossialos (2012), this project has established that aspects related to social capital are useful to re-conceptualize and to better understand enrolment rates in SP.

Besides the CBHI, virtually all transactions are taking place within one's face-to-face community. Only through personalized channels, customers feel secure not to be cheated. This is at least partly the result of overall low levels of universal trust on the village level and the acceptance to employ lower standards for those outside of one's established face-to-face community. Moreover, not only the transaction as such, but also the nature of most products which are consumed is related to personalized interaction. Both millet beer and mobile credit have very strong social components, as they are mainly consumed to interact with other people within one's face-to-face community. Thus overall, it is thus uncommon to 'bridge' the difference between those inside of one's face-to-face group and others.

In the case of illness, the face-to-face group is limited further, as solidarity there is mainly executed within the family. Family members have a moral obligation to provide financial assistance, and their help in a case of illness is therefore largely taken for granted. When the illness is not grave, only the nuclear family is responsible for finding financial means. Only if it is a grave illness, solidarity within the extended family is activated. Help from non-family members is not compulsory, but it is welcomingly accepted. To a certain extent, the focus on a very limited group in which solidarity is exercised in a case of illness is related to illness being something very personal, which one is reluctant to share with outsiders.

Participation in SP requires people to change this focus on the face-to-face group. Instead, solidarity as exercised in SP constitutes an abstract, impersonal obligation, thus a

detachment of the person who falls sick and the one who pays for the treatment. The respondents suggest that a large number of people are not willing to amend the family as a unit in which solidarity is exercised. In SP, risk-sharing is taking place within the scope of the prefecture. However, as the prefecture is perceived merely as an administrative entity and not a bonding factor, participation in SP would require willingness to engage in universal bridging solidarity.

To overcome the dilemma of an abstract as opposed to a personalized nature of solidarity, the engagement of local volunteers is crucial. Aouda is one the villages with the highest rates of enrolment, which can be largely traced back to the engagement of Noel Pagniou, the local volunteer. In that role, Noel has manage to convince a considerable share of the population to partipate. A positive relationship seems to exist between 'level of personal trust towards Noel' and insurance participation. Within the very narrowly defined group called 'Friends of Noel', participation in SP is at almost 100%, which suggests that with a large effort, high rates of enrolment are possible. Many of those who participate cannot recall the terms of their participation, for example with regard to the co-payment. However, they trust Noel that he would not have tried to convince them of participation if it was not beneficial for them. This application of personalized trust refers to the same mechanism which has been described earlier as a basis for transactions. Thus for people who know Noel, adherence to an abstract view of solidarity is facilitated through personalized relations.

Interestingly, the introduction of SP does not seem to have the potential to crowd out existing patterns of insurance participation based on kinship. Rather, the two seem to e complementary, which is largely due to the insurance's focus on high-probability low-cost diseases. Insurance participation does improve the health-seeking behavior of adherents, i.e. they seek treatment earlier, whereas for those who are not insured it is more difficult to find the money for treatment at the clinic. As a consequence, non-adherents often rely on auto-medication as a first resort. As only the nuclear family is responsible for minor illnesses, the patterns of solidarity for such illnesses are not altered. As the insurance only rarely covers high-cost treatments, also adherents of SP frequently need to rely on help from the extended family for serious conditions.

Another detrimental factor which is partly related to low levels of trust in the society is Platteau's argument of the non-familiarity with risk-sharing. In line with, also the

population of Aouda typically relies on arrangements based on balanced reciprocity rather than on institutionalized risk-sharing which can lead to winners and losers. This is exemplified by the rotating working groups which are very popular amongst Kabye men. Also in the case of health, the kinship-based solidarity in the long run equals out, as everyone has to pay for each other one time.

