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Linking Social Capital to Therapeutic Practices in Korhogo, Côte d'Ivoire

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Abstract

In the northern areas of Côte d'Ivoire most affected by the 2010/2011 post-electoral armed conflict, the functioning and use of health services were negatively influenced. This study seeks to describe the nature of the social capital of Korhogo households and to analyze its influence on their choices in terms of therapeutic practices. The study, both quantitative and qualitative, was carried out in the North of the country, more precisely in Korhogo, a city located in the Poro region. The questionnaire was administered to 588 heads of households in 49 enumeration areas. In these EAs, 38 semi-structured interviews and 6 focus groups were also organized with health workers, traditional healers and local leaders. Overall, households perceive two forms of social capital: individual social capital and collective social capital. On the basis of this more or less clear knowledge of social capital, almost all households (92.8%) say they rely on the "human resources" dimensions compared to just over two-thirds (69.2%) for those relating to financial resources. Modern medicine (36.1%) and traditional medicine (32.8%) are the most dominant in the region. The majority of households (83.0%) are led to opt for a therapeutic practice following discussions with the members of their networks. However, the human, material and financial dimensions of social capital have little influence on the choice of therapeutic practices for households. All initiatives aimed at strengthening solidarity are likely to contribute to promoting the health and well-being of disadvantaged households in situations of socio-political crises.

Key words: Korhogo; households; Social capital; therapeutic practices

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INTRODUCTION

The importance placed on friendship plays a role in building health, well-being and happiness for 323,200 people from 99 different countries around the world (Lu et al., 2021). In this sense, the concept of social capital becomes a considerable factor in ensuring the quality of compliance with therapeutic practices in less advanced societies (Story, 2013). This confirms the dependence between the activation of social networks - in particular relatives and friends - and the improvement of therapeutic practices in sub-saharan Africa (Amoah et al., 2018 ; Kouassi, 2008 ; Bossart, 2003).

But in West Africa, different cultural and religious practices continue to influence on the people's attitude and understanding to their health matters (Chukwuneke *et*

al., 2012). This situational reality suggests that the success of participatory policy approaches rests to a large extent on taking into account these social and cultural factors of health, thus helping to facilitate the reconciliation of health care services to communities (Lu *et al.*, 2021 ; Amazigo *et al.*, 2007). However, when it comes to making decisions about how to deliver health services, there is a lack of community inclusion (44%) in the West African sub-region (Lu *et al.*, 2021).

In Côte d'Ivoire, the economic crisis of 1980, then the successive political crises from 1999, had an impact on various sectors, in particular that of health. Indeed, the use of modern medicine represented only 35% of cases of illness (Kouassi *et al.*, 2008). This situation has had a negative impact on the operation of public health projects and programs. For example, studies on updating the current state of control of neglected tropical diseases revealed that the interruption of the effective distribution of ivermectin between 2003 and 2008, resulted in an increase in the prevalence and the density of microfilarial onchocerciasis in most endemic districts (Koudou *et al.*, 2018). The post-electoral armed conflict of 2011, led by the decade of crisis experienced by Côte d'Ivoire, fragmented the social fabric with the deterioration of trust between communities. In fact, during this period of crisis, mistrust was the majority factor (64%) which had a negative impact on social relations, in particular those maintained between friends (Sylla *et al.*, 2018). The process of community building and taking into consideration the own set of vulnerability conditions of their network members can so positively affect the resilience and quality of social capital (Burke *et al.*, 2016 ; Moser, 1998). In short, the question is to know how social capital contributes positively or negatively to the behavioral process of seeking health care among members of households in rural and urban areas in the north of the Republic of Côte d'Ivoire. The objective of this study was to understand the role played by social capital on the therapeutic practices of households in northern Côte d'Ivoire. More specifically, the aim was to describe the nature of the social capital of Korhogo households and to analyze its influence on the choice of therapeutic practices in this locality of the country.

