**UNIVERSITE DE YAOUNDE I**

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**POSTGRADUATE SCHOOL FOR SOCIAL AND EDUCATIONAL SCIENCES**
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# PATTERNS OF HEALTH INSURANCE SCHEMES AMONG PEOPLE OF THE BIYEM - ASSI COMMUNITY IN YAOUNDE – CAMEROON: A CONTRIBUTION TO ANTHROPOLOGY OF DEVELOPMENT

A dissertation submitted and defended in partial fulfilment on September 11, 2024 for the requirements for the award of a Master's degree in Anthropology

**Specialization:** Anthropology of Development

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**Academic year : 2023-2024**

# AVERTISSEMENT:

*To*

*My mother Madam Kesam Mariana*

## ACKNOWLEDGEMENT

It is with a heart leaping with joy that I wish to appreciate all those who stood by me to make this research achieve its success. My sincere appreciation is directed to my supervisor, Prof. Paschal KUM AWAH whose profession and academic insight, his time and energy spent to ensure that this research grabs the minds of the people as a scientific material can never be underestimated. His efforts have been very important in realizing this research

My gratitude is tailored to the Head of Department, Prof. Paul ABOUNA, for his expert style of administration and coordination of our academic documents, including his profound lectures that has brought us this far in our educational lives.

My sincere thanks goes to all the lecturers of the Anthropology Department who have instilled in us the concepts and theories on how to handle social phenomena with an anthropological insight; Prof. MBONJI EDJENGUÈLÈ, Luc MEBENGA TAMBA, Antoine SOCPA, DELI TIZE TERI, AFU Isaiah KUNOCK, Lucy FONJONG. Dr. Alexandre NDJALLA, ANTANG YAMO, Seraphin BALLA NDEGUE, Evans NGAH KAH, Constantine ASANGWA, Germaine NGA ELOUNDOU and Antoinette NGA EWOLO. I specially thank, Dr. Exodus TIKERE MOFFOR for finding time to read and correct this dissertation.

I am thankful to all my informants for making themselves available to provide responses during the interview and actively participated so that my objectives where met.

I am grateful to my course mates for the wonderful ideas, knowledge and experiences we shared during our studies.

I thank you my friends for the support and encouragement you showed me during my studies and the write up of this dissertation. I thank you in a very special way Mr. Ami Bienvenu because I never would have made it through without your wholehearted support. You started with me from scratch and whenever I needed updates, clarifications and doubted myself in any way you were there to clarify and reassure me. Thank you Mr. Takang Bisong Joshua for sacrificing so much time out of your busy schedule to proof read this final version of my dissertation.

I specially gratify my children for their endless prayers and encouragements to my studies. That alone has given me the push I needed to attain this level of education in my life. I equally extend my sincere thanks to all my relations whose names have not been mentioned here, but who took part in making this research to be accomplished.

## ABSTRACT

This research is titled “Patterns of Health Insurance Schemes among people of the Biyem-assi community in Yaounde-Cameroon: a contribution to Anthropology of Development”. Many people living in the Biyem-assi community do not have health insurance coverage. Few formal sector workers and civil servants enjoy an employment based health insurance plan from the private and public insurance schemes. Low income and informal sector workers pay for healthcare out-of-pocket-which acts as a barrier to access. The researcher who thinks that these people do not have access to a strategic health insurance protection decided to investigate and document how people living in this community finance their healthcare by asking the following research question; What are the patterns of health insurance schemes that enable the people of Biyem-assi to access healthcare? These question let us to propose the following research hypothesis; the people of Biyem-assi may access healthcare through a complex web of insurance schemes; these research question and hypothesis were used to develop the research objective which is; to explain the patterns of health insurance schemes that enable the people of Biyem-assi to access healthcare.

In order to attain the objectives of this research, we employed the qualitative research approaches and methodology. The data collected was qualitative, with in-depth interviews and observation methods to collect primary data, including documentary reviews to collect secondary data. Recorded data was transcribed, coding for identification and categorization of themes was done to draw insights into the data. The analysis process was content based and interpretation for data collected was given a thorough description to make it meaningful. We used three theories to discuss the “adverse selection” and “moral hazards” concepts in insurance coverage. conventional economic theory of the demand for health insurance propounded by Thomas Besley (1991), the theory of vanishing welfare gains in health insurance, by John Nymams (2003) and the interpretive theory of culture and health insurance promoted by Seleskovitch (1968).

The findings of the research revealed that people perceived health insurance as being a scheme of savings for healthcare and so contributed their savings to these schemes; the people of Biyem-assi belong to several groups with insurance scheme activities including: faith based schemes, ethnic based, professional based, standard based health insurance schemes, just to name this few, where they contributed in kind or cash to secure their coverage. Almost all informants belonged to a form of health insurance scheme, but some people navigated across many of such schemes in the form of insurance scheme shopping. This research was limited to the qualitative approaches and methods but quantitative and mixed approaches for further research may reveal the trends of subscription for health insurance coverage.


**Key words**: *Health care, health insurance scheme, health financing, out-of-pocket-expenditure*

## RÉSUMÉ

Cette recherche s'intitule « Modèles de régimes d'assurance maladie parmi les membres de la communauté de Biyem-assi à Yaoundé-Cameroun: une contribution à l'anthropologie du développement ». De nombreuses personnes vivant dans la communauté de Biyem-assi n'ont pas de couverture d'assurance maladie. Peu de travailleurs du secteur formel et de fonctionnaires bénéficient d'un régime d'assurance maladie basé sur l'emploi dans le cadre des régimes d'assurance privés et publics. Les travailleurs à faible revenu et du secteur informel paient leurs soins de santé de leur poche, ce qui constitue un obstacle à l'accès. Le chercheur, qui pense que ces personnes n'ont pas accès à une protection stratégique en matière d'assurance maladie, a décidé d'étudier et de documenter les manières dont les habitants de cette communauté financent leurs soins de santé en posant les questions de recherche suivantes: quels sont les modèles de régimes d'assurance maladie qui permettent aux habitants de Biyem-assi d'accéder aux soins de santé?, Le question nous permettent de proposer l' hypothèsis de recherche suivante: Le habitants de Biyem-assi peuvent accéder aux soins de santé par le biais d'un réseau complexe de régime d'assurance; le question et l'hypothèsis ont été utilisé pour développer l'objectif de recherche suivant: pour expliquer les modèles de régimes d'assurance maladie qui permettent aux habitants de Biyem-assi d'accéder aux soins de santé.

Afin d'atteindre les objectifs de cette recherche, nous avons utilisé des approches et méthodologies de recherche qualitative. Les données collectées étaient qualitatives, avec des entretiens approfondis et des méthodes d'observation pour collecter les données primaires, ainsi que des analyses documentaires pour collecter les données secondaires. Les données enregistrées ont été transcrites, codées pour identifier et catégoriser les thèmes afin de mieux comprendre les données. Le processus d'analyse était basé sur le contenu et l'interprétation des données collectées a fait l'objet d'une description approfondie afin de les rendre significatives. Nous avons utilisé trois théories pour discuter des concepts de «sélection adverse» et de «risques moraux» dans la couverture d'assurance; le théorie de l'économique conventionnelle de la demande d'assurance maladie proposée par Thomas Besley (1991), la théorie de la disparition des gains de bien-être dans l'assurance maladie de John Nymams (2003) et la théorie interprétative de la culture et de l'assurance maladie promue par Seleskovitch (1968).

Les résultats de la recherche ont révélé que les gens percevaient l'assurance maladie comme un système d'épargne pour les soins de santé et contribuaient donc à ces systèmes; les habitants de Biyem-assi appartiennent à plusieurs groupes avec des activités de systèmes d'assurance, y compris: des systèmes basés sur la foi, basés sur l'ethnie, basés sur la profession, des systèmes d'assurance maladie basés sur les normes, pour n'en nommer que quelques-uns, où ils contribuaient en nature ou en espèces pour garantir leur couverture. Presque tous les informateurs étaient affiliés à une forme de régime d'assurance maladie, mais certaines personnes naviguaient entre plusieurs de ces régimes, sous la forme d'une recherche de régimes d'assurance. Cette recherche s'est limitée à des approches et méthodes qualitatives, mais des approches quantitatives et mixtes pourraient révéler les tendances en matière de souscription à une couverture d'assurance maladie.


**Mots clés** : *Soins de santé, régime d'assurance maladie, financement de la santé, dépenses personnelles.*

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# LIST OF ACRONYMS AND INITIALS

## List of Acronyms:

**AIR**: American Institutes of Research

**AIDS**: Acquired Immune Deficiency Syndrome

**ASCA**: Accumulating Savings and Credit Associations

**ART:** Anti-Retroviral Treatment

**BEPHA**: Bamenda Ecclesiastical Province of Health Assistance

**BMHO**: Boyo Mutual Health Organization

**FAO**: Food and Agricultural Organization

**HI**: Health Insurance

**HIC**: Health Insurance Coverage

**HIS**: Health Insurance Schemes

**IFI**: Informal Financial Institutions

**KOMCUDA**: Kom Cultural Development Association

**NSIF**: National Social Insurance Fund

**NIC**: National Insurance Commission

**NGO**: Non-Governmental Organization

**NADECO**: Njinikom Area Development Cooperation

**PHI**: Private Health Insurance

**UHIC**: Universal Health Insurance Coverage

**WHO**: World Health Organisation

**HIL**: Health Insurance Literature

## List of Initials:

**CBHI**: Community Based Health Insurance

**CWA**: Catholic Women's Association

**CMA**: Catholic Men's Association

**GNP**: Gross National Product

**HIV**: Hunan Immune deficiency virus

**LMICs**: low and middle-income countries

**NSSF**: National Social Security Fund

**MFI**: Micro-finance Institutions

**NHI**: National Health Insurance

**OOP**: Out of Pocket Payments

**PLWA:** People Living with HIV/AIDS

**SRM**: Social Risk Management

**UHC**: Universal Health Insurance

**WB**: World Bank

**YCW**: Young Christian Workers

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# GENERAL INTRODUCTION

## 1. Introduction

This part of the research introduces the reader to the context of the study. Here, the researcher explains the domain and why a research of this nature is of importance to the community. The researcher continues with a justification of the study, while explaining a personal experience that provoked a research of this nature, which was closely followed by a scientific justification, the importance of the concept to the society as a whole. In this section, we equally had to deal with the research problem and the problematic which led to the research questions, the research hypotheses and the objectives of the research. In order to gather related data for this research, we designed a research methodology, where we used primary and secondary methods of data collection to obtain relevant data for the research. Data analyses techniques were also outlined in this section of the research which helped the researcher to draw conclusions concerning the findings of the research.

## 2. Context of the study

In Cameroon like many low income countries, access to quality healthcare is hampered by several factors, such as poverty, high cost of care, and out-of-pocket payment policies (Dercon, 1999). Health which is defined by WHO, (1948) as a state of complete physical, mental, and social well-being is not merely the absence of disease or infirmity. In 1986, the World Health Organization made a further clarification which defines health as "a resource for everyday life and not the objective of living. It supports an individual's function in the wider society, since a healthful lifestyle provides the means to lead a full life with meaning and purpose. Frenz et al. (2005) holds that health has an intrinsic value (it produces wellbeing) and an instrumental value (it is an important determinant of economic development). Health therefore plays a primordial role in the economic development of every community, although quality healthcare poses as a major challenge among households in the communities. Increased efforts towards providing quality healthcare is however paramount (Criel, 2005) because many people still suffer from the low healthcare access syndrome. According to the World Health Organization, up to 3.5 billion people in the world still lack access to the needed healthcare services. Child disability in sub Saharan Africa is closely linked to poverty (WHO, 2011). According to Morrison (2010), in Cameroon, the percentage of children suffering from acute malnutrition ranged from approximately 15 to 20 percent and about 42 million children below five years old suffered from acute malnutrition in 1996.

Over the last decades, health insurance has been found to increase health services utilization as a financial instrument which enables low-income households to manage their financial risks (Dror, 2007) and reduce catastrophic out-of-pocket expenditures. According to (Thomas, 2003), health insurance is a formal arrangement where insured persons (beneficiaries) are protected from the costs of medical services that are covered by the health insurance plan (the benefits). The

provisions of the universal health insurance coverage hold that, all people in the global space should have access to quality health services without any financial hardship (WHO, 2015). This concept resonates with the developed countries, but is limited in scope within the low and middle income countries. In the developed countries, health insurance has been used as a main tool to close the gap that exists in healthcare between the rich and those with limited resources. But in low and middle income countries like Sub-Saharan Africa, including Cameroon, the concept of health insurance operates within a different cultural context, where formal sector workers and civil servants enjoy an employment based health insurance plan from the private and public insurance schemes. This context gives health insurance a holistic outlook that is patterned to meet the needs of a category of people who make up less than 10 percent of the total population. Majority of the low income people and informal-sector workers do not have access to this strategic health insurance protection. They therefore pay for healthcare out-of-pocket, which is one of the most inefficient and inequitable forms of health financing and act as a barrier to access (Evans, 2005).

This pattern however does not fit squarely to meet the globally defined requirements of the universal health insurance coverage sustainable development goals projections for 2030, thus proponents of health insurance may think that, Africans including Cameroonians living in the Biyem-assi community do not have a health insurance scheme. We now set out to investigate and document what obtains a health insurance policy for people living in the Biyem-assi community by asking some Research Questions, which were translated to research hypotheses that were used to formulate research objectives that guided the researcher throughout the data collection and write up of these dissertation.

## 3. Justification of the study

There are two principal justifications at the foundation of this research work: Personal and Scientific justifications.

### 3.1. Personal justification

I developed keen interest in carrying out a research in the health insurance domain over a long while since the first time I leant about the concept. I was job hunting, so I was hired to work for an insurance company. Here I discovered many products in the insurance market including car insurance, housing insurance, personal accidents insurance, civil liability insurance, professional liability insurance just to name a few. However, health insurance captured my intuition and sense of belonging. I was working at the front office then, but I noticed how people always cue in and outside the health department and out of curiosity, I was told that they have health insurance coverage and usually come around to ask for reimbursements after consultation and treatment and/or a payment voucher for either lab tests and medication. I did not understand what all that meant, but I decided to learn more about it. So during the first workers association meeting, the

delegate had a discussion on these and reminded all newly employed personnel to register. I immediately asked for registration modalities and registered, where I discovered that all workers and their household members were covered by the policy and could enjoy all healthcare benefits from consultation, laboratory tests, and hospitalization. Each time I went for consultation, certain advantages were considered, were after filling a document that is counter signed by the doctor, I only had to pay a coinsurance amounting to 20% of the entire bills as the health insurance policy covered the remaining 80%. Workers are covered 100% for all laboratory tests and also for every hospitalization. Reimbursements are made directly to the 'conventional' hospitals or to the insured once medical payments were made out-of-pocket to hospitals outside partnership convention. It is mind blowing to know that worker's children also enjoy the same benefits from the policy. My son gets sick often and his healthcare costs are always so enormous; a situation which should have actually been a burden to my family's income, but with the health insurance policy, we can easily access timely advanced medical care for his consultation and treatment to avoid any catastrophic conditions and extreme charges.