The centrality of risk-sharing and differing notions of solidarity can be exemplified when comparing SP to the GG, a localized savings scheme. The GG manage to attract large numbers of participants, also those who are not member of SP. In the GG, solidarity is executed amongst a group of 15-20 persons who have known each other before the launch of the group, typically living in the same neighborhood. As a consequence, a personalized nature of the group is given. The social control exercised in localized groups also helps to prevent cases of fraught. Moreover, the GG are based on the concept of balanced reciprocity. All members contribute a certain amount during the year and know that they are entitled to get back exactly the same amount at the end of the savings period. The only element of risk-sharing which is present in the GG is solidarity payment, which is handed out to members in a case of illness. Similar to the risk-sharing as introduced by SP, also the solidarity payment in the GG has led to irritation. However, in contrast to SP, risk-sharing is only a very minor aspect of the groups, so it has been accepted by the members of the GG.

Overall, this thesis demonstrates that different notions of solidarity are crucial to understand participation rates in SP. The theory of social capital helps to explain the patterns in which solidarity has taken place prior to the introduction of SP and is also useful to show why certain people decide to participate while others do not. In order to strengthen the centrality of this argument, the thesis has examined alternative explanations which have been established in the literature to be crucial for participation in SP.

Being healthy is of utmost importance in Aouda. As not being healthy can easily lead to serious conditions, being healthy – or being able to rapidly visit a health care facility – is crucial. However, differences exist with regard to the preferred treatment. Before the introduction of SP, everyone used to be his/her own doctor to a certain extent. One could rely on auto-medication, seek treatment at the healer, the herbalist or the healer. Moreover, when visiting the clinic one could choose one's medication of choice. Under SP, patients have to accept the treatment which they are prescribed by the nurses. Often, this debate

culminates on the issue whether the patient is entitled to receive an injection or whether he can also be cured with pills. Non-prescription of more expensive but equally effective drugs can have the effect of disappointing the adherents of SP, and in turn could influence participation rates, too.

Moreover, the supranatural sphere is decisive in determining the acceptance of the health insurance. At the start of the project, many people feared that participation in SP would attract an illness and in turn. This discourse has changed in Aouda, where insurance participation is now seen as something which can protect you from illness. In this regard, the current supranatural sphere of interpretation in Aouda is conductive of high participation rates.

Potentially, the state of the healthcare system can play a big role in the acceptance of a CBHI scheme. However, in the case of Aouda, the patients are largely satisfied with the services. In contrast, the case of Fazao shows that a mal-functioning of a clinic can easily lead to a drop in participation rates. Still, with regard to Aouda, the state of the local USP does not seem to be a detrimental factor for participation in SP.

Not only limitations with regard to the choice of treatment can influence enrolment rates, but also a limitation with regard to the number of treatments which one is entitled to. The voucher system introduced by the supporting NGOs in 2012 intends to reduce over-consumption in order to improve the financial viability of the scheme. However, at the same time it has the potential to increase the dissatisfaction of those who are enrolled. New vouchers have to be obtained at the volunteers or the animators, which sometimes causes logistical problems. Thus, also the attempt to combat quantitative overconsumption can lead to the unintended consequences of dissatisfaction amongst adherents.

More frequent participation amongst ‘the rich’ and those with a frequent salary does not seem to be true in Aouda. In particular the introduction of INAM, the compulsory health insurance for civil servants, is relevant in this context. While the two insurance schemes ar not mutually exclusive, the launch of the INAM has led to a decrease in participation in SP amongst those with salaried jobs. Moreover, some of ‘the rich’ argue that they would only participate when the insurance is extended to include more varied treatment.

A certain number of people live in Aouda who cannot afford to buy a health insurance. Still, the vast majority of those who participate in SP do not seem to be wealthier

than those who do not participate, and it would be misleading to see SP as a project driven by the affluent. In sum, the relation between income and insurance participation can be described as reversely u-shaped: neither those at the top of the income distribution nor those at the bottom of it are likely to participate, whereas those in the middle should be seen as the 'target population' of SP. The majority of those who do not participate seem to have different spending preferences: they rather opt for other items such as for example millet beer or mobile credit, whereas the insurance is not attractive enough. This in turn can be explained by the break with conventional patterns of solidarity and risk-sharing described before.