1. METHODOLOGICAL FRAMEWORK

1.1 Location of the Site, Study Population and Sampling

The department of Korhogo is located in the north of the country (635 km from Abidjan); it is the capital of the Savannah District and the Poro Region. Korhogo is the largest and most important city in this part of the country. Like all the cities of the former Center-North-West zone (territories under the control of the former Ivorian rebellion), this department suffered from the cessation of state investments with the withdrawal of the public administration, from the onset of the crisis in September 2002. He was therefore chosen to collect the data relating to this study. In this department, the sites chosen have been grouped into two categories which follow:

sites with at least one health center (the town of Korhogo and the villages of Balèkaha and Nakaha);

sites that do not have a health center (the villages of Moroviné and Nagounzinkaha).

The study covered both urban and rural areas of the town of Korhogo. The twenty-three districts of the town of Korhogo obtained after processing the sampling frame provided by the Regional Directorate of the National Institute of Statistics (INS) were concerned by the study as well as the surrounding villages.

The quantitative survey used a two-stage stratified survey. At the first stage, the enumeration areas (EAs) were drawn by unequal probabilities. At the second stage, the households to be interviewed in the enumeration areas were drawn at random. In each household, the questionnaire was administered to the head of the household or to his representative considered capable of responding to the collection tool.

The minimum size of the sample was understood by the formula:

n = required sample size
t = 95% confidence level (typical value of 1.96)
p = prevalence of the percentage of IEC activities in the study area
e = 5% margin of error (typical value of 0.05)

To take into account the effect of the sampling plan, the size was multiplied by the sampling coefficient D = 1.5 which gave us a minimum size of 576 individual households to be interviewed. In practice, 588 households were interviewed in 49 ZD.

For individual interviews and focus groups, discussions were conducted with the administrative and prefectural authorities so that the choice of neighborhoods and villages to be surveyed is based on their knowledge of the realities of the study site. In the 23 districts of the city and the four (4) villages of Korhogo, 23 semi-structured individual interviews were organized, of which 13 concerned health workers (practitioners of modern medicine) and 10 with traditional healers and local leaders. For the focus groups, 16 focus groups were carried out with young people and elderly people throughout the study area. The realization of each focus group required the presence of 10 people. A total of 160 people were counted with this survey technique.

1.2 Data Collection Techniques and Methods of Analysis

The questionnaire included sections on (i) therapeutic practices, (ii) dimensions of social capital and (iii)

influence of social capital on therapeutic choices of households. After data verification, the data was transferred to the SPSS statistical analysis software for tabulation and analysis. The analysis focused on the 588 households that responded to the collection tool. It was univariate and bivariate. The significance of the statistical relationships was measured by the Chi-square test or the linear correlation test. The degree of significance of the associations was indicated by the value of Pearson's p and the appreciation of the relationships between qualitative variables required the calculation of the V of cramer. In the same period, 183 socially competent people were interviewed across the entire Korhogo Department. The interview guides were administered to included open-ended questions on (i) perceptions of social capital and (ii) perceived links between social capital and therapeutic practices. They aimed to understand in depth the concrete actions taken by the network vis-à-vis sick people. The factual accounts prompted by the questions enabled populations to reveal the benefits or harm of their social capital, as well as their participation and contributions in the care of populations for their survival. The focus groups, on the other hand, were intended to spark debates around the morbid experience and therapeutic practices of populations, the therapeutic aid network and social capital and therapeutic practices. The data from the interviews were recorded using a dictaphone, transcribed into Word. For the analysis of these data from the qualitative study, the cross-sectional synthesis of the interviews is obtained by the content method following a process of thematic analysis of verbatims (Bryman, 1984 ; Braun and Clarke, 2006).