Working in a non-life insurance company, we treat files for insured clients working for multinational and international companies, who with their families enjoy the health insurance benefits from their employment. We understand that such benefits always make them smile at the coverage apparitions, ranging from 80%, 90% and even 100%. This sharing of healthcare burden is a lot helpful to insured clients as they can manage illness without stress. They have the opportunity to access multiple improved health facilities for better healthcare services. The estimated working insured populations including those insured in other insurance companies could not even make up 10% of the total population of the community. This tickled our minds and we started asking questions concerning low income members of the community who depend on informal work activities for a livelihood. Health insurance is important for everybody, but never for once did we notice this category of people coming to ask for health insurance coverage. We almost concluded that the health insurance policy was reserved for the relatively "rich" people of the community who could afford to pay for their coverage. Given the opportunity to study and defend a Master's II degree in Anthropology, the interest to find literature on health insurance coverage for this category of people could not be suppressed.

It was based on the above that we decided to carry out a research on "patterns of health insurance schemes among people of the Biyem-assi community", intending to explain how these patterns enable the people of this community to access healthcare. The researcher's intention was to understand the perception of health insurance coverage among these people, to investigate the mechanisms that they use to finance healthcare and to determine the power struggle in health insurance schemes to satisfy community member's healthcare needs.

### 3.2. Scientific justification

A research of this magnitude can be justified scientifically because previous studies in the Biyem-assi locality focused on the following: "Accessing knowledge, attitude and practices of Health care workers regarding biomedical waste management at the Biyem-assi District Hospital, Yaounde" (Autaon, 2000); "Health related quality of life among the elderly in Cameroon: A case of Biyem-assi Health District" (Numfor, 2016); "Demographic and socioeconomic determinants of smoking in the Biyem-assi Health District" (Zakariaou, 2018), just to name this few. These studies and many more are important for the development of the Biyem-assi community but were not in any way related to patterns of health insurance schemes and healthcare financing among the people of this community. The absence of research on this aspect was a glaringly important that during an intended literature review to pursue a masters II degree in the University of Yaounde I, we sought to investigate how people living in the study area finance their healthcare in order to access timely medical services. Therefore, in a bit to close the gap of literature here, the researcher designed a current research on patterns of health insurance schemes among people of the Biyem-assi community, with an intention to explain the patterns of health insurance schemes that enables the people of this community to access healthcare.

## 3. Research problem

Based on the above, the research problem is the fact that majority of the low income people and informal-sector workers living in the Biyem-assi community do not have access to a strategic health insurance coverage. Instead, they place the burden of maintaining their health on themselves (Weinger & Akuri, 2007) and often suffer from catastrophic out-of-pocket-healthcare expenditure (spending exceeding about 40% of nonfood consumption) which acts as a barrier to access, since these people do not have access to strategic health insurance coverage. The advancement of medical sciences and the rising standards of living has made it unacceptable for people to suffer or die from lack of access to basic healthcare (Asfaw, 2009). Unfortunately, healthcare access as a basic necessity is limited in developing countries due to the resource paucity in healthcare systems (Borges, 2017). It has been well recognized by policy makers that a well-functioning heath system is imperative for the entire population to have an adequate access to healthcare services (Dror, 2013). The economic crisis in several developing countries has resulted in the reduction of the healthcare budget. As a consequence, looking for an alternative solution to efficiently finance healthcare is the most important concern for policy makers (Ambler, 1994).

Informal sector populations have limited access to healthcare facilities and services that cater for their health needs (World Bank, 2013). Illness therefore still represents a permanent threat to their income earning capacities (Patricia, 2020), and keep exposing household members to high financial risks (danger that can translate into the loss of capital and relates to the odds of money

loss). Although a vast majority of these populations have concerns about their health and recognize a variety of factors that endanger it, they have previously had little means regarding how to finance their healthcare and access timely medical services. Some researchers have reported on Private and Public Health Insurance Schemes, which accordingly reduces out-of-pocket healthcare expenses amongst formal sector populations through an employment based health insurance coverage plan (Borghi et al, 2016). There is still need for an extensive research regarding patterns of health insurance schemes that enable informal sector uninsured indigenous people to finance their healthcare. This present research is therefore an Anthropological perspective to investigate and document what obtains an insurance policy for people living in the Biyem-assi community. The focus was on aspects relating to patterns of health insurance schemes that enable these people to access healthcare; their perception of health insurance coverage; the mechanisms they use to finance healthcare and the dynamics of health insurance schemes used to satisfy community members healthcare.

**4. Statement of the problem**

Anthropology remains a vast field of research in social sciences within which all subjects relating to community participation can be studied. This research situates itself in the branch of health insurance, aimed at improving access to healthcare facilities through the participatory approach to risks pooling and risks sharing among community members. Many researchers from other social science disciplines have carried out studies in the domain of health insurance, mainly: Psychology, Sociology, development, within which they were aimed at understanding aspects relating to community members and health insurance knowledge, attitude, and literacy, just to name this few.

Autaon, (2000) carried out a research on "Accessing knowledge, attitude and practices of community members towards health insurance coverage". The objective of his research was to determine the knowledge and attitude level of informal sector workers towards health insurance subscription in the community. According to this research, health insurance knowledge provides access to healthcare with financial risk protection. Most of the respondents, about 80% had no prior knowledge on community based health insurance, while only 9% of the participants had a good knowledge about community based health insurance in the community. The findings therefore revealed that, knowledge and attitude influenced enrolment to Community Based Health Insurance Schemes.

Asahngwa (2019), who also carried out a study on "The impact of the Mutual Health Scheme on access to prevention and treatment services for HIV/AIDS positive patients in rural Boyo in Cameroon", was out to investigate the importance of the scheme on prevention and treatment services for people living with HIV/AIDS (PLWA). According to this study, limited

financial resources impede access to healthcare services especially for the rural poor including PLWA in Boyo. PLWA usually have to pay for a lot of treatment related services whose cost deprives many of them from their Anti-Retroviral Treatment (ART). According to Asahngwa (2019), the creation of the Boyo Mutual Health Organisation (BMHO) in 2007 was a timely intervention to enable the people of this community to access quality healthcare including PLWA, by reducing heavy expenditures for healthcare, considering that these PLWA needed regular and constant healthcare and counselling services.

While Autaon's research was based on the influence of knowledge and attitude of community members towards health insurance subscription, the objective of Asahngwa's study was specifically to assess the activities of the BMHO to the lives of the PLWA in that community. These however did not in any way relate to our research which is out to explain the patterns of health insurance schemes that enable people of the community to access healthcare, therefore there existed a gap that needed to be filled. This present research is therefore an Anthropological perspective that accesses patterns of health insurance schemes in the Biyem-assi, with the main objective being to explain the patterns of health insurance schemes that enable the people of this community to finance healthcare. Specifically, to understand the perception of health insurance coverage among the people of the Biyem-assi community, to investigate the mechanisms they use to finance healthcare, and to determine the power struggle of health insurance schemes to satisfy the health needs of the people of Biyem-assi in Yaounde – Cameroon.

## 5. Research questions.

### 5.1. Main research question

What are the patterns of health insurance schemes that enable the people in Biyem-assi to access healthcare?

### 5.2. Specific research questions .

How do people of the Biyem-assi community perceive health insurance coverage?

What are the mechanisms used by the people of Biyem-assi to finance healthcare?

What are the power dynamics among health insurance schemes to satisfy community member's healthcare?

## 6. Research hypotheses

Research hypothesis has to do with ideas or explanations for something that is based on known facts but has not yet been proven. Or it could be considered as tentative answers to the main and specific questions of a research to be carried out, which awaits confirmation or refusal. Thus this research has a main hypotheses and specific hypotheses.

### 6.1. Main research hypothesis

The people of Biyem-assi may access healthcare through a complex web of insurance

schemes.

**6.2. Specific research hypotheses**

The people of Biyem-assi perceive health insurance as a scheme of savings for healthcare;

They belong to community based groups whose activities constitute healthcare financing mechanisms;

Community based groups use health insurance schemes activities to satisfy member's healthcare needs.

**7. Research objectives**

Research objectives are usually active statement about how the research is going to answer the general and specific research questions.

**7.1. Main research objective**

To explain the patterns of health insurance schemes that enables the people of Biyem-assi to access healthcare;

**7.2. Specific research objectives**

The specific objectives of this study are as follows;

To understand the perception of health insurance among the people of Biyem-assi community;

To investigate the mechanisms used by community members to finance healthcare access;

To determine the power struggle in health insurance schemes to satisfy community member's healthcare.

**8. Research Methodology**

This section contains a description of the physical steps taken to gather data for the study. It describes study participants and the procedures such as the administration of the interviews. It also describes the instruments that are used to collect data, the variables that are very central to the study and details sampling designs and sampling methods, collection designs and their techniques, data collection, editing as well as data analysis procedures.

**8.1. Research design**

The qualitative approaches were used to collect, analyse and interpret data. We used in-depth interviews to collect primary data and to generate in-depth description of the mechanisms used by community members to finance healthcare. We focused our interviews with household heads, insurance facilitators and health workers in the Biyem-assi community. Some follow-up telephone interviews were conducted as the research progressed and additional information came to light, requiring us to go back and ask additional questions from the informants.

**8.2. Setting**

This study was focused on the Biyem-assi neighborhoods located in Yaounde, the center region of Cameroon: Rond-point Express, Acacias, Carrefour Biyem-assi, Rue Saint-Marc, Maison

Blanche, Montée des Sœurs, Montée Jouvence, Superette, Tam-Tam, and TKC.

### 8.3. Sample and sampling

Sampling has to do with selecting among a population a particular group of persons to be used in carrying out the investigation.

#### 8.3.1. Sample

Sampling constitutes the selection of a smaller group from a larger one or a study population such that the group is representative of the larger population.

#### 8.3.2. Sampling techniques

The Snowball and Convenience sampling techniques were used during the data collection process: Snowball sampling technique because, most interview sessions helped us to meet other participants with defined criteria for the research, and also references of some books that we read linked us to other references that we exploited for the literature reviews. Convenience sampling technique, because we identified and interviewed some participants at the hospital centres as patients or workers and at the insurance offices when clients came in to subscribe for their car insurance policies.

#### 8.3.3. Sample population

For the purposes of this research, the researcher preferred to work with the English-speaking population of this community. This is because communication was fluent and clear for expression and so understanding the subject matter between the researcher and the respondents was easy.

#### 8.3.4. Sample criteria

The purpose of this is to document variations and identify important common patterns. The criterion for this research was simple; respondent must be a household heads, health and insurance workers, patient on consultation and/or community based insurance scheme facilitators.

#### 8.3.5. Sampling process

The sampling process involved the selection of various individuals to participate in the research by making it a non-probabilistic technique. We identified the sites and those who fell under our selection criteria were invited to take part in the research. When agreed, they were enrolled. In the case where they did not agree, we moved to the next until we attained the quota of the various neighborhoods of Biyem-assi in Yaounde. The informants were selected on the basis of certain criteria that would be cited here; informant should be able to express in English language and pidgin English, should be a head of household, should be a health insurance facilitator, should be a health worker, just to name a few. That is how respondents were spotted and invited to participate for the study. Interviews took place in English and Pidgin, but most interviews took place in English, which is the most commonly spoken language among Anglophone families in the

area. A translator was not needed as the researcher is originally from one of the English speaking regions of Cameroon and lives in the locality where the research was carried out. Interviews started with initial questions and then proceeded to follow-up probes, depending on the initial responses. This helped to ensure that the participant was not being influenced to respond in a particular way and confirmed that information gathered from participants mirrored the actual situation. For confidentiality purposes, pseudonyms were used in the research so we do not disclose the identity of the participants. Interviews were conducted in shops, offices, health facilities, stalls, houses just to name this few. The interviews lasted no more than 20 minutes. An example of the interview prompts includes: Do you belong to any social group in your community? If yes, what are the mechanisms used to finance health care? Can you briefly explain how the procedure is carried out? What are some of the advantages of health insurance coverage? Are you a member of a voluntary health insurance organization? If the response was yes, we asked more specific follow-up questions, such as: Why did you enroll in community-based insurance schemes? If the response was no, we asked: Where did you get the money to pay your healthcare bill? Did you receive financial help from friends? Why? Did you receive financial help from family members? Depending on the responses, we asked more specific follow-up questions, such as: Do family members have an obligation to provide financial support when you are sick? Why? Depending on responses, we asked specific follow-up questions to gather adequate information about health insurance in the community.

**8.3.6. Sample size**

A feature of qualitative sampling is the fact that, the number of cases sampled is often small. This is because, as mentioned above, a phenomenon always appears once to be valuable. Given that the research is purely qualitative, it is not easy to present quantities before the data collection process, we shall use the non-probability sampling techniques to collect informants for the study.

**8.5. Methods of data collection**

This research was focused on the ‘Patterns of health insurance scheme in the Biyem-assi community. In order to fulfil the objectives of this study, we made use of the primary and secondary research methods.

**8.5.1. Primary research methods**

The study is qualitative; therefore, we employed primary qualitative research methods such as: face-to-face interviews, direct and indirect observation, recordings etc.

**8.5.1.1. Interviews**

The researcher used interviews, which is a face-to-face discussion process where the researcher facilitates some sort of conversation with the research participant to gather useful

information about the research subject. This conversation can happen physically as a face-to-face interview or virtually as a telephone interview or via video and audio-conferencing platforms. During an interview, the researcher has the opportunity to connect personally with the research subject and establish some sort of relationship. This connection allows the interviewer (researcher) to gain more insight into the information provided by the research participant in the course of the conversation.

**8.5.1.2. Observation**

Following the nature of our study, we used the qualitative observation method to collect sensitive data, especially such information that the client may not be able to respond to during the interview process. In order to gather useful information to fulfil the objectives of our study, we used direct and indirect observation.

**8.5.2. Secondary research methods**

**8.5.2.1 Documentary Research**

We researched on documents in libraries, websites, books, articles, thesis and dissertations using a qualitative snowball research method, where we used references in books and websites reviewed to read other books in the library, and search additional websites to acquire additional materials for the research work. Most of the documented information was acquired from the university of Yaounde1 library, and the research statistic centers in and around Yaounde. In these libraries we read books, encyclopedias', journals, articles and dissertations. Some information was gotten from the internet where references of related documents helped us to gather more secondary data for the study. In order to interpret the secondary data, we carried out an intensive literature review from both public and private libraries. These enabled us to come out with references of books, journals and articles that were read during the write up proper.

**8.6. Data collection techniques**

Techniques of data collection have to do with the ways in which the researcher collected the data from the field. In regards to this work, techniques that were used are; in-depth interviews focus group discussions and direct observation.

**8.6.1. In-Depth Interview**

The researcher used interviews, which is a face-to-face discussion process with the participants. It facilitated a conversation with the research participants, where we gathered useful information about patterns of health insurance schemes in the community.

**8.6.2. Direct observation**

**W**e used the direct observation method as a technique to collect data for the study, especially where the respondent was unable to provide information required for the study. We used direct observation at the hospitals secretariat to observe how insured participant's health files were

treated, indicating the coinsurance, co-payments and deductibles.

**8.6.3. Indirect Observation**

The researcher used indirect observation by participating and observing participants with catastrophic health conditions, and who do not have to benefit from any health insurance coverage to notice how out of pocket expenditure can be a burden to their finances.

**8.7. Tools of data collection**

To enable the researcher collect data at the field, data collection tools were used for an up-to-date data and to register all the necessary information that was gotten from the field during the study. This was in order to avoid missed out information on the field. Instruments such as interview guide, focus group discussion guide, observation guide, camera, tape recorder, pens and block notes.