These explanatory variables are crucial to get a more complete picture of possible reasons for participation or non-participation in Aouda. In particular the discussion on the poor has provided the insight that it is not *the* determining factor, as suggested by other studies. Other variables such as the qualitative and quantitative limitations on access to healthcare have hinted to aspects which can further be detrimental for insurance participation. As such, they are useful to complement the findings on solidarity and risk-sharing. Still, this thesis has established while these aspects matter, they are not as central as solidarity and risk-sharing.

In a next step, this thesis has attempted to reveal why participation rates differ within the village of Aouda. Age does not seem to be a relevant factor –amongst all age groups, the likelihood of not participating seems to be equal. While the younger ones are desperate to improve their living conditions, they do not see participation in SP as a way to achieve this. In this regard, the stratification according to religion and ethnicity is more revealing.

Amongst the Kabye, participation is relatively frequent. This is true about Animist and Christian Kabye, also because frequent interaction exists between them. In particular amongst the Animists, supranatural explanations for illnesses – in particular witchcraft – are frequent. However, rather than leading to a decrease in participation amongst the Animists, the longstanding existence of witchcraft has led to an overall low level of trust, which then results in the relatively low rates of enrolment as described before. Moreover, amongst the Kabye, the tendency to visit a healer in a case of illness as a first resort is diminishing, rather

resorting to seeking treatment at the clinic. Potentially, this has the effect of strengthening participation in SP.

In contrast to the Kabye, the Muslim Kotokoli in Aouda hardly participate in SP. While religion seems to be largely irrelevant in this context, the Kotokoli's position as a minority group is crucial. The prefecture of Sotouboua in general and SP in particular are dominated by Kabye. In SP, the animators as well as most of the volunteers are Kabye. As personalized relations between members of different ethnic groups are rare, it is difficult for them to have a trusted volunteer who could facilitate participation in SP. As the Kabye do not feel represented by the scheme, they have resorted to strengthening the intra-ethnic network of solidarity, which seems to be better developed than amongst the Kabye. As established before, the willingness to engage in abstract risk sharing arrangements requires the existence of bridging social capital, which – in the case of the Kabye – is facilitated through the engagement of the volunteer. As this 'link' between the personalized and the abstract is missing amongst the Kotokoli, they have resorted to a strengthening of bonding social capital, which in turn is detrimental for participation rates in SP. The argument of the minority position being crucial is strengthened by the experience from the CBHI scheme in the neighboring province, where the Kotokoli are in the majority position. There, they show a willingness to employ bridging social capital by participating in the insurance in large numbers.

In its fifth year, SP has not managed to convince a large share of the population. The low rates of virtually all CBHI schemes in the region suggest that the problems may not be related to aspects related to the scheme's individual setup, but to structural aspects such as those described in this thesis. As argued repeatedly, different conceptions of risk-sharing and solidarity are primarily responsible for the low rates of enrolment in Aouda. At this stage, it needs to be questioned whether it is realistic to expect a change of mind concerning these concepts to take place within the project duration of five years. Referring back to the theoretical part, Putnam (1993) has shown that the prevailing modes of societal interaction in Italy can be traced back hundreds of years. Also others (Fukuyama, 2001; Ostrom, 2000) acknowledge that to change the social structure of a society requires a tremendous amount of effort. It consequently seems overconfident to hope for a change in the patterns of social capital within the timeframe of a typical development project.

To a certain extent, the idea of the CBHI as executed currently also puts the idea of a 'community-based project' upside down. A wide range of local actors is included in the decision-making process: the insurance is steered by a board of volunteers elected by the members of the insurance, which also has the function to supervise the work of the insurance's CEO. The voluntary elected members have likewise the possibility to determine the fees for the coming year and the co-payment. Still, as argued throughout this thesis, the ideas of solidarity and risk-sharing as propagated by SP are fundamentally different from local ideas. SP has been largely designed by employees of the donor organizations, and their knowledge and logistics is still indispensible for the continuation of the scheme. While the local population is thus activated for the execution of the scheme, its setup is hardly in line with a 'community-based' approach.