2. ANALYSIS AND DISCUSSION OF THE RESULTS

2.1 Importance of Sociability in Household Health Demand

In Africa, populations have a therapeutic pluralism which could be explained by the multiplicity of factors determining the demand for health care. Notably, it is possible to modify changes in the use of therapeutic care depending on the socio-demographic characteristics, environmental factors and the severity of the disease of the target individual (Jean *et al.*, 2012 ; Sackou *et al.*, 2019 ; Yoro, 2012). But, these economic and social factors influence the health of populations differently depending on the conditions and inequalities specific to each African country (Eshetu and Woldesenbet, 2011). It follows that the high cost and the remoteness of health services can explain the alternation in therapeutic acts which remain very frequent in Côte d'Ivoire (Cisse, 2011). Regarding the types of therapeutic practices of household members in Korhogo, the social network occupies a prominent place in their decision-making. In contemporary black Africa, this alternation is made possible thanks to a wide range of therapeutic remedies, ranging from modern medicine to traditional medicines, through the healing cults of Judeo-Christian or prophetic religions or even maraboutic practices (Yoro, 2012). Analysis of the situation in Korhogo revealed that modern medicine (36.1%) and traditional medicine (32.8%) constitute the orientations of the majority of household members. It also emerges that Chinese medicine (19.4%) and self-medication (11.6%) are practiced by less than one in five people in the household social network. But for various reasons, the propensity to resort to modern medicine seems globally low in korhogo, compared to the four (4) types of therapeutic practices offered by the household network. In general in Côte d'Ivoire, the rate of use of modern medicine represents only 35% of cases of illness in disadvantaged households (Kouassi *et al.*, 2008). Indeed, it has been proven that the perceived geographical inaccessibility due to the distance to basic health services is associated with inappropriate care practices and therefore with the high risk of depression for patients (Eshetu and Woldesenbet, 2011 ; Tomita *et al.*, 2017). How should we explain this state of affairs? In this vein, the social resources available by the populations in the north of the country may constitute a factor explaining therapeutic practices in social networks. Indeed, discussions between network members on health issues have contributed to influencing therapeutic practices for the majority of households (86.2%) in the districts of the town of Korhogo. For 83% of residents, the optional choice of a therapeutic practice was encouraged by discussions with other members of their social network. From the analysis of the assessment of social relations, it emerges that exchanges and advice with members of the network on issues of illness or health can generate social capital in terms of the use of therapeutic care by households. In the following sections, highlight the dimensions of household social capital that may influence therapeutic practices.

2.2 Human and Financial Resources Perceived as Dimensions of the Mobilized Individual and Collective Social Capital

From a sociological perspective, two constitutive forms of social capital are often mentioned, both in field theory and in the structural analysis of social networks. Burt's theory of structural holes generally states that an actor benefits from having contacts that do not have a direct connection between them (Burt, 1995). Because, in the absence of a relationship between two people, a third party can act as an intermediary and derive information and material benefits (social capital). For households in the north of Côte d'Ivoire, it is clear that individual social capital is to be distinguished from collective social capital. Subsequently, the theory places particular emphasis on the social capital of actors, in its both individual and

collective dimension. In the understanding of the holders of this theory, individual social capital, which has a mediating effect on the relationship of trust, determines its collective dimension, especially in China (Wu, 2018). In the Ivorian context in Korhogo, households describe individual social capital as arising from the activities and personal relationships that an individual has linked without the help of a third person. Thus, they believe that the «actual or potential resources» which belong to the individual, may come from his own activities or from those of the people with whom he has personally developed a relationship. However, individual social capital can serve the individual himself and also be made available to other people or members of the network to which the individual belongs.

> "What we sweat in the face, through the network or personal friends, belongs to us. But you can benefit other people when you want to at one point or when you think they need them to solve a number of problems." (Focus group, 33-year-old adult, urban environment)

As for collective social capital, households consider it to be that which an individual acquires through other people. Indeed, this capital is that which is generated, individually or collectively, for individuals belonging to partner organizations. This conception of social capital covers the individual relationships that individuals in a family may have with other people who are not part of their siblings, to the extent that their relationships can generate resources for all of its members. So even if these remain unique to a few, that does not prevent others from benefiting from them. But collective social capital implies collaboration with other families or other organizations. In this case, the social capital generated by the families or related organizations is collective social capital.