**8.7.1. Interview guide**

In order to complete an effect interview session, we used an interview guide, containing the questions that the researcher asked the participant during a face-to-face discussion with the respondents at the field. This was used especially for household heads to ask questions relating to health financing mechanisms used to finance health care, in order to provide solutions to the catastrophic out of pocket expenditure for health care.

**8.7.2. Observation guide**

An observation guide was used to direct and remind the researcher of the relevant points to be observed and taken note of while field as well as the topics of interest associated with the research's topic.

**8.7.3. Camera, tape recorder, pens and bock notes**

This digital tools were used during the field work to facilitate the collection of data.

**8.7.3.1 A tape recorder and/or telephone**

A tape recorder was used during interview sessions participants to record discussions during the face to face interview sessions in order to avoid mission out on any important information from the informant. We also used tape recorders during all observation sessions, while recording activities of participants in a relevant act. The researcher recorded replies from respondents during their discussion in the field in order to recall details of information that was given but the researcher was unable to note correctly in her jotter.

**8.7.3.2. A camera and /or telephone**

A camera was used to take pictures of some participants found at the hospital. Tape recorder of phones; the researcher will use one or both to record discussions with the respondents during the interview process, especially during the focus group discussion.

**8.7.4. A Note book and a pen**

The researcher used the note book and the pen to jot down responses from the respondents during the face to face interview sessions and observations of participants activities at the filled.

**8.8. Procedures for collecting data**

Initially, the researcher presented a research proposal on an interest research topic at the department of Anthropology, which was approved by the supervisor. We obtained an authorization to do field research from the Head of Department. We proceeded by designing an ethical consent document which was presented at every level necessary to obtain permission to access respondents in the community were the study was carried out. The ethical consent document indicated that there was going to be respect for human beings during the research process, including the avoidance of problems with confidentiality, which would be considered unethical because the Ethics committees usually look very carefully for questions that are unethical. Once we obtained permission to access the study area from the council authority, we proceeded to the field and began the data collection process.

Presentation of personality at the place of research; before accessing the hospital centers, we approached the hospital director to do a proper presentation of the research objectives, while seeking his authorization to access the hospital to carry out research. Same procedure was repeated once we got to an insurance company before the interviews or observations commenced. We systematically did a proper presentation to each respondent we approached for an interview process, making them to understand that the study was purely for academic purposes, with reassurance of their respect for humanity and confidentiality of information.

**8.9. Data management**

When the face to face discussions and interviews was conducted at the field, data collected was carefully edited, sorted and coded to eliminate the inconsistencies and errors that were made during the data collection process in the field. Then information was registered with certain important details that were not mix up with other data, for example; respondents name, place, date and time of interview. When data has been carefully registered with the above variables, it shall carefully be stored in places where the researcher can access information whenever necessary. For example, computer, USB key, telephone, emails just to name a few.

**8.10. Methods of Data analysis and presentation**

**8.10.1. Content analysis**

The social science proposes a wide range of methods of analysis, anthropology shares in the methods which were used in this study as a social science discipline. However the choice of a method or the other depended on the kind or type of data collected. “Since cultural analysis starts from a sheer beginning and ends where it manages to get before exhausting its intellectual impulse” (Geertz, 1973). As earlier mentioned, the qualitative data collection techniques were used to

acquire data for this research. Data collected was inspected, transformed with useful modeling standards, aiming to discover useful information for the study. Cleaning which had to do with checking the accuracy and the completeness of the data, while removing any irrelevant information and making corrections as needed. Data was transcribed by making meaning out of assorted information during the research process and sorted in a way to make sense out of some information that was collected in a hurry and to throw away less important information. Even recordings that were made during discussions in the interview sessions were transcribed to come out with relevant information that was related to the objectives of the research. Videos and snap shots taken during the observation process were viewed view with the aim of transcribing and making meaning out of the information that was videotaped and snapped.

Our interviews were used to transcribe using the content based analysis and so doing we selected the content to be analyzed based on the research questions. After which we determined the coding categories by setting up rules as we came up with themes related to the topic of dissertation then categorized the responses under these big themes. After the setting up of the rules we coded the different categorize then code the content. Also, we checked the validity and reliability of the content by finding correlations and patterns in order to communicate the various concepts. Furthermore, we were able to check the validity and reliability of the data collected by understanding the intentions of the respondents through gestures and comments, behavior put in place to answer questions. This format of analyzing helped us to avoid repetitions as we were able to group their responses under specific broad themes.

The content analysis exercise helped us to choose the adequate approach. We used content and context analysis. With the content analysis we took what people said and the context was within the health care activities of household heads of the Biyem-assi community which is among the approaches to qualitative research. With life history, the narration of history was done by a key respondent called the narrator accompanied by another person. This historic version does not exactly carry facts or truth, but it was important in this research work to know about the past events which was helpful for this research work. We also opted for the naturalistic enquiry. This is an inquiry conducted in natural settings (in this case on the streets) using natural methods such as observation, interviewing, thinking, reading and writing in natural ways by a researcher.

### 8.10.2. Identifying codes and reducing the codes to themes

Codes were derived through transcribing and labeling words or phrases containing meaning. This analysis therefore led us to the use of content analysis. This is a research technique for making replicable and valid inferences from texts to the contexts of their use.

### 8.10.3. Analyzing iconographic data

Iconography refers to the use of images, pictures or photographs and symbols to represent

ideas or the particular images and symbols used in this way by a researcher. The analysis of images consists in identifying every item on it as well as the various aspects. Once this is done, every identified item and aspects are later put in its context to have a global constitution reality. Colors are not to be neglected in this exercise. They have a lot of meaning as far as analysis is concerned; we took note of shapes, forms, colors, textures and the images that were observed in the field.

**8.11. Interpretations**

Interpretation comes from the Latin word "interpretare" which means: explaining and making sense out of something. Interpretation therefore, the legal act of giving or conferring sense to a theoretical framework as Mbonji, (2005) defines it as "what a researcher finds in a theory, a specialization or much more what he or she formulates in his own words and which will serve as a key of understanding the data of the problem. The theoretical framework was gotten from three theories, including: The conventional economic theory of the demand for health insurance, propounded by Thomas Besley (1991); The theory of vanishing welfare gains in health insurance that was propounded by John Nymams (2003); The Interpretive theory of culture and health insurance that came up strongly, following the publication of the doctorate degree of Danica Seleskivitch (1968).

**9. Ethical consideration**

We presented an ethical consideration document which proved that the study was purely for academic purposes and not for any political objectives. We obtain the consent of the informants before carrying out the research. The informants willingly accepted to give us information after all the conditions needed for answers to questions were read to them. We assured our informants that the information they give us will be used strictly for academic purposes before them taking part in the interview and focus group discussion. We assured informants of the confidentiality of information provided during the interview process, in which case, names of informants shall not be made public during the transcription of the data, they shall be kept in a safe place to ensure that no second party should see. Finally, the privacy of our informants shall be respected, as we shall organize to speak to those who do want to speak in the presence of others interview with them different from the others.

**10. Interest of the study**

We carried out research on 'pattens of health insurance coverage in the Biyem-assi community of Yaounde – Cameroon'. The interests of such a study cannot be underestimated as it impacted both practical and scientific interests.

**10.1. Practical interests of the study**

High-quality health care affects health and wellness among members of the community. A health insurance policy which is a contract between an insurance company and a policy holder

intends to safeguard against high and unexpected health care costs. Although policy holders pay a monthly or yearly premium, co-payments, co-insurance, and deductibles, it is expected that the total is far less than that required if paid fully out of pocket. There are several means by which an individual can get health insurance coverage, either through a self-owned health insurance policy, or as part of an employment package, or through a local community-based health insurance schemes.

Health insurance may either be beneficial if it is provided by a government agency, private business, or non-profit organization. To determine cost, a provider estimates collective medical expenses of a population, and then divides that risk amongst the group of policy subscribers. In concept, insurers recognize that one person may incur large unexpected expenses, while another may incur none. The expense, then, is spread among a group of individuals to make health care more affordable for the common good of all.

Depending on the level of impairment, poor health usually requires a comprehensive, multidisciplinary healthcare team that may include a combination of the following: paediatrician, neurologist, radiologist, orthopaedic surgeon, physical therapist, occupational therapist, and vocational therapist etc. Imparting knowledge concerning health insurance coverage following this study shall be significant to the health insurance knowledge of members of the community, whose means and occupational exposure may influence their acquisition of a health policy to assists them to cut down on out of pocket expenditure and benefit adequate health care facilities.

**10.2. Scientific interests**

A dissertation on this study shall be deposited to the department of Anthropology in the University of Yaounde 1, and to achieve of the department to be used for study references by other students in future. Health insurance scheme activities in the community increased awareness of the concept and change of perception of health insurance coverage in the community, which benefits insurance providers as subscriptions for the coverage is likely to increase and then improve the productivity of insurance companies in and around Biyem-assi Yaounde. Also, the Cameroon fiscal policy on taxing health insurance contracts shall realise increased funds due to multiple health insurance subscriptions by community members. Findings from this research work shall equally help the Cameroon policy makers in the decision making process, especially where decisions have to be made concerning health insurance issues on health care manage.

**11. The Delimitation of the study**

The scope of the study has been reduced to levels manageable to the researcher, yet broad enough to allow for collection of enough data that enables the research to answer the important questions and fulfil its objectives. Health insurance is a very broad concept for which all of it cannot be studied at once, thus it was reduced to a specific context where the researcher sought to

investigate community members knowledge and perception to health insurance coverage. The setting of the study was reduced to a smaller group of persons to be studied for accuracy and efficiency. Reason why this study was limited to the Biyem-assi community of Yaounde 6 district area with group of people in the community, in a particular time frame; from the 15 of April and ended on the 31st of May 2023, but some follow up telephone interviews were conducted as the research progressed and additional information came to light requesting us to go back and ask additional questions from the earlier participants.

**12. Structure of the work**

This write up consisted of a general introduction, five chapters and a general conclusion. The general introduction introduces the research topic and the study context, followed by the justifications of the study (personal and scientific), research problem, and statement of the problem, significance of the study, then the research questions, hypothesis and objectives of the study. This section equally introduced the reader to the methodology that was employed to collect and analyze the data and obtain the results of the study. The five chapters are distinguished as follows:

Chapter one is the general presentation of the Biyem-assi health district in to the Economic phase, physical phase and human phase.

Chapter two of this research work has been segmented in to: the Literature review, Theoretical framework, and Conceptual frame work.

Chapter three elaborates information on community member's perception of health insurance coverage.

Chapter four is a presentation of patterns of health insurance schemes in the community. This chapter elaborates findings on the patterns of health insurance scheme open to members of the Biyem-assi community.

Chapter five presents information on the power struggle among health insurance schemes in the community to satisfy member's healthcare.

# CHAPTER ONE: PRESENTATION OF THE BIYEM-ASSI HEALTH DISTRICT

## 1.0. Introduction

The Chapter one focuses on the setting where this research was carried out. It is a description of the Biyem-assi community, which portrays various characteristics that range from physical, economic, and human characteristics. The physical has to do with the geographical presentation of the locality, while the human phase carries information on the socio cultural and socio economic activities of people in the locality. The Biyem-assi community has distinctive regional - cultural traits, religious and political traditions as well as ethnic varieties of all communities in Cameroon. It is hosting both English and French speaking Cameroonians from various regions of the country that have settled in this area for many years. They practice their different ethnic cultures, religions and political traditions.

## 1.1. Geography

The locality of Biyem-assi occupies a very vast residential area in the Map of Yaounde in Cameroon. It is located between longitude 11o 22’20’’and 11o 30’00’’ to the East, and latitude 3o 82'80"and 3o 48'00"to the North of the area. It has an equatorial climate with four seasons: two rainy seasons and two dry seasons. There is a long and a shot rainy season, where the long rainy season lasts for four months; from March to June, and the short rainy season lasts for two months; from September to October every year. There is equally a long and a short dry season, where the long dry season lasts for 4 months; mainly from November to March and a short dry season which lasts for two months that is from July to August every year. The Biyem-assi community includes several other well-known neighborhoods in the setting, some of which include; Rond-point Express, “Acacias avec son marché populaire”, Carrefour Biyem-assi, Rue Saint-Marc, Maison Blanche, Montée des Sœurs, Montée Jouvence, Superette, Tam Tam, and TKC. For these research findings to be exhaustive and representative, the research shall be carried out in all the neighborhoods that make up the Biyem-assi community of Yaounde.

Yaounde is the capital of Cameroon and the chief town of the Central Province. Yaounde located some 300 (km) from the Atlantic coast, between 3o5' North latitude and 11o31' East longitude (Yogo, 2005). It is surrounded by 7 hills which are responsible for its particular climate and the highest of which are located on the West and North-West sides. Yaoundé has an area of 13,614 ha in 2002 and a population of about 2 million inhabitants in 2006. Its geographical limits are to the West, the district of Nbankomo; - to the East, the Mefou-Afamba department - to the south, the Mefou-Akono department - to the North, the Okola district.

**Map 1:** The map of Cameroon


**Source: Yaounde 6 Council, Consulted on the 17 March 2022 at 2 pm.**

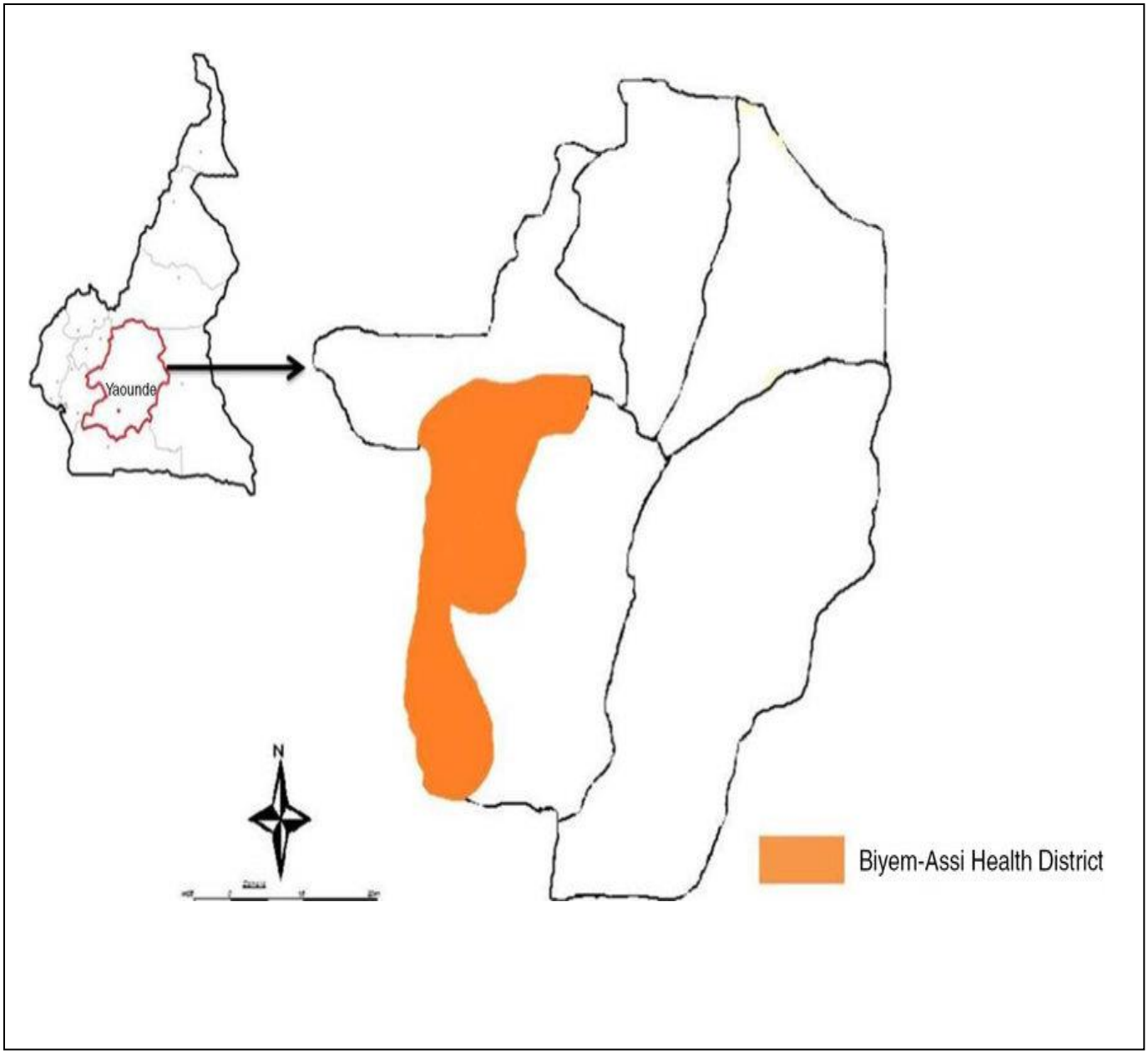
The map 1 above is an illustration of the map of Cameroon showing the location of Yaounde in the central region of the Country

**Map 2: The map of Mfoundi Division**


**Source: Yaounde 6 Council Consulted on 17 March 2022 at 2 pm.**

The map 2 above is an illustration of the location of Biyem-assi in the Mfoundi division in Yaounde the central Region of Cameroon.