Frequently, the insurance schemes which are currently established in West Africa aim at repeating the success of health insurances as executed in late 19th century Europe, in particular that of the Friendly Societies in Great Britain. Like SP, they were self-administered and relied on voluntary participation. However, in contrast to Friendly Societies, SP has not emerged as a 'bottom up' project, but has been introduced in a top-down approach, thus similar to the health insurance introduced by Bismarck in Germany. From a functionalist point of view, the absence of a CBHI scheme could indicate that a particular society has not deemed it necessary to come up with such a project. While particularly the success of the GG precludes such a line of reasoning, it indicates that a development project can only be successful if it is in line with the pre-existing local beliefs – in the case of SP, especially risk-sharing and solidarity.

With regard to the applicbility of social capital theory, this project has shown that it can be a useful tool in explaining patterns of participation. However, at the same time, it is questionable to what extent a 'complete' picture can emerge by elaborating solely on aspects which are related to aspects of social capital. Some of the aspects which are potentially relevant for participation rates in SP such as risk-sharing or local perceptions of health and illness cannot be explained by social capital theory. Therefore, it is important not only to focus on considerations of social capital, but to employ a framework which leaves room for other considerations as well.

This thesis has further demonstrated that qualitative research relying on a single case study which attempts to establish 'thick descriptions' of insurance participation is helpful to understand patterns of enrolment. Accepting a 'thin description', I would have been likely to accept what people stated in the first place – that they do not participate because of a lack of money, confirming other studies which have established the same (cf. Aladji Boni et al., 2009). Only because I dug deeper into the context-dependent aspects particularly of solidarity, I was able to refute the centrality of the lack of money as a reason for low participation rates.

However, at the same time the qualitative approach of this project has led to limitations with regard to the applicability of the findings. Being a single case study on participation rates in the village of Aouda, the study has only limited applicability to other contexts. Exploratory visits to other villages were conducted as part of this project which largely confirmed the data gathered at Aouda. Therefore, I am confident that the patterns worked out in this thesis are not only true about Aouda, but about participation rates in the Prefecture of Sotouboua in general. In contrast, the applicability to other contexts can only be speculated about.In addition, the qualitative setup has enabled me to detect variables for insurance participation which could be detected by Dekker and Leliveld's (2011) study. However, the nature of a qualitative project at the same time does not allow for a quantification of the variables which have been detected, thus to show how big the effect of the variables actually is. In this sense, the data gathered during this project could constitute a basis from which further research on these matters can be conducted.

8. References

Adams, R. H. (2006). *Remittances and Poverty in Ghana*. World Bank Working Paper. Retrieved 19 June, 2013, from http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2006/01/31/000016406_20060131160228/Rendered/PDF/wps3838.pdf

Adler, P. S., Kwon, S-W. (2002). *Social Capital: Prospects for a new Concept*. Academy of Management Review. Vol. 27 (1), pp. 17-40

Ahuja, R., Jütting, J. (2003). De*sign of Incentives in Community Based Health Insurance Schemes*. Retrieved 19 August, 2013, from http://www.icrier.org/pdf/WP-95.pdf

Al Kourdi, Y., Graziella, G., Gnimadi, J., Valcke, I. (2005). *Etude de contexte et de faisabilité pour la mise en place d'un système alternatif de financement de la santé dans 5 districts de la Région Centrale et des Plateaux*. Plan Togo/Louvain Développement: Cotonou/Lomé

Aladji Boni, R., Yacoubou, I., Galland, B. (2009). *Appui Suisse aux Mutuelles de Santé à la conception de la Réforme de l'Assurance maladie universelle au Bénin*. Cotonou: Swiss Agency for Development and Cooperation

Andrews, A. C., (2012). Consideration for health microinsurance product development – a case study of Jamii Bora Trust in Kenya. In: *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 211 – 230

Anyango, E., Esipisu, E., Johnson, S., Malkamaki, M., Musoke, C. (2007). *Village Savings and Loan Associations – Experience from Zanzibar*. Retrieved 14 August, 2013, from http://www.fsdu.or.ug/pdfs/VSLAs%20-%20experience%20from%20Zanzibar.pdf

Arnott, R.; Stiglitz, J.E. (1991). "Moral hazard and nonmarket institutions: Dysfunctional crowding out of peer monitoring?" *The American Economic Review*, pp. 179–190.