> "Here among the Sénoufos, there are collective goods that belong to the whole family. Land, for example, is a common good of the maternal family or the paternal family, depending on the area. So you cannot as an individual make the commitment to give some part of the land to someone without the input of all other family members." (Community leader, urban environment).

> "I am a member of an NGO working in the health field. We often have the support of other large NGOs or certain organizations that provide us with care kits. As the leader of the NGO, you cannot afford to do anything with the resources or donations of the NGO, because those resources are not for you. They belong to the NGO which will have to make them available to vulnerable personnel» (Member of an NGO in the Ahoussabougou district).

Insofar as social capital is considered to be a factor of interpersonal trust in the social network (Kuenzi, 2008), it can be decomposed into "actual or potential resources" of an informational, financial, material and human nature, as well as into relationships of trust or moral support. These resources can therefore be mobilized to solve a certain number of problems in the social network. Regarding the social resources mobilized, almost all households in Korhogo (92.8%) declared that the human component remains the preponderant to meet the basic needs of the community in general and thus improve their living conditions over a certain period of time. number of resources. Overall, we note that just over two-thirds (69.2%) and less than a third (30.1%) said they rely on financial resources and material, respectively. However, the information resource on which the social capital held by the actors and the structure of their relationships in a network would depend (Burt, 1995), is no longer a commonly available social resource because it represents only 29.0% of households met in Korhogo. Table 1 shows the proportion of households according to the type of resources available. In reality, the amount of social capital held by an individual is more so when he has information than others do not, which puts him in a position of strength. Consequently, the empirical results reveal that social actors find themselves in competition within this framework and no longer in cooperation (Coleman, 1998).

Table 1
Arranged social resources types

Resource type		Effective	%
Human ressources	Yes	518	92.8
	No	40	7.2
Financial ressources	Yes	386	69.2
	No	172	30.8
Material resources	Yes	168	30.1
	No	390	69.9
Know how	Yes	162	29.0
	No	396	71.0

Source: Field survey data, GNT-CI Project of CODESRIA, 2015

2.3 Social Capital and Therapeutic Practices: A Relationship Based on Solidarity in the Event of Illness

For the question of the existence of a relationship between the dimensions of social capital and therapeutic practices, aspects of social capital have been apprehended under four (4) variables which are: Consulting or Information resources, Human resources, Financial resources and Material resources. These dimensions of social capital can more or less influence the choice of practices relating to modern medicine, traditional medicine, Chinese medicine and self-medication. The Therapeutic Practices variable has been dichotomized into two modalities including Modern Medicine (including Chinese) and Other Types of Care which includes traditional medicine and self-medication. Chi-square tests help to establish the relationship between social capital and therapeutic practices. Table 2 provides information on this subject.

Table 2
Relationship between dimensions of social capital and therapeutic practices

Chi-square value		Therapeutic practices			
		Significance p	V from Cramer	Bond strength	
Social capital dimensions	Information Consulting or Resources	4.609	0.330		No link
	Human ressources	14.474	0.006	0.161	Low
	Financial ressources	16.695	0.002	0.173	Low
	Material resources	10.322	0.035	0.136	Low

Source: Field survey data, CODESRIA GNT-CI Project, 2015

The analyzes carried out show the information or advice received by households has no statistical link with their treatment choices (Chi-square = 4.609 and p = 0.091). In the light of the literature, this result seems to be in contradiction with other empirical work postulating that social relations can generate social capital of a symbolic nature, or even affection, which promotes healing via a curative function. In this regard, it has been shown that problems as well as deviant behaviors in physical and psychological health increase sharply in socially isolated people, and especially the youngest (Hämmig, 2019). However, this does not mean that many households in Korhogo take into account the advice given by the members of the network. Indeed, if some ignore these informational resources from their social network, others take into account the opinions of their relatives, friends or colleagues in the choice of therapeutic practices because they are aware of the plurality of knowledge, especially in the field of health.