**Map 3:** The location of the Biyem-assi health district




**Source: Yaounde 6 Council Consulted on 17 March 2022 at 2 pm.**

The map 3 above illustrates the Biyem-assi health district in the Biyem-assi community of Yaounde in Cameroon.

### 1.1.1. Climate

The climate in the city of Yaounde and its environs is equatorial, characterized by the alternation of two dry seasons and two rainy seasons. The average temperature is 23.5oC, varying between 16 and 31oC depending on the season, and the annual rainfall is 1650mm. The average humidity is 80% and varies during the day between 35 and 98%. The frequent winds are humid and blow in the direction of the southwest; the violent winds are oriented towards the northwest. The

vegetation is of the intertropical type with a predominance of the southern humid forest (Wéthé, 2001).

### 1.1.2. Relief

Morphologically, Biyem-assi in the city of Yaounde is located largely in the watershed of the Mfoundi River. There are four types of terrain:

- Low-slope ridges whose land is easily urbanized;
- The hills that can be developed with slopes varying from 5 to 15%;
- Hills that are very difficult to develop with a slope greater than 15%;
- Floodable valley bottoms, generally with a slope of less than 5%.

From these types of land, two major zones are derived. The non-constructible zones include, on the one hand, the low slope sectors (less than 5%), including the valley bottoms that are generally subject to flooding, and on the other hand, the steep slope zones, permanent sites of erosion and landslides. The areas suitable for construction or urbanization are the slopes and sites with a slope of between 5 and 15%.

### 1.1.3. Hydrography

The city's hydrographic network is very dense and essentially composed of the Mfoundi River and its tributaries. These ensure the natural drainage of runoff and surface water that is discharged into the Mefou River, which in turn discharges its waters into the Nyong River. It is upstream of this last point of rejection that is the current catchment area of raw water intended for the production of drinking water for the inhabitants of the city of Yaoundé and its surroundings. In addition to these waterways, the city has several lakes and natural or artificial ponds whose waters are dangerous for public health because of the discharge of water non-functional wastewater treatment plants (as in the case of the municipal lake), household waste and water from latrines located in swampy areas.

### 1.1.4. Vegetation, Flora, and Wildlife

Research in the Biyem-assi Yaounde topography shows that the neighbourhood is characterised by a lot of hills and valleys. This area is found in the heart of the Equatorial evergreen forest where forest vegetation is supposed to cover every square meter of the domain. The area is also in a tropical domain where the sun is constantly overhead and with high atmospheric humidity. There are also secondary forests, gallery forests and tree forests. The vegetation of this zone is highly influenced by the climatic factors of the region. It also constitutes a mixture of flooded swamp forest. The natural vegetation cover has witnessed profound changes following anthropogenic factors that have prevailed in the region over the years. The swampy zones of the East and South-Eastern region are occupied by large expanses of swamp forest constituted essentially of Hygrophilous vegetation species; dead palms and other trees are dominant in this

area. Most upland vegetation is grassland with little signs of primary vegetation. This can be accounted for by bush burning. Still, according to several species are listed here. They include monkeys, antelopes, elephants, porcupines, rats, several species of birds, reptiles, and for aquatic life a variety of fish.

**1.1.5. Soils**

The soils in here originated from a thick mantle of granitic intrusion over which lies the bedrock forming a good basement for alluvial deposition. In terms of thickness, these soils vary from a few centimeters 2013); there are four main soil types in the region, which consist of ferralitic soils, swampy soils, loamy - sandy soils, Lateritic soils. This distribution is however patchy and is not uncommon to find different soil types prevailing within the same area. These soils are derived from the weathering and decomposition of rocks in association with a decomposed organic component.

The distribution of soil types therefore closely follows the distribution of the geologic framework. The composition of the parent material plays a decisive role in the properties of young soils and may exert an influence on the oldest soils. The Lateritic soils are formed from the weathering of basalts which after oxidation results in the formation of a brownish colored soil type rich in composition and favors agricultural activities. The soils are highly permeable with top soils made up of black silt loam. The abundant vegetation on the marsh has less decomposed organic matter on the organic soil profile. These soils have a high water retention capacity that is greatly reduced only in the dry season. That is why many crops cultivation succeeds in this area. The soils are rich and productive, and this can be seen from their high yields. The soils are usually very hard during the dry season because of exposure to the sun by farming activities. The soils are usually very hard due to the trampling effects of the animals which compact the soils. This is usually when the floodwaters have retreated, and the seasonal hydromorphic soils are left with green vegetation that serves as fodder for grazing animals. Cattle rarer are the practice here given that the soils here favor the growth of pasture and the presence of watercourses like streams and rivers which attract grazers for cattle rearing. These animals before going allowed cow droppings which enrich the soils and make it favorable for crops production. This area is found in the heart of the Equatorial evergreen forest where forest vegetation is supposed to cover every square meter of the domain. The area is also in a tropical domain where the sun is constantly overhead and with high atmospheric humidity.

Just like many Bantu countries in Africa, the aborigines of Yaoundé were Pygmies. These Pygmies were pushed out by the invading Ewondo. Similar to the Fang (Beti, Bulu, and Fang) where they constitute a major part, the Ewondo came from Northern Sanaga to seek refuge in the hills of the South. They were escaping from the Foulbe in the North who constituted

their main threat of the Century. They formed the Mvog who are found distributed on the hills that constitute the present Yaoundé town. Yaoundé was founded in 1888 by the German Colonial Administration. It became the capital of the French territory under the League of Nations in 1922. During the 2nd World War, it was temporarily shifted as the capital of the former East Cameroon Province. With the independence of the country in 1960, the city has remained the political capital. The Yaoundé metropolis plays double administrative roles. It is currently the Regional and National capital. Yaoundé is the Political Capital of both the Centre Region and Cameroon and has a population of over 1.800.000 (BUCREP, 2010).

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**1.2. Historical Setting**

The Biyem-assi district takes its name from the Etoug-ebe River that crosses it. The name of this district comes from the concatenation of Biyeme and assi. Biyeme mean Biyem, and Assi refer to "domestic animal». This is because in the past, some times between 1925 and 1930, all kinds of cattle were raised on one of the slopes of the Biyem-assi community. Biyem-assi would also means in local dialect; “the bottom or by the bottom” or “at the foot of”. Literally, Biyeme Assi could be understood as "we are stuck on the ground or down" (Essono, 2016). During World War I, Yaounde was occupied by Belgian troops from the Congo. After Imperial Germany's defeat in that war, France held Eastern Cameroon as a mandate of the League of Nations and Yaoundé was chosen to become the capital of the colony in 1922. A military garrison which was built in 1895 continued to enable further colonization. Yaoundé experienced rapid growth and continued as the seat of government for the Republic of Cameroon upon its independence in 1960 and the geometric progression in the population density continued rapidly. In 1980 Biyem-assi was still an uninhabited suburb of Yaoundé with very little human existence sported here and there. The district has experienced a demographic explosion since the beginning of the 1990s and displays one of the highest densely populated sub divisions in Yaoundé with about 300,000 inhabitants (Editions Asuzoa, 2016) .

During the 2nd World War, it was temporarily shifted as the capital of the former East Cameroon Province. With the independence of the Country in 1960, the city has remained the political capital. The Yaounde metropolis plays double administrative roles. It is currently the Regional and National capital. Yaounde is the Political Capital of both the Centre Region and Cameroon and has a population of over 1.800.000 (BUCREP, 2010). Yaoundé is the capital and second largest city of Cameroon. Georg Zenker, a German scientist, led a group of people who settled in Yaoundé in 1888. Yaoundé is located in the Ewondo region between the Nyong and Sanaga rivers in southern Cameroon. Cameroon emerged as a major source of the slave trade in the sixteenth century. The Portuguese, British, French, Dutch, and Americans were heavily active in the New World trade along the coast. The Transatlantic Slave Trade was abolished in the 1800s, but European countries remained active in Africa. On the eve of the Partition of Africa Gustav Nachtigal, a German diplomat signed a treaty with two Duala chiefs in 1884 that led to the establishment of German Kamerun. In 1909, Yaoundé became the capital of German Kamerun. During World War I, British, French, and Belgian troops invaded German Kamerun. Belgian troops occupied Yaoundé throughout the war. Following the end of World War I, the League of Nations divided Kamerun, giving the British control of the Southern territory and the French control of the remainder of the territory. Yaoundé became the capital of French Cameroun. Infrastructure investments such as road and railway projects connected Yaoundé to Douala, the largest city in French Cameroun, and the northern region of the territory. Following World War II, nationalism emerged in British Cameroons and French Cameroun. Nationalists formed the socialist Union des Populations du Cameroun (UPC) in 1948. The UPC called for independence from Great Britain and France and reunification of the two territories. On January 1th 1960 France granted independence to French Cameroun. Ahmadou Ahidjo became the first president of the Republic of Cameroon.

Following the division of Cameroon into British and French-ruled League of Nations mandates after World War I created Anglophone and Francophone regions. The emergence of the population of the setting follows with the English-speaking region consists of the Southwest and Northwest provinces, where Pidgin English is the lingua franca and English is taught in school. The educational system and legal practices derive from those of England. The French-speaking region consists of the remaining eight provinces, where French is the lingua franca, the French school system is used, and the legal system is based on the statutory law of continental Europe. This region is dominant in numbers and power. Tension between the two regions increased after the introduction of a multiparty political system in the 1990s.

The English-speaking region is divided into two cultural regions. The Grass fields peoples of the Northwest Province consist of nearly one hundred chiefdoms each ruled by a divine king (fon). Most of these chiefdoms have patrilineal or dual descent kinship systems, although

some groups, such as the Kom, are matrilineal. Polygyny and fertility are important cultural values, although this varies by wealth and education. The social organization and culture of the Grass fielders are closely related to those of the French-speaking Bamiléké peoples of the Western province. Like the Bamiléké, Grass fielders often are in opposition to the central government. The peoples of the Southwest province had less hierarchical systems of governance and social organization.

Most of the southern peoples are Christian or engage in traditional, animist religious practices. The Center, South, and East provinces are characterized by dense tropical rain forest. The Center and South are culturally dominated by the Beti peoples, which include the Ewondo, Eton, and Bulu, and are linguistically and culturally related to the Fang of Gabon. They are patrilineal, grow root crops and peanuts for their own consumption, and grow cocoa as a cash crop. The Ewondo were early converts to Catholicism. The current president is Bulu, and many prominent authors are Beti. Peoples in the East include the Maka and Gbaya, both with relatively egalitarian forms of social organization in Cameroon which reciprocity is a key value. Forestry and tobacco farming are important sources of income. The East province is also home to the Baka, a tropical forest forager (pygmy) group of about thirty thousand to forty thousand living in small camps that exchange forest products with nearby farmers. The Littoral province is in the coastal rain forest region in the southwest. It includes the largest city, the port of Douala, and the industrial, hydroelectric, and bauxite mining area near Edea.

The southern part of the French-speaking area includes the high plateau region of the West province, which includes the Bamiléké and Bamoun peoples. Both are culturally similar to the Grass fielders. The Bamiléké constitute roughly 25 percent of the population. In rich volcanic soils they grow food crops and coffee. The population is dense, and the Bamiléké served as a labor reserve population in the twentieth century, resulting in large, entrepreneurial urban émigré population. The large urban population is prominent in commerce and higher education. Since the conversion of Sultan Njoya to Islam early in the twentieth century, the Bamoun have been a largely Muslim people. Sultan Njoya, a man of unusual intellect, developed an original alphabet and wrote a history of his people and dynasty. A sense of a common national culture has been created through shared history, schooling, national holidays and symbols, and enthusiasm for soccer. However, ethnic distinctiveness remains, and ethnic identity became an increasingly important source of social capital during the 1990s.

Following the opening of the University of Yaoundé in 1962, the centralization of government functions in 1972 led to growth and a diverse population in Yaoundé, where most English speaking people from the South West and North West settled at the Biyem-assi area of the city of Yaounde. Major ethnic groups include the Fulani and Bamiléké. The government and civil

service are the central industries in Yaoundé. Agriculture, manufacturing, and several research centers also play a vital role in the Yaoundé economy. Ahidjo served as president for 22 years and resigned in 1982. Paul Biya became the president of Cameroon in November 1982 and remains in power. Today, Yaounde is the political capital of Cameroon, Africa and home to the famous Unity Palace (at Etoudi), Cameroon's presidential palace. Due to Cameroon's form of centralized governance, Yaounde as the capital city houses all government ministries and administrative support structures. Yaounde Cameroon today is made up of almost all ethnic groups in Cameroon. The majority of the over 1.5 million inhabitants are from the French Cameroun, Ewondo tribe and surrounding neighboring ethnic groups. You will find a small representation of all 250 plus ethnic groups of Cameroon in Yaounde.

A major part of the foreigners in Yaounde are French citizens, Chadians, Nigerians, Moroccans, Gabonese, Americans, and a large representations of other nations through their diplomatic missions. A national culture was first formed by external powers through colonization. Even regional cultural differences emerged originally during the periods of mandate and trusteeship. A sentiment of common national identity is particularly strong in major institutions of socialization such as schools and during international soccer matches, visits by foreign dignitaries, and times of international dispute. Ahmadou Ahidjo, a Muslim from the northern city of Guider, who was president from independence until 1982, attempted to foster national integration by posting civil servants to areas outside their ethnic homelands. His successor, Paul Biya, is a Catholic of the Bulu (Beti) people of the South province.