Bationo, B. F. and L.-M. Ouedraogo (2012). Solidarity in the extension of micro health insurance - the problem of enrollment in mutual health organizations in Burkina Faso. *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 415 - 428

Bending, M. and T. Arun (2011) *Enrolment in Micro Life and Health Insurance: Evidence from Sri Lanka*. Retrieved 10 May, 2012, from http://www.microfinancegateway.org/gm/document-1.1.9423/enrolment%20in%20microlife.pdf

Blaese, J. (2012). Reflections on the impact of selected cultural factors on acceptance and success of community-based health insurance – examples from Ghana and India. *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 393 - 414

Bonan, J., O. Dagnelie, P. LeMay-Boucher, and M. Tenikue (2011), "*Is it all about money? A randomized evaluation of the impact of insurance literacy and marketing treatments on the demand for health microinsurance in Senegal*." ILO Microinsurance Innovation Facility Research Paper.

Bourdieu, P. (2008). The Forms of Capital. In: Woosley Biggart, N. (ed.). *Economic Sociology*, pp. 280 – 292. Oxford: Blackwell Publishers

Bossart, R. (2010). “In the city, everybody only cares for himself”: social relations and illness in Abidjan, Côte d'Ivoire. *Anthropology & Medicine*, Vol. 10 (3), pp. 343 - 359

Coast, J. (1999). The appropriate uses of qualitative methods in health economics. *Health Economics*. Vol. 8. Pp. 345 - 355

Cole, S., Gine, X., Tobacman, J., Topalova, P., Townsend, R., Vickery, J. (2011). *Barriers to household risk management: Evidence from India.* Technical report, eSocial Sciences. Working Papers.

Coleman, J. (1999). Social Capital in the Creation of Human Capital. *The American Journal of Sociology*. Vol. 94 (supplement), pp. 95 - 120

Comité Local de Planification de Sotouboua. (2009). *Programme de Développement Local*

Participatif de la Prefecture de Sotouboua 2009 - 2011

Criel, B. (1998). District-based health insurance in sub-Saharan Africa. Part I: From theory to practice. *Studies of Health Services, Organization and Policy*. Vol. 9. Antwerp.

Criel, B., Waelkens, M. P. (2003). Declining subscriptions to the Maliando Mutual health Organisation in Guinea-Conakry (West Africa): what is going wrong? *Social Science & Medicine*. Vol. 57. pp. 1205 - 1219

De Bruin, M., Nyamnjoh, F., Brinkman, I. (2009). *Mobile Phones: The New Talking Drums of Everyday Africa*. Barmenda, Cameroon: Langaa

De Allegri, M. (2006a). *To Enrol or not to Enrol in Community health* Insurance. Frankfurt: Peter Lang

Allegri, M. (2006b). To *enrol or not to Enrol in Community Health Insurance*. Frankfurt/Main, Peter Lang.

De Weerdt, J., Dercon, S. (2006). Risk-sharing networks and insurances against illness. *Journal of Development Economics*. Vol. 81 (2), pp. 337 - 356

Dekker, M., Leliveld, A. H. M., ‘t Hart, C., Gnimadi, J. (2010). Can’t buy me Health: Financial Constraints and Health Seeking Behaviour among rural Household Members in Central Togo. In: *Markets of well-being: navigating health and healing in Africa*, Dekker, M., and van Dijk, R. (eds). Pp. 255 – 282. Leiden: Brill

Delval, R. (1980). *Les Musulmans au Togo*. Paris : Publications Orientalistes de France.