> "We live in a society where you cannot know everything regardless of your age; It is therefore clear that in some cases, especially at the level of health care, one can ask for and take into account the advice of other people» (Comment from the president of the village youth).

In addition, sociability relationships can arise from political social capital, the mobilization of which requires considering the risks of social inequalities (Eriksson, 2011). For example in Ghana, the self-assessed health of populations is significantly impacted by the support and encouragement of voluntary community organizations, unlike social participation (Avogo, 2013 ; Amoah, 2018). Moreover, households in Korhogo recognize that community relations are mainly founded only if one takes into account the advice of the social network.

> "Sometimes when I have health issues, in addition to being able to go straight to the hospital, I refer to some members of the religious community for guidance. As a leader of a religious community, I also provide support in terms of counseling some members of the community.»

However, apart from the «Advice or Information Resources» dimension, we note that there are links between human, financial and material resources, on the one hand, and the choice of therapeutic practices, on the other. Indeed, we have for the relation between:

> "human resources" and the choice of therapeutic practices (Chi-square = 14.474, p = 0.006; Cramer's V = 0.161),
>
> «financial resources» and the choice of therapeutic practices (chi-square = 16.695; p = 0.002; Cramer's V = 0.173),
>
> "material resources" and the choice of therapeutic practices (Chi-square = 10.322; p = 0.035, Cramer's V = 0.136).

However, these links between capital and the choice of therapeutic practices are very weak. From a theoretical point of view, the existence of links between human, financial and material resources and the choice of therapeutic practices can be based on solidarity, a kind of social capital of an economic nature, called for operational purposes «aid". Thus, financial assistance from social networks remains the basis of a redistribution of resources in the sense that it intervenes to cover the occasional expenses of individuals or their communities in modern health care (Aye *et al.*, 2002 ; Rocco and Suhrcke, 2012). These economic resources of an individual's social network define their chances of access to work income, happiness and therefore mental health (Rahayu and Harmadi, 2016 : Majeed and Ajaz, 2018). This conception of solidarity which also includes the help of associations, is highlighted in all the communities in Korhogo where the majority of household heads borrow money from their friends and acquaintances to meet health needs in the absence of financial availability.

From the above analysis, it emerges that the therapeutic practices of the households studied are influenced by the social capital generated from three sources (Akcomak *et al.*, 2008), namely personalized trust, community support and financialized solidarity.

CONCLUSION

In Africa, economic and cultural resources undoubtedly constitute considerable social capital in the choice of therapeutic remedy. In this research, we seek to understand how social capital influences the therapeutic practices of households in Korhogo. However, in this region belonging to the northern part of the Ivory Coast, the economic crisis of 1980, then the successive political crises from 1999, had a negative impact on various social sectors, in particular health. These crises also fragmented the social fabric with the deterioration of trust between friends from different communities. This is the problem developed in this research. The mixed approach adopted for data collection combined questionnaires, semi-structured interviews and focus groups. Analyzes of the quantitative and qualitative data collected, it emerges that the informational and material benefits drawn from the relational networks of the inhabitants of the north of the

Ivory Coast tend more to guide their therapeutic choices. Indeed, even if our study is limited by the absence of an approach to analyze the links between the dimensions of social capital and the types of therapeutic recourse, it suggests, however, that modern medicine and the traditional therapeutic medicine for households, are more significantly linked to the mobilization of human and financial resources drawn from legal and physical persons. The latter who happen to be individuals belonging to the local network and to organizations comprising relatives who participate in a more or less subtle way in the construction of the support process. The reciprocal relations generating social resources of an emotional or economic nature lead to opting for modern or traditional care in the event of illness of populations made vulnerable by the successive crises in the country. Thus, members of the household network seem more present in the event of illness and therefore remain more ready to take more action in terms of material and financial assistance. This state of affairs is part of the legendary «African solidarity» operating under the logic of risk sharing by all members of a community. However, our analysis from socioeconomic perspectives is that household members in the north of the country would benefit from strengthening the mobilization of resources from distant relationships that could improve their treatment and treatment practices. Therefore, all initiatives aimed at maintaining or renewing the network of socio-economic activities shared by all household members will help promote their health and well-being.