Ethnic Relations in Biyem-assi Yaounde, in addition to regional and ethnic distinctions, coalitions and tensions exist on a local level. People from the northern areas are collectively referred to as "northerners" by their southern compatriots and share some cultural attributes related to their Islamic religion. Anglophone and Francophone peoples of the Grass fields (Grass fielders, Bamiléké, and Bamoun) share common attributes and have practiced their own inter chiefdom diplomacy for several centuries. The ethnicisation of party politics and the increasing importance of ethnicity in relation to economic claims have led to conflicts between "autochthonous" (indigenous) and migrant populations.

**1.3 Administrative Setting**

Most of Yaoundé's economy is centered on the administrative structure of the civil service and the diplomatic services. Owing to these high-profile central structures, Yaoundé has a higher standard of living and security than every other part of Cameroon. The constitutional law of 18 January 1996 modified the regime of the Urban Community of Yaounde, which remains headed by a government delegate, but which also created 6 urban district communities with elected municipal councils. In accordance with Decrees 92/187 of 1 September 1992 and 92/207 of 5

October 1992, the administrative divisions were created in the Department of Mfoundi, including Yaounde VI. Decree 93/321 of 25 November 1993 created within the Yaoundé Urban Community, the Yaoundé VI Urban District Community, with the headquartered in Biyem-assi and headed by Lord Mayor Jacques Yoki Onana (2020); Biyem-assi is therefore the capital of the 6th district of Yaoundé and hosts the sub-divisions of the Mfoundi Division.The community of Yaoundé 6 is located on a collinear site (city of 7 hills). The regional economy is dominated by agriculture (cocoa, bananas, food crops, livestock and fishing), trade and industry. The city is a tourist destination and communicates with four other very economic cities, namely those of: Douala, Bafoussam, Ebolowa and Sangmelima. The city is growing in an anarchic manner through traditional subdivisions at the expense of public subdivisions. The flood-prone lowlands are densely populated. Several rivers flow through the valleys and several areas are landlocked. This situation hinders access to basic services such as drinking water and sanitation. Urban travel is by private transport. The city is administered by a municipal authority, followed by the central administration through its deconcentrated body and a government delegate. At the national level, the State of Cameroon has inventoried the sources of GHG emissions and their value. The sources identified are: energy, industry, agriculture, land use and waste. The document produced shows that agriculture and land use are the main sources of production. In addition, the State has developed the strategy for reducing GHGs by 2035. These documents provide a framework for activities in the field of GHGs at both the national and local levels.

We can hardly discuss Yaounde VI in isolation without the other city councils sharing boundaries. The Yaounde VI municipality is bounded by Yaounde II and Yaounde VII to the North, the Yaounde IV to the South, Yaounde V to the East and Mbankomo to the West. The other council areas include the following; the community of Yaoundé I District, whose seat is fixed at Nlongkak 1 and which is bounded to the North and North West by the district of Okola, to the South by the district of Yaoundé IV (Ewoué stream), to the South-West by the district of Yaoundé III (Mfoundi River and Bd of May 20, 1972), to the West by the district of Yaoundé II (Warda crossroads, New road Bastos, penetrating the Presidency), to the east and north-east by the district of Soa.

The district communities of Yaoundé II, whose seat is fixed at Tsinga 1 and which is bounded to the south by an unnamed street from the rue du Dr Jamot to the crossroads of the Ministry of Posts, avenue Lucien Fourneau, Bd Rudolph Douala Manga Bell, route de Douala to the crossroads of Matgénie, river Abiergue, ribs 902, 967 and 690; to the southwest by the Anga River to its confluence with the Mefou River, to the west by the district of Mbankomo, to the northwest by the district of Okola . The community of Yaoundé III division, whose seat is fixed in Efoulan and which is bounded to the north by the district of Yaoundé II, to the east by the Mfoundi

River, to the West by the Mefou River from Hill 690 downstream to its confluence with the Anga River, to the South by the Mefou River to its confluence with the Nsa'a River; The community of Yaoundé IV District, whose seat is located in Kondengui and which is bounded to the north by the district of Yaoundé 1st, to the North-East by the unnamed river (Nkolo II) coast 686, to the East and South-East by the Anga River to its confluence with the Mefou River, to the West by the Yaoundé III District. The Community of Yaoundé V District is limited to the north and west by the division of Yaoundé 1, to the East by the Department of Mefou-Afamba, to the South by the Yaoundé 4 department.

**1.3. Leadership and Political Officials**

The twenty-seven-year period of single party rule left a legacy of an authoritarian political culture. At the national level, government leadership resides in the president and his cabinet. On the local level, the "prefet" (district officer) and "sous-prefet" are the most powerful administrative officials. Positions in government are determined through a combination of know-how, party loyalty, and ethnic and regional background. In many areas, local and national forms of leadership coexist. For example, the chiefdoms of the Northwest and West provinces form states within a state, with fons sharing power with government officials. Some chiefs served as rallying points for opposition groups during the political crises of the 1990s.

**1.3.1. Social Problems and Control**

There are several police forces, including internal security police, gendarmes, and military police. The legal system combines the case law system of the British with the statutory law system of the French. Theft is a common crime, and the U.S. State Department issues regular warnings about bandits in the tourist regions of the Northern provinces. Local chiefs serve as justices of the peace and receive a small salary. Officially, criminal law is no longer in their jurisdiction, although they often settle disputes regarding theft, trespass, and personal injury or assault via witchcraft.

Customary law combined forms of dispute resolution ranging from rituals of reconciliation to banning and capital punishment. A combination of discussion and the use of oracles still are used in most cultures. Since the colonial era, the jurisdiction of local chiefs and councils has eroded. Informal social control mechanisms include gossip, ostracism, and fear of occult, ancestral, or divine retribution for wrongdoings.

**1.4. Social facilities**

Biyem-assi is well placed when it comes to education and health facilities which make the researcher already have some expectation about the kind of responses she will expect to get from the respondents in the field.

**1.4.1 Educational Facilities**

Since independence, the country has achieved a high level of school attendance. Primary enrollment in 1994 included 88 percent of children. Secondary education is much less common (27

percent), with boys attending secondary school more frequently than girls. Instruction is in French and English, although the second national language usually is introduced only in secondary school. Primary education lasts for six years in Francophone areas and seven years in Anglophone areas in the past. Secondary education lasts for an additional seven years. School attendance is highest in the cities, especially Yaoundé and Douala, and lowest in rural areas. Despite the relatively high level of school attendance**,** 21 percent of men and 35 percent of women had no formal education in 1998. All quarters that make up the Biyem-assi community have well established educational structures to serve the ever growing populations of that area. At the central of Biyem-assi, there are equally several educational establishments as follows:

- École Publique de Biyem-assi 1 «École des sources»,
- École Publique de Biyem-assi 2,
- Collège Les Sapins,
- Collège Ebanda, Collège privé du savoir,
-CollègeFleming,
- Collège privé laïc « Les Pigeons»,
-Lycée de Biyem-assi.

While less than 3% of men and 1 percent of women attend institutions of higher learning, advanced study is widely regarded as a route to upward mobility. Originally, the University of Yaoundé was the only comprehensive university, while regional universities specialized in particular subject areas. Yaoundé also housed the University Centre for Health Sciences, a medical school servicing several African countries. In the 1990s, the University of Yaoundé was broken up into several campuses, each devoted to a different field of study. The regional universities became more comprehensive, leading to some decentralization in higher education. Many people pursue a doctoral degree overseas.

### 1.4.2. Health Facilities

In 2010, under Mayor Jean Claude Adjessa Melingui, Yaoundé began a flood reduction project, the Yaoundé City Sanitation Master Plan, to deal with "severe floods that disrupted the city 15 to 20 times a year, affecting as many as 100,000 people at a time." After four years, the frequency of flooding had been reduced from fifteen to three times a year, and cases of water-borne diseases such as typhoid and malaria were reduced by almost half. Although Melingui died in 2013, local officials are continuing his efforts to transform the city. Ongoing improvements to sanitation infrastructure are being carried out under a "FCFA152 million plan, largely financed by loans, primarily from the African Development Bank and the French Development Agency", slated for completion in 2017(Essono, 2016)**.**

There are some hospital centers located at Biyem-assi include the following:

- Hôpital de district de Biyem-assi,
- Hopital des sœurs and
- Mbingo Baptist hospital.

For the purpose of the study, we shall concentrate our findings at the Mbingo Baptist Annex hospital. This is because the researcher prefers to work with the English speaking community shall be working with the English-speaking population, and there is evidence that most workers at this hospital center have an English-speaking background.

**1.4.3. Medicine and Health Care**

Health care consists of biomedical treatment, traditional practices (often closely bound to traditional religion). The Islamic medicine in its combinations depends highly on belief, cost, proximity, and the advice of kin and neighbors. Biomedical health care facilities are provided through the national government and Christian missions as well as by private physicians. There are health centers, maternal child health centers (offering prenatal, childbirth, well-baby, and under-five care), and private, general, and central hospitals. In rural health centers, nurses often play a direct role in diagnosis and treatment, and perform surgical operations. Pharmacists are an important source of biomedical advice. Vendors of prescription medicines also give advice to patients and their families, although their understanding of disease may differ from that of physicians and pharmacists.

**1.4.3.1 Traditional practitioners include herbalists**

Bone setters, diviners, and ritual specialists who may supplicate spirits or ancestors; these practitioners adapt to changing conditions by incorporating new ideas and medicines into their practices. There has been a tendency toward the predominance of herbalists and individual treatment. Gradually, they are moving away from being ritual specialists to community wide treatment. Many practitioners specialize in the treatment of particular afflictions. Patients readily consult practitioners from different cultural groups.

**1.4.3.2. The Islamic medical system**

This is derived from Arabic and Greco-Roman sources. These medical practitioners not only are important sources of treatment for northern Muslims but also are popular to other peoples. Many non-Muslims seek protection from evil by displaying symbols of Islamic blessings in their houses.

**1.5. Economy and Commerce**

There exist many industries in Yaoundé like Brewery industry, tobacco, dairy products, beer, clay, glass goods and timber for carpentry workshops. Yaounde as a metropolitan city in recent years has been flourishing in the distribution of products such as coffee, cocoa, copra, sugar cane and rubber. Local residents in the area engage in urban agriculture, some products of which

are used to sell and make money. The rearing and selling of an estimated 50,000 pigs and over a million chickens is common

There are many commercial centers in the city of Yaounde. The main commercial centres spotted around the heart of the city in places like 'Avenue Kennedy' where supermarkets, shops, stores, main office of some enterprises or representations and hawkers are hosted. Small scale farming assists in increasing the exportation of agricultural products. The main subsistence crops include; plantains, beans, potatoes, yams, cassava and corn. The ewondo women take part in agricultural activities as they produce principally food crops used not only for family consumption but also to increase their income. They commonly produce vegetables (Ndole), Cassava (manioc) and corn. The city centre of Yaounde houses government offices, some large hotels, and the central market. The Bastos neighborhood with most homes owned by Cameroonians, place host to majority of the embassies, companies and resident of European, American and other continent community experts. There are many densely populated neighborhoods that make up the Biyem-assi locality. These include the Acacia Round point, Express Round Point, Jouvance, Round Point Express and the Biyem-assi Round point. The population densities in the road junctions give them Central Business Districts (CBD), as businesses boom throughout, thanks to the increasing population. So many business ventures spring up and grow along the road. Businesses like hotel facilities, provision shops, beauty salons, barbing centers, restaurants, fish roasting, soya roasting, chicken and goat meat joints are found in the neighborhood**.**

MTN and ORANGE shops, readymade dress shops, Micro finance and banks some with ATM services, branch offices represented, hospitals and schools, travel agencies, snack bars and drinking sports, with churches are there to serve the huge populations. Food stuff markets easily develop mostly in the evenings where fresh agricultural products and vegetables are being marketed by farmers returning from their farms to sell to people returning from work in the evenings. These road junction areas are always bustling and hustling till pass mid night, hosting a lot of criminal activities which threaten human life and peace; seizing people's handbags carrying phones, money, documents, and sometimes even brutalizing victims in the course of executing their mission. Living standards in these road junction areas is usually very high as business owners simply benefit from the high population densities and high demands to ask for exorbitantly high prices. Landlords too are not left out, as they try to maximize their profit margins at all course. They request for very high rents and frustratingly large number of months to be paid in advance, a condition that most often discourages young business owners from starting up smoothly, especially those who do not have enough capital. These road junction huge populations have reportedly resulted to a lot of destruction of social facilities. There is the Acacia Road junction which is recently being nicknamed 'Carrefour Cacas' because of its insalubrity, disgusting mouths dump, excrements,

including human droppings coming from septic tanks on the road between Biyem-assi Lac, ‘descent Acacias’ and ‘Rond Point Express’. The intersections therefore have very serious sanitation problems as the pollution it brings is not good for the health of humanity. The phenomenon is aggravated during the rainy seasons, as rain water pushes the excrement to human settlements. The smells make road users to nickname these intersections as "Carrefour Caca".

Most of Yaoundé's economy is centered on the administrative structure of the civil service and the diplomatic services. Owing to these high-profile central structures, Yaounde has a higher standard of living and security than the rest of Cameroon. Major industries in Yaoundé include tobacco, dairy products, beer, clay, glass goods and timber. It is also a regional distribution center for coffee, cocoa, copra, sugar cane and rubber. Local residents engage in urban agriculture. The city is estimated to have "50,000 pigs and over a million chickens." Despite the security issues and humanitarian crises that have plagued the central African nation, its economy remains stable. In fact, there is diversification of its productive economic activities, with the services sector contributing about half of the total domestic production. However, like many African countries, Cameroon has long suffered from corruption, which dominates almost all the sectors, particularly in the capital city. Oil, gas and mining revenues are rarely reported, which implies massive graft. In addition, there is weak protection of real and intellectual property, and the judicial system is vulnerable to political manipulation. According to Yaoundé 6 City Council data, over 130 floods struck the city between 1980 and 2014, causing massive loss of life and economic damage. However, there has been a reduction of flooding in the city since the establishment of a sanitation master plan to address the issue. Another measure was to relocate people living along the drainage routes and in low-lying flood zones (Cameroon, 2015).

**1.6. Money and banking**

There are several commercial banks in the city of Yaounde including the central bank of Cameroon (BEAC). The numerous banks in and around the city that offers banking services like savings, loans, exchange of currencies, money transfer etc. some are solely national while others are international and global and are highly represented in the Biyem-assi locality. Besides banks, Biyem-assi has micro finance institutions. They are preferred by the majority of the population because they are convenient enough to small salary earners, petit business operators. Unlike with banks creating or opening an account at micro finance institutions are relatively cheaper and affordable to the majority of persons and the process is stress free. They provide most of the banking services proposed by the banks, but go beyond by providing other services like proximity savings. This is an operation where by agents of the micro finance go towards persons especially those involved in small scale businesses with the goal of creating accounts for them and pass daily to collect their savings.