Douglas, M. (1982). *Risk and Culture*. Berkeley, University of California Press.

Dercon, S. (2002). *Income Risks, Coping Strategies and Safety Nets*. Retrieved 19 August, 2013, from http://www.econstor.eu/bitstream/10419/53051/1/346063647.pdf

Ewald, F. (1991). Insurance and Risk. In: *The Foucult Effect. Studies in Governmentality*. G. Burchell, C. Gordon and P. Miller (eds.). Chicago, University of Chicago Press.

Feierman, S., Janzen, J. M. (1992). *The social Basis of Health & Healing in Africa*. Berkeley: University of California Press

Fine, B. (2001). *It Ain't social, It Ain't Capital and It Ain't Africa*. Retrieved 15 June, 2013, from http://eprints.soas.ac.uk/2334/1/it_aint_social_ben_fine.pdf

Fonteneau, B., Galland, B. (2006). The community-based model, Mutual health organizations in Africa. In: Churchill, C. (ed.*): Protecting the poor – A micro insurance compendium*, Geneva. Pp. 378-400

Fukuyama, F. (2001). Social Capital, Civil Society and development. *Third World Quarterly*. Vol. 22 (1), pp. 7-20

Geertz, C. (1973). *The Interpretation of Cultures*. New York, Basic Books.

George, A. L., Bennet, A. (2005). *Case Study and Theory Development in the Social Sciences*. Cambridge, MA: MIT Press

Hampshire, K. R., Owusu, S. A. (2013). Grandfathers, Google and Dreams: Medical Pluralism, Globalization and New Healing Encounters in Ghana. *Medical Anthropology*. Vol. 32(3), pp. 247 - 265

Jawad, R. (2009). *Social Welfare and Religion in the Middle East*. Bristol: The Policy Press

Jehu-Appiah, C., Aryeetey, G., Agyepong, I., Spaan, E., Baltussen, R. (2011). Household perceptions and their implications for enrolment in the National Health Insurance Scheme in Ghana. *Health Policy and Planning*. Vol. 27 (3), pp. 222-233

Jütting, J., Tine, J. (2000). *Micro insurance schemes and health care provision in developing countries: An empirical analysis of the impact of mutual health insurance schemes in rural Senegal*. Retrieved 20 April, 2013, from http://www.microfinancegateway.org/gm/document-1.9.28704/2891_file_02891.pdf

Jütting, J. P. (2005). *Health Insurance for the Poor in Developing Countries*. Aldershot, Ashgate.

Katz, A. H., Bender, E. I. (1976). Self-Help Groups in Western Society: History and Prospects.

Journal of Applied Behavioral Science. Vol. 12 (3), pp. 265 - 282

Leliveld, A. and M. Dekker (2011). *Determinants of participation in community-based health insurance schemes. Findings from Togo*. ECAS Conference. Uppsala.

Leppert, G., Degens, P., Ouedraogo, L-M. (2012). Emergence of micro health insurance in sub-Saharan Africa. *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 37 - 58

Malinowski, B. (2007). Method and Scope of Anthropological Fieldwork. In: *Ethnographic Fieldwork. An Anthropological Reader*. A. C. G. M. Robben and J. A. Sluka. Oxford, Blackwell.

Marsland, R. (2007). The modern traditional healer: Locating “Hybridity” in modern traditional medicine, Southern Tanzania. *Journal of Southern African Studies*. Vol. 33(4), pp. 751 – 765

Matul, M. McCord, M., Phily, C., Harms, J. (2012). The landscape of micro health insurance in Africa. *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 59-87

Matul, M., Dalal, A., De Bock, O., Gelade, W. (2013). *Why people do not buy microinsurance and what we can do against it*. Retrieved 20 April, 2013, from http://www.ilo.org/public/english/employment/mifacility/download/mpaper20_buy.pdf