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REFERENCES

Akcomak, I. S., Mohnen, P., Weel ter, B. J., Borghans, L., Garretsen, J. H., Groot de, H. L. F.; Soete, L. L. G., & Verspagen, B. (2008). *The impact of social capital on economic and social outcomes.* VerUniversitaire Pers Maastricht.

Amazigo, U. V., Okeibunor, J., Matovu, V., Zoure, H., Bump, J., & Seketeli, A. (2007). Performance of predictors: evaluating sustainability in community-directed treatment projects of the African programme for onchocerciasis control. *Social Science & Medicine, 64*, 2070-2082. doi:10.1016/j.socscimed.2007.01.018

Amoah, P. A. (2018). Social participation, health literacy, and health and well-being: A cross-sectional study in Ghana. *SSM Popul Health, 4*, 263–270. doi:10.1016/j.ssmph.2018.02.005

Amoah, P. A., Edusei, J., & Amuzu, D. (2018). Social networks and health: Understanding the nuances of healthcare access between urban and rural populations. *Int. J. Environ. Res. Public Health, 15*(973). doi:10.3390/ijerph15050973

Avogo, W. A. (2013). Social capital, civic engagement, and self-rated health in Ghana. *African Population Studies, 27*(No 2), 188-202.

Aye, M., Champagne, F., & Contandriopoulos, A.-P. (2002). Economic role of solidarity and social capital in accessing modern health care services in the Ivory Coast. *Social Science & Medicine, 55*(11), 1929-1946. doi:10.1016/s0277-9536(01)00322-7

Bossart, R. (2003). *« En ville, chacun est dans son chacun » : une étude anthropologique sur l'importance des relations sociales en cas de maladie à Abidjan (Côte d'Ivoire).* Doctoral thesis, University of Basel.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bryman, A. (1984). The Debate about Quantitative and Qualitative Research: A Question of Method or Epistemology? *The British Journal of Sociology, Vol. 35*(N° 1), 75-92. https://doi.org/10.2307/590553

Burke, H. M., Moret, W., Field, S., Chen, M., Zeng, Y., & Seka, F. M. (2016). Assessing Household Economic Vulnerability in HIV-Affected Communities in Five Regions of Côte d'Ivoire. *PLoS ONE, 11*(9), e0163285.

Burt, R. S. (1995). *Structural Holes. The Social Structure of Competition.* Cambridge (Mass.): Harvard University Press.

Chukwuneke, F. N., Ezeonu, C. T., Onyire, B. N., & Ezeonu, P. O. (2012). Culture and biomedical care in Africa: The influence of culture on biomedical care in a traditional African society, Nigeria, West Africa. *Niger J Med, Vol. 21*(N0 3), 331-333.

Cisse, A. (2011). *Analysis of health care utilization in Côte d'Ivoire.* AERC Research Paper 201, African Economic Research Consortium, Nairobi.

Coleman, J. (1998). *Foundations of Social Theory.* Belknap Press of Harvard University Press.

Eriksson, M. (2011). Social capital and health: implications for health promotion. *Global Health Action, 4*(5611). doi:10.3402/gha.v4i0.5611

Eshetu, E. B., & Woldesenbet, S. A. (2011). Are there particular social determinants of health for the world's poorest countries? *Afr Health Sci., 11*(1), 108–115.