**1.7. Urbanism and Architecture**

Yaoundé has road infrastructures that are more or less satisfactory both in quality and quantity. However, the maintenance of the principal arteries of the city is unacceptable by many dwellers especially in the Biyem-assi neighborhood. The renovation work carried out by the various councils have for the past years been a bit slow as portholes are seen at the center of the road, which disturbs circulations and cause a lot of traffic congestions. Some neighborhoods in the city have actually experiences a lot of ameliorations when it comes to road maintenance on the state of roads. Roads have been paved and the sizes expanded notably the Nkolbison neighborhood and the on-going construction of the "auto route" network, which has encouraged a lot of settlements to develop along the new road construction. As far as habitat is concerned in the city of Yaoundé, we can notice the presence of well- planned neighborhoods as well as very poorly planned ones. If one takes a walk in areas such as odja and Bastos, we will discover that not only are the houses well-constructed, the road paved facilitating the access, and urban planning has been well appreciated there. On the hand the contrast is glaring between the less privileged livings in the poorly planned areas of Biyem-assi and Obili localities. Social stratification can be portrayed here where the 'haves' and the 'have not' live in separate areas. This is a picture of the realities of the urban milieu. There is almost no physical contact between the two social classes except on public grounds or public milieus. A good example is the Wada neighborhood where we can find street children, beggars, to beg from cars or occupants who park their vehicles due to traffic or other reasons.

Due to rapid population growth and urbanization, the city of Biyem-assi is fast expanding. There are suburban areas developing progressively as rural drainage brings many to the cities. Unoccupied pieces of land in the peripheries are being bought at an alarming rate, construction works are carried out causing the city to go bigger. Despite this situation, the population concentration in the urban center of the city does not seem to feel the impact. This is due to the large population influx that is registered on daily basis. Most villages and small towns in rural Biyem-assi area have a marketplace in a central location that may house a weekly, biweekly, or daily market, depending on their size. Most markets have separate areas for women's products (produce and palm oil), and men's products (livestock and bush meat). Official buildings are often located near these markets or along the central axis leading through smaller towns.

Architectural values vary by settles from different regions. For the population that moved from the rain forest and the Grass fields, poto-poto (earthen plaster on a wooden frame) and mud brick rectangular buildings roofed in palm thatch or corrugated iron are common. Traditional Grass field's architecture is constructed of "bamboo" (the spines of raffia palm fronds); square or rectangular buildings with sliding doors were topped by conical thatched roofs. The doorposts of royalty had elaborate carvings. Traditional architecture in the north includes round mud buildings

crowned in thatch. Walled compounds usually include a separate granary. Throughout the nation, structures built of concrete bricks, corrugated iron roofs, and iron grillwork have replaced other forms of housing. Much of daily life occurs in public areas such as the courtyards of polygynous compounds. Privacy is often suspected, especially among peoples with a strong belief in malevolent and occult powers.

**1.8. Transport and circulation**

The Biyem-assi area of Yaounde has been noted for very serious transport and circulation problems. Besides the fact that there is a very poor road network linking the neighborhoods in this community, there are so many transportation agencies stationed in this area, including; Amour mezam express, General bus services, Guarantee express, Forden bus services, international air lines just to name this few. It is true that these agencies facilitate movement of people traveling from Yaounde to other parts of Cameroon and back to Yaounde. These however also create a lot of congestions between the hours of 8am and 5pm, usually disrupting movement of school children in the morning when such vehicles are moving out of town and workers in the evening when the vehicles are moving back in to town. Apart from the large size 70 seaters buses which in the course of transporting early morning travelers may also disturb circulation. Taxis and commercial motor bikes transporting children and workers in the morning hinder circulation. There are also many township taxis and commercial motor bikes that go out early to transport school children and workers. When the least cross road block disturbs any movements, within the next five Minuit these come together and aggravate the stiff circulation, causing lateness in every body's daily activity.

**1.9. Food and Economy**

The sharing of cooked food is one of the major ways to cement social relationships and express the high value placed on human company among the inhabitants of Biyem-assi Yaounde. Sharing food and drink demonstrates hospitality and trust just, representing the cultural traits of the English speaking populations who make up the majority of citizens in this locality. Social support networks among kin and friends, particularly between country folk and their urban relatives, are held together symbolically with gifts of cooked and uncooked food. Sacks of beans, maize, or peanuts "from home" can be seen on the roofs of bush taxis traveling between the countryside and urban centres. Meals consist of a cooked cereal or root staple accompanied by a sauce or stew. In the southern areas, the major staples are root crops such as cassava and cocoyam's, and plantains; in the moist savanna and Grass fields, maize and plantains; and in the arid north, sorghum and millet. Rice and pasta have become popular. Staples may be boiled, pounded, or fried; most commonly they are made into a thick porridge shaped into oblong balls. Sauces usually have a base of palm oil and ground peanuts. Vegetables such as greens, okra, and squashes are common. Hot peppers, onions, ginger, and tomatoes are popular condiments. Dried or fresh fish or meat may be

included in the sauce. Uncooked fruits such as bananas, mangoes, papayas, oranges, and avocados are popular snacks and desserts; they are not considered part of meals.

In many regions, men and guests eat before women and children. Hand washing is part of the etiquette of meals. Whether from a separate dish or a common pot, a small ball of porridge is formed by three fingers of the right hand and then dipped in sauce. Westernization has led families to eat together around a common table, using separate place settings and cutlery. Food taboos vary by ethnic group in this locality. The Bassa of the Littoral province settled in this locality serve a gourmet dish of viper steaks in black sauce, but only the oldest males among the Ewondo (Beti) of the Center province may eat viper. Totems of specific clans, healers, or royal dynasties are taboo to certain members of some ethnic groups.

**1.9.1 Food Customs at Ceremonial Occasions**

At the visit of an honoured guest, a wedding, or a funeral, a chicken, goat, sheep, or steer is served to guests. Special drinks, such as palm wine and millet beer as well as bottled carbonated drinks, beer, and wine are served at these occasions. Among the Bamiléké, as part of coronation festivities, the newly installed paramount chief ceremoniously serves each subject a handful of beans mixed with palm oil to symbolize the chief's ability to ensure food and fertility in his realm. The locality of Biyem-assi is basically self-sufficient in food, applying to the whole republic, although the distribution of food is variable. Per capita gross national product (GNP) was $610 in 1996. From 1990 to 1996, the GNP declined and it has shown slight increases since that time. Cameroon has a trade surplus but is burdened by debt. Agriculture, including the production of food and cash crops such as coffee, cocoa, and cotton, employs almost two-thirds of the labour force. Many people produce mainly for themselves, selling the "surplus" at local markets. In road junction areas, there are grocery and dry goods stores. Restaurants and bars, taxis, and domestic labour involve an increasing proportion of the labour force.

Major industries include mining and aluminium processing, forestry, and the manufacture of beverages. Petroleum is a significant source of national income. Wood, coffee, cocoa, cotton, and palm oil are the principal exports. The trading partners are France, Nigeria, the United States, and Germany. Principle imports include consumption goods; semi-finished goods; minerals; industrial and transportation equipment; and food, beverages, and tobacco. The division of labour is determined largely by formal education (for civil servants) and gender. There is some specialization by ethnic group such as herding by Fulani, the butchering and meat trade by Hausa, and transportation by Bamiléké.

**1. 10. Social Stratification**:

There is a high degree of social inequality among people of various tribes and cultures who settle at the Biyem-assi locality. Among the Fulani, Grass fielders, Bamiléké, and Bamoun the

traditional social organization included hierarchical relations between members of groups with different status (royalty, nobility, commoners, and slaves). Other ethnic groups have a more egalitarian social organization in which age and gender are the major factors in social stratification. New forms of social inequality based on access to political power and level of formal education coexist with indigenous forms of stratification. Although a cosmopolitan lifestyle has developed among the wealthy and the intelligentsia, markers of cultural distinctiveness and obligation to kin and ethnic compatriots remain. Regional differences in wealth also exist: the far northern and eastern areas have less access to wealth and infrastructure. Housing styles differ by class in these areas. The wealthiest people have concrete houses painted in bright colours and surrounded by high walls. Those houses have flower gardens and interior furnishings such as upholstered furniture and armoires. The poorest people live in mud houses with thatched or corrugated iron roofs, sparsely furnished with beds and stools made of local materials. Styles of dress also vary by class; the wealthiest can afford Italian leather shoes to accompany the latest European and African wardrobes, while poorer people wear cloth wrappers and second hand European-style clothing. The wealthiest tend to speak French or English even at home, while the poor people speak local languages and Pidgin English as a communication means with friends and family.

The government sponsors many social welfare programs, largely through the community development and extension services of the Ministry of Agriculture. The Biyem-assi locality has benefited from social welfare services of all types, including educational and health facilities, as well as social amenities including street lights, rod network, just to name a few. Nongovernmental organizations (NGOs) have also become increasingly involved in social welfare and the development of civil society, benefiting the population in the setting in various ways. Their importance has increased as government functions have been cut back during a period of economic and political crisis. There are NGO spotted everywhere. Two categories of NGOs exist in this area. Those focusing on social problems such as AIDS awareness, condom distribution, and street children; and ethnic development associations that link urban migrants with their home villages, build hospitals, schools, and bridges "back home," and organize urban ethnic festivals. Ethnic associations often are organized as rotating credit associations, building on a long tradition of mutual aid in both rural and urban areas. They reflect the increasing importance of ethnicity in national and local politics.

In a typical traditional setting, women are made to be responsible for feeding their families. Apart from formal activities including their jobs, they carry out activities that would permit them raise finances to fulfil their responsibilities such as growing staple food crops, petty businesses just to name a few. Men on the other hand clear the land and provide meat, oil, and salt, including growing of cash crops. Among the pastoral populations, men herd the livestock and women process

dairy products. People move with their cultural traits, such that the populations settled in the Biyem-assi locality practice such activities as in their traditional communities. In general, men have higher social status than women. They have more rights with regard to marriage, divorce, and land tenure within most local systems of social organization and more access to government bureaucracy and the courts. However, women may have informal power within households, enforced through their control of subsistence activities and their role as conduits to female ancestors. Many women are prominent in higher education and government ministries.

**1.11. Marriage, Family, and Kinship**

Among many ethnic groups in the Biyem-assi community, first marriages historically are arranged with varying degrees of veto power by the potential bride and groom, but individual choice of stressing companionship is becoming more common. Most southern groups prefer exogamous marriage, while the Fulani tend to be endogamous. Polygyny is a goal within many groups but is not always financially attainable. Some women prefer small-scale polygyny for the company and mutual aid a co-wife might provide. Domestic organization varies widely throughout the Biyem-assi community. Rural polygynous compounds are composed of a male head of a household surrounded by his wives and their children. Wives and children usually sleep in separate dwellings within the compound. In both urban and rural areas, child-rearing by a close relative (a kind of foster arrangement) is common. The organization of kinship varies widely, as do local rules of inheritance. The inheritance of land is often separated from that of movable property. The inheritance of wives may serve as a form of old-age insurance for women without grown children, since marriage provides access to land. Among many groups, traditional titles and honors may be inherited. Most northern groups, such as the Fulani, are patrilineal. The kinship organization of most Grass fielders, Bamiléké, and Bamoun is variously described as patrilineal or dual descent. The Kom people of the Grass fields are a notable matrilineal exception. Most forest peoples are patrilineal.

**1.12. Socialization**

Child bearing is highly valued, and infants are given a great deal of daily and ritual attention. Generally, infants are kept close to the mother and breast fed on demand. Once they can hold the head upright, they are carried by siblings. Infants generally sleep with their mothers. The arrival of a baby is the occasion for visits during which the newborn is cuddled, bounced, bathed, and spoken to. Beliefs and practices concerning child rearing vary by ethnic group. Commonalities include the importance of learning by example and through play and imitation of the tasks of adults. Children are taught to observe astutely but remain reserved and prudent in what they report. Remembering one's ancestors, elders, and origins is an increasing concern of parents whose children spend long hours in public schools and often leave their homelands to find work in urban

centers and on industrial plantations.

Greetings, use of proper names, and use of praise names are important parts of daily etiquette in many regions of Cameroon. At meetings, each person should be greeted by name or with a handshake. Serving and graciously receiving food is an important symbol of hospitality and trust throughout the country. Respect is accorded to elders throughout Cameroon. Protocol regarding speaking and seating during an audience with a chief is highly developed in regions with hierarchically organized cultures (Fulani, Bamiléké, Banoun, and Grass fields).

**1.13. Religion**

The city of Yaounde and its environs is known for various religious movements. Its cosmopolitan nature reflects the religious plurality in the area. Christianity however has more followers than the other religions like the Islamic faith in the area. There exist within Christianity several denominations dominated by the catholic with Yaounde having one of the archdiocese of the country. There are equally other dioceses around the city. The Catholic Church outnumbers the other religions with monasteries. Nevertheless, there are other Christian dominations present in the city of Yaounde. Among which is the evangelical church of Cameroon, the protestant church, the Presbyterian Church, the Seventh - day Adventist, the Jehovah witnesses, the Baptist not leaving out the Pentecostal movements that have in the last years registered a significant proliferation in the city. The dominant Pentecostal churches include the Full gospel mission and the Apostolic church**.**

**1.13.1. Religious Beliefs**

In Biyem-assi Yaounde and Cameroon in general, citizens have a variety of religious beliefs, and many individual combine beliefs and practices of world religions with those of their own culture groups. A large percent of the populations residing in this locality are members of the Christian denominations. We can see from the number of catholic churches established in this area. About 25 percent practice mainly "traditional" religions and approximately 22 percent are Muslim. Most Christians living here are people who moved from the southern areas, while most Muslims population moved from the north. These are settled in the setting of this study and have established their families over a very long period. Traditional religions are systems of practices and beliefs that adapt to changing social conditions. Most involve the veneration of ancestors and the belief that people, animals, and natural objects are invested with spiritual power**.**

**1.13.2. Religious Practitioners**

In addition to Christian and Muslim clerics, religious practitioners include the ritual specialists of cultural groups. These specialists may be political leaders, spirit mediums, or healers. Their spiritual power may be inherited, learned, or acquired through their own affliction and healing. Generally, they combine their religious activities with other forms of livelihood.

### 1.13.3 Rituals and Holy Places

For Muslims, a pilgrimage to Mecca is a source of honor. Among animists, holy places often include sacred trees or groves, unusual rock formations, and the burial places of ancestors. These places are often sites of propitiatory offerings to ancestors or spirits. Offerings include special foods, palm oil, libations of palm wine, and chickens. Among the monarchies of the Grass fields, sacred places include sites of former palaces where rituals that promote fertility and good fortune for the chiefdom are performed. Several cultures, including the Bamiléké in the west and the Maka in the east, practice divination and/or perform public autopsies to determine the cause of death. These peoples are particularly concerned with death caused by witchcraft. In many cultures, a death is announced through public wailing by women. Grass fields peoples bury their dead quickly but observe a week of public mourning called cry-die. Close relatives shave their heads. Approximately a year later, lavish death celebrations honor the deceased, who has become an ancestor. Death provides the occasion for the most important ceremonies of the forest forager groups (Baka, Kola, and Medzan). The forest spirit is believed to participate in death ceremonies by dancing under a raffia mask. The honoring and veneration of ancestors are common to nearly all groups. Ancestors may be remembered in oral literature (the Fulani), buried in elaborate tombs in the family courtyard (Catholic Ewondo), or reburied and provided offerings of prayer, food, and shelter (the Bamiléké). The Fulani, like other Muslims, believe in an afterlife of material rewards for those who obey Allah's laws.