Mladovsky, P., Mossialos, E. (2006). *A conceptual framework for community-based health insurance in low-income countries: social capital and economic development*. Retrieved 20 November, 2012, from http://eprints.lse.ac.uk/13183/1/LSEHWP2.pdf

Morduch, J. (1999). *Between the State and the Market: Can Informal Insurance Patch the Safety Net*? Retrieved 19 August, 2013, from http://www.microfinancegateway.org/gm/document-1.9.24605/2747_file_02747.pdf

Ostrom, El. (2000). *Social Capital: A fad or a fundamental Concept?* Retrieved 20 November, 2012, from http://www.exclusion.net/images/pdf/778_latuk_ostrom.pdf

Owusu, A. Y., Afutu-Kotey, R. L., Kala, M. (2012). Access to micro health insurance in Ghana: Literature review and proposed analytical framework. *Handbook of Micro Health Insurance in Africa*. H. J. Rösner, G. Leppert, P. Degens and L.-M. Ouedraogo. Berlin, LIT. pp. 361 - 376

Piot, C. (1999). *Remotely Global. Village Modernity in West Africa*. Chicago: The University of Chicago Press

Piot, C. (2011). Nostalgia *for the Future. West Africa after the Cold War*. Chicago: The University of Chicago Press

Platteau, J.-F. (1997). Mutual Insurance as an Elusive Concept in Traditional Rural Communities. *The Journal of Development Studies*. Vol. 33 (6), pp. 764 – 796

Platteau, J.-F., Ontiveros, D. U. (2013). *Understanding and Information Failures: lessons from a Health Microinsurance Program in India*. Retrieved 10 July, 2013 from http://ilo.org/public/english/employment/mifacility/download/repaper29.pdf

Popper, K. R. (2002). *The Logic of Scientific Discovery*. London: Routledge.

Portes, A. (1998). Social Capital: Its Origins and Applications in Modern Sociology. *Annual Review of Sociology*. Vol. 24 (1), pp. 1-24

Preker, A. S., Carrin, G., Dror, D., Jakob, M., Hsiao, W., Arhin-Tenkorang, D. (2004). Rich-Poor differences in health care financing. In: Preker, A. S., Carrin, G. (eds.). *Health financing for poor people, resource mobilization and risk sharing.* Pp. 3-52. Washington D.C: World Bank.

Putnam, R. D., Leonardi, R., Nanetti, R. Y. (1994). *Making Democracy work: Civic Traditions in Modern Italy*. Princeton, NJ: Princeton University Press.

Ridde, V., Haddad, S., Yacoubou, M., Yacoubou, I. (2010). Exploratory study of the impacts of Mutual Health Organizations on social dynamics in Benin. *Social Science & Medicine*. Vol. 71. pp. 467 – 474

Rutherford, S. (2000). *The Poor and Their Money.* Oxford: Oxford University Press.

Straker, G. (1994). Integrating Western and African healing practices in South Africa.

Van Staa, A. L., Hardon, A. (n.d.). *Injection practices in the developing world. Results and recommendations from field studies in Uganda and Indonesia*. Retrieved 10 June, 2013, from http://apps.who.int/medicinedocs/pdf/s2232e/s2232e.pdf

Weber, M. (2002). *Wirtschaft und Gesellschaft*. Tübingen: Mohr

Wiesmann, D., Jütting, J. (2000). *The Emerging Movement of Community-Based Health Insurance in Sub-Saharan Africa: Experiences and Lessons Learnt*. Retrieved 12 August, 2013, from http://www.oecd.org/dev/2510509.pdf

Woolcock, M., Narayan, D. (1999). *Social Capital: Implications for Development Theory, Research and Policy*. Retrieved 20 November, 2012, from http://deepanarayan.com/pdf/papers/woolcock.pdf

Zhang, L., Wang, H., Wang, L., Hsiao, W. (2006). Social capital and farmer's willingness-to-join a newly established community-based health insurance in rural China. *Health Policy*. Vol. 76. Pp. 233 - 242