Hämmig, O. (2019). Health risks associated with social isolation in general and in young, middle and old age. *PLoS ONE, 14*(7), e0219663. doi:10.1371/journal.pone.0219663

Jean, K., Anglaret, X., Moh, R., Lert, F., & Dray-Spira, R. (2012). Barriers to HIV Testing in Côte d'Ivoire: The Role of Individual Characteristics and Testing Modalities. *PLoS ONE, 7*(7), e41353. doi:10.1371/journal.pone.0041353

Kouassi, B. (dir.), Akoete, A. E., Asante, F., & Assenso-Okyere, K. (2008). *Pauvreté des ménages et Accès aux soins de*

santé en Afrique de l'Ouest-Burkina Faso, Côte d'Ivoire, Ghana, Mali et Togo. Paris: Editions Karthala.

Koudou, B. G., Kouakou, M.-M., Ouattara, A. F., Yeo, S., Brika, P., Meite, A., Aba, E., King, C. L., Kouakou, R., Weil, G. J., & Fischer, U. P. (2018). Update on the current status of onchocerciasis in Côte d'Ivoire following 40 years of intervention: Progress and challenges. *PLoS Negl Trop Dis, 12*(10), e0006897. https://doi.org/10.1371/journal.pntd.0006897

Kuenzi, M. T. (2008). *Social capital and political trust in West Africa.* Cape Town: South Africa: Afrobarometer.

Lu, P., Oh, J., Leahy, K. E., & Chopik, W. J. (2021). Friendship Importance Around the World: Links to Cultural Factors, Health, and Well-Being. *Front. Psychol., 11*(570839), 1-15. doi:10.3389/fpsyg.2020.570839

Majeed, M. T., & Ajaz, T. (2018). Social Capital as a Determinant of Population Health Outcomes: A Global Perspective. *Pak J Commer Soc Sci, Vol. 12*(1), 52-77.

Moser, C. O. (1998). The asset vulnerability framework : Reassessing urban poverty reduction strategies. *World Development, Vol 26*(N0 1), 21-45. doi:10.1016/S0305-750X(97)10015-8

Rahayu, T. P., & Harmadi, S. H. (2016). The Effect of Income, Health, Education, and Social Capital on Happiness in Indonesia. *Asian Social Science, Vol. 12*(No. 7), 75-87. doi:10.5539/ass.v12n7p75

Rocco, L., & Suhrcke, M. (2012). *Is social capital good for health ? A European perspective.* Copenhagen: WHO Regional Office for Europe.

Sackou, J. K., Tiade, M. L., Hounsa, A. A., Malik, S. K., Coulibaly, M., Desquith, A. A., Kadjo, F. K., Agoua, S. A., Oga, S., & Kouadio, L. K. (2019). Prevalence and factors associated with hypertension in Anonkoi 3, a peri-urban area in Abidjan (Côte d'Ivoire). *J Public Health Afr, 10*(1106), 90-94. doi:10.4081/jphia.2019.1106

Story, W. T. (2013). Social capital and health in the least developed countries: A critical review of the literature and implications for a future research agenda. *Glob Public Health, 8*(9), 983–999. doi:10.1080/17441692.2013.842259

Sylla, K., Kablan, C., Traore, K., & Dagniogo, Y. A. (2018). Incidence socio-économique du conflit politico-militaire de 2002 en Côte d'Ivoire. *European Journal of Business and Social Sciences, Vol. 6*(No. 11), 169–189. http://www.ejbss.com/recent.aspx-/

Tomita, A., Vandormael, A. M., Cuadros, D., Slotow, R., Tanser, F., & Burns, J. K. (2017). Proximity to healthcare clinic and depression risk in South Africa: Geospatial evidence from a nationally representative longitudinal study. *Soc Psychiatry Psychiatr Epidemiol., 52*(8), 1023–1030. doi:10.1007/s00127-017-1369-x

Wu, B. (2018). From individual social capital to collective social capital: empirical evidence from inter-firm financing trust network. *J. Chin. Sociol., 5*(18). https://doi.org/10.1186/s40711-018-0088-3

Yoro, B. M. (2012). Pluralisme thérapeutique et recours aux soins en milieu rural ivoirien: approche méthodologique. *Recherches qualitatives, 31*(1), 47-61.