### Conclusion

This is a study to access patterns of health insurance scheme in the Biyem-assi community. This area was selected to carry out this study because it is caught between a blend of urban, semi urban, rural and traditional settings where issues of health care is a serious problem to more than 60% of the total population of the area. Knowing that health insurance coverage, a health policy offered by Insurance companies in this locality can subsidize health care to members, it was necessary to assess public knowledge about health insurance coverage, how the knowledge about this coverage impacts on health care management and to highlight the impact of lack of this coverage to households out of pocket expenditure on health care management in the community. We equally discovered that Biyem-assi hosts a number of private insurance companies, all of which offer health insurance coverage. The choice of this study area was to be sure that the population understands the activities of the health insurance facilities and the advantages open to them once they subscribe for the coverage. The researcher lives and works in Biyem-assi, where this research work was carried out, in this case, she lives with the day-to-day experiences of the population of Biyem-assi community. Because of convenience to meet up with the daily activities of studying and working at the same time, it was important for this study to be carried out at the setting, which

will enable the researcher collect adequate information for the study.

This chapter is a presentation of the Biyem-assi community which is the setting of the study. It is located in Yaounde and is the head quarter of the Yaounde 6 municipality. Yaounde being the administrative capital of Cameroon with a high level of centralized administrative offices, we noticed that there is a high level of population influx from the different regions of the country, thus most settlers in this area are people from different ethnic groups of the country, moving with their socio cultural and socio economic and different religious practices in the area. Large population movements have resulted to an economy is booming with large markets, large trades, importation and exportation of goods at all levels. There is the presence of large companies and many NGO's, large road network and construction sides, digital technology, and as a consequence the rapid growth of the population leading to all pros and cons of a population increase in an area; high housing rents, pollution, development, just to name a few.

We shall proceed to chapter two of this dissertation which is presented in three sections; literature review, theoretical framework and conceptual framework. The Literature review highlights the work of other writers that relates to the research topic. The theoretical framework is the contribution of theorists that have been used to better explain the functioning of the health insurance terminology, and then conclude the chapter by defining related concepts that have been used to explain the functioning of health insurance coverage.

# CHAPTER TWO: LITERATURE REVIEW, THEORETICAL FRAME WORK AND CONCEPTUAL FRAMEWORK

## 2.0. Introduction

The chapter two in this research is the information of different scholars in relation to our research topic, which is "Patterns of Health insurance schemes among people of the Biyem-assi community in Yaounde: a contribution to Anthropology of development. Health insurance is a crucial sector in measuring healthcare management among households in the communities and has remained in focus for many researchers all over the world (Thomas, 2003). Following a documentary review of books and extensive internet search, data collected on the field of insurance was presented in three broad sections, including Literature Review, Theoretical Framework, and conceptual framework, beginning from the literature review.

## 2.1. Literature review

Literature reviews examines scholarly literature surrounding a subject-area, topic, or historical event (Labaree, 2000). Literature reviews surveys prior research that is published in books, scholarly articles and any order sources relevant to a particular area of research, and by so doing, provides a description, summary and critical evaluation of these works in relation to the research problem being investigated (Cuban, 1993). They often explore common trends, themes, and arguments, examining how perceptions of an event have changed over time. Following our study objectives, our literature review shall present scholarly arguments concerning the evolution of patterns of health insurance schemes in the community of Biyem-assi in Yaounde Cameroon.

### 2.1.1. The concept of health insurance

Of all the risks faced by household members in the community, health risks pose the greatest threat to lives and livelihoods (Greene, 2016). The uncertainty of the timings of illness, and its huge treatment costs make financial provision difficult for households (Blumberg, 2001). The rapid increase in medical expenditure combined with the family's consumption expenditure has caused people to rethink the financing of their health care systems. Health insurance allows people to finance their medical care so that they can alleviate some of their financial pressure (Parker, 2019). Health insurance gives partial reimbursement to people for expenditure on selected diseases. Reviewing contributions by authors on specific subjects remains an indispensable process in any scientific work. Noting what has been said and their limits which could be in space or time or context enables a situation where there is no repetition. Other areas of the study could be explored and contributions made to enhance the progress of knowledge. It is in this light that scientific works, books, articles and journals were reviewed in the issue of Health insurance coverage in relation to health care management among community members. This was done in order to avoid repetition and plagiarism and to add to knowledge first to the discipline of anthropology, then to it sisters' disciplines including sociology, philosophy etc. The type of literature review employed in this study is the thematic literature review. This implies reviewing or analysing secondary data with

the use of themes elaborated in the research work.

Health insurance according to Robert (2017) is generally a contract between an insurer and an insured, where the insurer agrees to pay all or some of the insured person's healthcare costs in return for a premium amount. The Health Insurance Association of America 1997 believes that health insurance is an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The purpose of health insurance is to protect the insured against the risks associated with the disease, or more precisely, against all events leading to medical intervention (Tanya, 2018). The contract is usually a one-year agreement, during which the insurer is responsible for paying specific expenses related to illness, injury, pregnancy, preventative care.

Thomas (2003) thinks that health insurance is an agreement which generally comes with exceptions to coverage. These include deductibles which require the insured to pay certain healthcare costs "out-of-pocket", usually up to a maximum amount before the insurance company coverage begins. Insurance plans with higher out-of-pocket costs are generally less expensive this is because the insurer covers a smaller percentage of all healthcare costs. Carrin (2002), on the other hand believes that, health insurance is an agreement in which an insurer agrees to pay for some or all of the insured person’s medical expenses in exchange for a premium payment. It works best when risk pools are large and when the health risks associated with the covered population are diversified, that is when the healthy can subsidize the sick.

While many writers view insurance coverage differently, even though referring to the same mechanisms, Jotting (2001), adds the pooling aspect in his understanding of health insurance. According to him, health insurance is a way to distribute the financial risk associated with the variations of individuals’ healthcare expenditures, by pooling costs over time (pre-payment) and over people (pooling). Therefore, health insurance which involves pooling risks and resources is widely regarded as a means to ensure equity in healthcare to protect households from catastrophic health spending and improve access to healthcare, especially among the poor and vulnerable population in the societies. Health insurance allows for the transferring of healthcare costs at fixed payment or contribution and it responds to the goals of fairness in financing because beneficiaries pay according to their means to guarantee their rights to healthcare services. Prepayment and sharing of the burden of sickness has been recognized as a key for making health care affordable among households in the community.

Health insurance encompasses risk-sharing and it is supposed to reduce unforeseeable or even unaffordable health care costs to calculable, regularly paid premiums. But in many communities, public and private health insurance which are the most popularly known forms of health insurance coverage in most communities cover almost exclusively the formal sector households, with a coverage rate of no more than 10 present. According to World Bank, (1994), the

majority of the informal sector households do not have access to this kind of social protection and often have to rely only on out-of-pocket payments for healthcare. Out of pocket health payments is one of the most inequitable forms of health financing, which according to Evans, (2005) acts as a barrier to access to health care facilities and can drastically reduce the entire financial worth of the households while contributing towards household poverty.

Generally speaking, a health insurance plan is designed to cover the treatment of acute medical conditions which first appear after the start of the policy (Lawanson, 2017). Each health insurance product comes with a core cover which provides a basic level of cover, on top of which the insured may be able to add extra benefits and adjust his cover limits to enhancing his protection. The core plan will usually include inpatient and day-patient treatment and sometimes cancer cover too. In addition to the core cover, depending on the plan, the insured can select other health extension benefits such as: Outpatient care, Preventive care, Laboratory services, Prescription drugs, emergency services, Hospitalizations, Mental health care, Rehabilitation, Maternity and new-born care, Paediatric services (Thomas, 2003). Although each health insurance policy and provider may have their own lists of what they do not cover, some common exclusion includes: Conditions and symptoms which were present before the start of the policy, which according to Thomas (2003), are called pre-existing health conditions. Also, chronic illnesses which require long-term treatment and have no known cure as well as cosmetic surgery, fertility treatment, off-label prescriptions, accident and emergencies are not covered under the policy.

Health insurance coverage is initially defined in terms of the types of health care services for which it will pay. Coverage is further defined by the criteria that these services must meet, such as that those services are performed by a doctor or under the orders of a doctor (Greene, 2016). Coverage is further defined based on where, or in what specific settings, such as hospitals, emergency rooms, and outpatient services, by restricting payment to that service that is "necessary and appropriate for prevention, diagnosis, treatment, and rehabilitation of illness or injury" (World Bank, 2004). Incidentally, coverage does not include that much prevention and rehabilitation; it is much more oriented towards diagnosis and treatment of illness and injury. Some services that might otherwise meet the above definitions are specifically excluded if insurers do not think they are necessary and appropriate, while some classes of services are treated differently than others and are excluded from coverage (Paradise, 2012). For those services that are "covered," insurance may pay only up to certain limits as specified by the policy. The limits may be in terms of the number of visits, the number of days in the hospital, or the total amount of claims paid, for example, 10,000, or 50,000, or 100,000, and so on for the lifetime of the policy. Some insurers only pay up to their approved fee schedule for services that if the doctor charges more, the patient may end up paying the difference. And, of course, insurers only pay after

the patient meets deductibles and after coinsurance is subtracted, unless the patient has already met his or her maximum liability for the insurance year, in which case insurers will pay more. Health insurance costs can vary significantly from one plan to another. In this case, health insurers can only set premiums primarily influenced by the: age - the older the person insured, the more likely they will need medical treatment, which will be reflected in the premium to be paid. In addition, a premium is likely to increase at each renewal as the insured person gets older. Premiums are also influenced by the type of health policy cover selected, the higher the coverage, high coverage requires high premium (Kirsten, 2016).

That is to say, the more benefits the insured has, the higher his premium will be. Such benefits may include the following: Additional benefits, for example requesting for 100% coverage, where the insurance company pays for all hospital and medical expenses, while the insured takes no out of pocket payments. This gives the insured person a very wide coverage, and so will be expected to pay very high premium. In the case of 80-20 coverage, where the insurer takes 80% and insured person takes 20% charges paid out of pocket, the premiums will reduce, and even drop further if the insurance coverage plan is 70%-30%, that is where the insurer takes 70% while the insured person pays 30% out of pocket. The state and local rules can affect the premium charged for an insurance policy. Before 2010 in Cameroon, there were no taxes allocated to a health insurance policy, so the premiums were being subsidized by the state for the amount of taxes expected to be paid per policy. Following an introduction of a tax on the health insurance policy, premium has increased by 19.25% for each health insurance policy subscribed. Stiff competition between insurers has also affected the premium paid for an insurance policy. Some insurers can agree to take premiums far less than the amount required just to maintain the client on their portfolio. Also, if the health insurance policy requires that the insured person be treated abroad, charging including evacuation and travels will be included, thus making the insurance policy more expensive. Insurers usually make smokers to pay more premiums as they have a greater risk of developing health problems. The higher the number of people involved in a health insurance policy, the lower the premium rates apportioned and vice versa. This because the premium paid for the pool of many will be used for the treatment of the few people who get sick within the insurance year. Premiums that could be charged for an individual person can be higher compared to a large family, due to fear of adverse selection.

### 2.1.2. Out-of-Pocket Expenditure and Health Care Management

When the community is experiencing high medical bills, many uninsured household members in the community are not able to follow recommended treatments. Some uninsured households however do not take prescribed drugs because they cannot afford the costs (Cohen, 2013). Because households without health insurance coverage are less likely than those with health

insurance coverage to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems, thus adding cost burden of care to the household income, which makes them to experience a decline in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with health insurance coverage (Greene, 2010). Lack of health insurance coverage, even for short periods of time, results in patients experiencing decreased access to care, and as such are less likely to have a regular up to date care for pressure or cholesterol checks than those with continuous health insurance coverage (Collins, 2012). Also, children who are uninsured for part of the year have more access problems than those with full-year public or private health insurance coverage (Cassedy, 2008).

Research demonstrates that gaining health insurance coverage restores access to healthcare considerably and diminishes the adverse effects of having been uninsured. This is because there is improvement in access to health care services, which leads to the utilization of modern and improved health facilities. As a result, there is self-reported healthcare as well as the reduction in catastrophic out of pocket medical expenditure among people who gained health insurance coverage (Baicker, 2013), leading to reduced mortality, as well as improvements in access to care and self-reported health status (Epstein, 2012). The implementation of acquiring health insurance coverage among households has been confronted with some undesired consequences. To begin with, enrolment in a health insurance program requires paying a premium, which constitutes the funds upon which the insurance program draws in order to compensate members who use insured health care services. The lack of these initial funds to pay for the premium is the main reason why some households do not become insured (Sanon, 2006). The payment modalities sometimes is a challenge to low income households, especially if the annual premium must be paid in a lump sum, they find it more difficult to pay (Jakab, 2001) instead of payments spread out over the year. The time of the year when the premium is due may also be a challenge to enrolment into health insurance facilities. If premiums must be paid when parents household's financial situations are tight, especially during the start of the school year when households also have to pay school fees, and at the end of the year when households are confronted with end of year festivities, enrolment will definitely be lower than expected (Groos, 2007).

Most often, low enrolment to health insurance coverage is because of the public's lack of knowledge on its benefits and most people fail to understand the side effects of out of pockets spending on health care and the negative effects of corruption to quality of care. To increase enrolment requires establishing proactive comprehensive strategies towards potential beneficiaries and healthcare providers so as to bridge the identified gaps and resolve identified barriers. According to Ongolozogo (2009), information and communication systems should be meant to

educate the community on the existing health insurance facilities in the area and its advantages through well oriented mass campaigns. Establish social groupings with local community associations should be educated on health insurance facilities, while reaching out to other community members in their church denominations to give possible announcements and teachings on the activities of health insurance facilities available in the community.

A health insurance scheme is a programme for the protection against the risk of incurring medical expenses among individuals. It is also a pooling of prepaid funds in a way that allows for risks to be shared. The health insurance scheme particularly suitable for the low income communities is the community-based health insurance scheme, which is an insurance scheme operated by organizations other than governments or private for profit companies (Esther 2013). This scheme is important when community's living becomes more complex, and when many poor people do not have access to health care services, largely attributed to lack of private out of pocket payment to finance health care, and men recognize the need for a system by which they could help each other in times of adversity (Hall, 2011). This innovative form of community financing which emerged in the second half of 1980s is a common denominator for voluntary health insurance schemes, organized at the level of the community. These Community based health insurance schemes have emerged as a strategy to increase access to health care in low income communities. They can form an important source of health security because they constitute an ethic of mutual aid, solidarity and the collective pooling of health risks. In several localities, these schemes operate in conjunction with health care providers, mainly some hospitals in the area.

Levine (2008) points out that the health insurance scheme became important in low income communities because of the unpredictable nature of spending on health care. While some individuals have an idea about the need for future medical services, the exact amount they spend on healthcare remains uncertain to them to a great extent. When a person experiences a bad shock to health, their medical expenses typically rises and their contribution to household income and home production (e.g. cooking or childcare). According to the WHO, "Each year, approximately 150 million people experience *financial catastrophe*, meaning they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs." (*WHO Factsheet N°320, 2007*). Economic changes, structural adjustment policies and public sector reforms have had a profound impact on health systems and the health seeking behaviour of households (Bloom, 2000). Low-income communities face growing and competing demands on their resources, and have to make choices between health providers, many of whom are poorly regulated or supervised (Davies and Sanders 1993).

In the World Health Report 2000, the WHO (2000) proposed the following health system goals; to contribute to good health, to be responsive to people's expectations, and to establish

fairness in the financial contributions to the health systems. Financial contributions for health are considered as fair when health expenditure of households is distributed according to ability to pay rather than to actual costs incurred as a consequence of illness. CHI schemes have not received considerable interests by many of the low income households in the community. They are voluntary, not for profit health insurance schemes organized at community level and specifically target those outside the formal sector, varying a great deal in terms of how they are managed and at what cost. Enrolment rates are often very low and have been declining over the years, often because premiums are charged at a flat rate. It has made this a highly regressive way of funding health care, as poor people are expected to contribute more than they can spare, given their financial strength, especially as compared to the 'wealthier' people in the community. Practice has shown that economic and financial barriers still exist with membership skewed against the poorest and the marginalized. The schemes therefore generate very little revenue and are not financially viable to cover catastrophic illnesses and those who are unable to contribute. For this reason, they have small risk pools and insufficient funds to cover large health costs.

Wagstaff and Pradhan (2005) quotes the Government of Ghana, 2009 to show that health insurance schemes are also challenged with operational issues particularly on claims processing and payment, demonstrating a lot of lack of trust on the administrators. Given the volume of claims submitted by providers, many schemes are unable to process them for timely payment to providers. Some claims are paid with a lot of error and fraudulent acts, which cause agitation by providers who may not wish to offer insurance services to members of the scheme.

### 2.1.3. Anthropology of health insurance coverage

The broad field of anthropology is the science of humanity that studies "everything human," focusing on what makes different people human in their own distinctive ways. Anthropology of health is the study of human biology and how it relates to cultural and physical environments through time (Dara, 2016). It emphasizes the effects of cultural and socioeconomic processes on biological and health outcomes in human populations (Harblay, 2020). According to Paschal (2021), Anthropology's interest in health, illness, prevention, and treatment is longstanding and increasingly robust. Access to insurance may be an important strategy for reducing poverty. Financial markets, and particularly insurance services, can help poor people manage critical risks such as a death in the family, illness or loss of income or property. Despite the growing importance and expansion of micro insurance services geared to low-income people, micro insurance penetration remains limited, leaving the vast majority of poor people without adequate protection. The use of "social life of insurance" in Anthropology refers to a framework for understanding insurance as a commodity whose worth lies both within and beyond its exchange value (Appadurai, 1986). Anthropologists have only recently turned their attention to health financing despite long

interest in mutual support and moral economy, informal insurance, and other community-based risk management arrangements, social capital, and reciprocity (Howest, 2019).

According to Steinberg, (2014), Mutual support means giving and receiving support that happens simultaneously. Mutual support is incredibly important in any community and form groups on voluntary bases by people who share the same life difficulties to help each other improve their wellbeing. It fosters a sense of belonging, cooperation, and solidarity among its members. It is a peer led group, with a structure expressly developing and enhancing reciprocity in these groups, through sharing and dialogue, experiential knowledge and expertise emerge from participants and are spelled out in words, compared and provided with some structures and become useful for all.

In addition to local safety nets and mutual aid arrangements, anthropologists have also contributed to our understanding of how health system viability is subject to a range of external and internal factors: the influence of supranational institutions, the terms of development assistance, the global market for medicines, the capacity of domestic health facilities, and the political circumstances surrounding health financing. This has documented the consequences of NGO involvement on health systems (Fisher, 1997) and the impact of structural adjustment on state-sponsored primary care (Chapman, 2010), and they have questioned influence of pharmaceuticals. Looking at policy has demonstrated how liberal economic reforms resulted in accessible but severely fragmented and limited basic health care (Jane, 2008). They have also pointed out how policy discourses can exacerbate access inequities at the intersections of class and gender (Foley 2009). More recently, anthropologist's directly addressing financing have called for critical examination of financial incentive policies aimed at achieving better quality of care (Berggren, 2005). Analyzed redefinitions of biomedical citizenship emerging alongside health insurance implementation (Ellison, 2014) and used ethnography to examine the relationship between health financing and health seeking behavior in the community (Seeberg, 2014).

Furthermore, developing health financing proposed avenues for research that engage for the social life of health insurance. Together, each individual topic highlights the multiple levels and vantage points through which to study health insurance's social life: We start from the patient perspective, move into critical constructs such as trust and quality, and then examine the relationships shaped by insurance. We set forth issues from provider perspectives and finally; we address issues at the level of the state and policymaking. Public Response to Health Insurance is one area for anthropologists to begin an investigation of public response to health insurance plans in LMICs is public understandings of and experiences with local forms of mutual aid and other types of financing plans offering lines of credit. Populations recently exposed to health insurance plans think about them in relation to previous exposure to other forms of assistance, and health

insurance responded to differently in contexts where indigenous forms of mutual aid are well established, such as rotating credit systems and cooperative societies (Ardener, 1996)

Experiences with life and car insurance as well as credit and debit cards appear to influence attitudes toward health insurance. Life insurance is seen by many as an investment for which a return is expected. A similar logic appears to underscore how some are looking at health insurance. In cases where one pays into health insurance, it is considered productive to maximize personal benefits without regard to risk pooling. In the case of car insurance, the hassle or frustration of filing claims has led many people to have a negative opinion of insurance, except for catastrophic events. Recent experience with credit cards has also influenced understandings of insurance. One key informant, the manager of a small hospital, explained how one of the biggest problems he faces with insured patients is that they tend to treat insurance more like a credit card than a debit card, they do not realize they are spending down a predetermined cap on charges. Equally important is how insurance as both a concept and an institution have been presented to the public by different stakeholders. Public perceptions of and demand for insurance are not static. They are sensitive to changing policy, practice, experience, and flows of information. Public perception of health insurance is being shaped by: stories about insurance and quality of care circulating within personal networks; rumors about insurance that index larger social and political issues; media reports that more often report on the sensational than the mundane; and insurance marketing that has become more proactive in the last five years. It will be important to explore further what information tends to undermine or increase confidence in insurance among different segments of the population, how this knowledge is generated, by whom, and toward what ends. Who Will Pay for Health Insurance and Why? Motivations for and against joining different health financing programs need to be examined both in terms of pragmatic and social relational considerations. Health service researchers have focused on the pragmatic issues that influence the weighing of costs and benefits.

Anthropologists can assist them to better appreciate indirect costs and opportunity costs, issues related to time and convenience, and differences in motivation between those who join insurance programs as a safety net for catastrophic health events and those who do so to secure more affordable routine care. With anthropological input, more fine-grained analyses of market segmentation can be developed. Studies in Ghana have reported on significant differences in enrollment and renewal of health insurance based on factors such as gender, marital status, religion, ethnicity, class, and perception of health status (Boateng, 2013). Future research can further investigate these differences in how insurance is valued by men and women of different age cohorts, ethnic and religious groups, and the like. In India, for example, will lower class women support the idea of paying into community-based insurance plans as a means of investing scarce resources that might otherwise be spent by husbands for personal reasons, a motivation reported in

the case of rotating savings and credit plans (Anderson, 2002), and will insurance reduce gender-related health care rationing inequities, given that uninsured poor women in India are less likely to be treated for illnesses than men (Iyer, 2007). Social relations have been insufficiently studied as a factor influencing health insurance subscription in Low and Middle Income Communities. Insurance is as much about the politics and distribution of responsibility as it is about the politics and distribution of risk (Simon, 2002). As such, insurance indexes the politics of responsibility not only at the level of the state and its obligations to citizens, but also at the community and household levels.

Insurance and Health-seeking Behavior is a key area for anthropological contribution is research on whether and how insurance coverage influences health-seeking behavior among different segments of a population. Little research has detailed how households subscribing to different insurance plans actually use services: for whom, for what, when, and how often? Do those who have insurance fill a majority of their health care needs at clinics covered by insurance, or they continue to engage in preexisting health care seeking patterns except for particular types of health care needs. It is also important to know whether supply-side services covered by insurance influence demand-side health-seeking behavior. For example, increases in caesarian birth rates have been linked to higher insurance payment to providers for this procedure in both LMICs (Murray, 2000) and higher income countries (Lee et al. 2004). The demand for cesareans by the medical team is on the rise in the community. To what extent will they be fostered by insurance coverage, and how much will demand be patient or practitioner driven? Rules governing referral and health system by passing are two other issues that may present a challenge to government health insurance programs. Paying out of pocket as a means to skip directly to tertiary level care or to attend a hospital not covered by insurance is a pervasive practice in our community identified during the preliminary research. The issue is whether insurance leads to more fluid patterns of referral and better access to valued parts of health care systems or if local populations find insurance itineraries cumbersome and attempt to bypass them. Trust a certain degree of institutional trust is necessary for people to pay into an insurance program, raising the need for sustained attention to this concept. How is institutional trust established above and beyond trust in the advocates of particular insurance programs? Trust in insurance programs may be lost or gained in response to several different factors ranging from perceptions of quality of care to the social relations of care delivery, expectations from programs, and perceptions of entitlement to misunderstandings related to filing insurance claims (Lofgren et al. 2008). However, decision-making is as much an emotional process based on impulse, hedging, and desperation as it is an economic one (Ergler et al. 2011).

Consequently, the standard models often fail to capture other dimensions that are better articulated through trust. What has received far less attention is the process of trust building by

local organizations that sponsor insurance plans (Narang, 2005). Trust in clinics supported by national, state, community, and the social life of health insurance in LMICs NGO-sponsored insurance programs appears to reflect more general levels of public trust in the funding source and its commitment to particular agendas and particular population groups. As noted by Mladovsky (2006), studying Community Based Health Insurance: "Solidarity, trust, extra-community networks, vertical civil society links and state-society relations at the local level affect the possibility of success of Community Based Health Insurance" Studies of the "social determinants of insurance" need to pay close attention to the social life and trajectories of insurance plans. How is trust built by insurance programs that start off slowly and build a consumer base over time and what contributes to loss of trust and popularity of insurance plans? Who is responsible when trust is lost marketers, agents, administrators, or health care providers? Re-conceptualizing quality of Care and Community Efficacy within a cultural context existing studies of health insurance in Africa have tended to pay little attention to community-based perceptions of quality of care (Spaan, 2012). Quality of care assessments have been largely based on evidence-based medicine criteria, which include the availability of resources, wait times, the qualification of who renders services, and occasionally whether providers speak the same language or are members of the same ethnic group as patients.

Medical anthropologists can add further depth to the assessment of quality of care by taking popular health culture into account. For example, one emerging issue in the community was patients' concern about the quality of medication available to them in clinics covered by the insurance plans. Previous anthropological research on pharmaceutical illustrates differences between patients' perceived needs and their perceptions of the quality of medicines and medical needs. Investigations of medicine perception and preferences raise fundamental issues about the way quality of care is likely to be judged. It also invites discussion on how best to educate the public about rational drug use and identify agents likely to undermine such efforts. In the community, such agents included both pharmaceutical companies and private practitioners with a vested interest in appearing to offer better quality medication. It is important to note that confidence in practitioners with whom one had an established relationship outweighed both trust in health messages and medicine brands and Insurance and Practitioner Patient Relations

One of the major gaps in the existing literature on health insurance in LMICs is its lack of attention to practitioner patient relations. A central research question is how insurance plans are likely to affect social norms and customary practice. Insurance plans may be problematic in places where it has long been customary to gift or indirectly pay government and indigenous practitioners for services as an incentive for good care or to forge personal relationships (Datta, 2014). In places where this practice is suspended as a matter of policy, will it be seen as undermining Medical

Anthropology Quarterly practitioner patient relations? In what contexts will such payment be seen as corruption or continue to be deemed a socially acceptable form of relationship building (Haller, 2005)? Another observation made during research is that social status is often an important factor in how a patient is treated at a clinic. Research on how patients with the same insurance benefits, but different social status, are treated in the same clinic can contribute to anthropological work on medical citizenship (Wailoo, 2006).

Research in the community suggests that the theory of moral hazard may prove useful in assessing a wide array of problems that arise when one or more stakeholders insurance utilization in self-serving ways that threaten the integrity of an insurance system. Moral hazard (Stone, 2011), applied in the present context, characterizes situations in which having insurance affects healthcare behavior on the part of both healthcare recipients and providers. These behavioral changes can manifest in a variety of ways, ranging from how people utilize health services to the health risks people take knowing they will receive care later. In most communities, it has been reported that insured patients receive extra or unnecessary health services because the patient does not bear the full economic cost of the bill. This over-consumption of services, often at the advice of practitioners, drains the shared pool of resources and drives up the costs of health care. Health providers and clever administrators attempting to maximize profits often game the system. Those responsible for clinic management for instance may seek financial advantage through such acts as over, under, and creative diagnosis; the liberal ordering of tests; and the inappropriate dispensing of medicines to max out or work within insurance benefit caps (Tiwari, 2012). To date, medical lobby groups have fought hard against insurance company attempts to establish standard reimbursement limits for different types of medical problems and procedures. Future studies should consider both provider motivation and consumer response to gaming behavior. According to Nichter (2012), members of insurance plans were unbothered by tests suspected to be unnecessary and, in fact, linked them to high-quality care and personal benefit. If and when insurance industry and public policy driven discourse directs attention to the moral hazard of gaming the insurance system, what effect will this have on perceptions of responsibility and health citizenship in both the general and health care provider community?

Anthropologists can draw on organizational ethnography, implementation science, and policy research when investigating the “organizational life” of insurance programs and reasons behind policy decisions (Cefkin, 2011). How insurance benefits and coverage options decided on are and what do they reveal about cultural values? Given the double burden of communicable diseases that characterizes health transition in LMICs, hard decisions lie ahead for decision-makers related to resource allocation to rapidly rising patient populations like diabetes patients, ageing populations, women beyond coverage of reproductive health, and mental health. In addition, mental

health is well documented as a global health problem too often deemed peripheral by planners and international donors who mistakenly assume that mental health is not a priority for poor people in less-resourced countries (Kessler, 2002). Actuarial planning refocuses attention on mental health, and introduces mental health services in primary health care settings. This will result in the pharmaceuticalization of psychosocial problems (Bell, 2012). Given a paucity of trained mental health staff, the tendency of busy doctors to overmedicate, and the influence of the pharmaceutical industry, ultimately, the types of data and assumptions will be used to justify decisions made and what role will special interest groups play in framing health problems as priorities worthy of insurance coverage.

As a horizontal approach aimed at strengthening health systems, UHC draws attention to relationships with the state and its governing institutions. State policies alter arrangements for health care provision in ways that new regulations reshape relationships to them. The major social transformations in during the past generated shifts in health care provisions and financing. The decentralization of government welfare practices in the 1980s fundamentally altered the role of government from provider in some countries to financier of health that resulted in increasing and inequitable out-of-pocket payments. Some countries are now using health insurance to refocus state efforts to manage the between government and providers.

**2.1.4. Evolution of health insurance**

In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance, and continued until the start of the 20th century where all laws regulating health insurance actually referred to disability insurance. Accident insurance was first offered in the United States of America by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the U.S. by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the U.S. effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911. Before the development of medical expense insurance, patients were expected to pay health care costs out of their own pockets, under the fee-for-service business mode. During the middle-to-late 20th century, traditional disability insurance evolved into modern health insurance programs. One major obstacle to this development was that early forms of comprehensive health insurance were enjoined by courts for violating the traditional ban on corporate practice of the professions by for-profit corporations. State legislatures had to intervene and expressly legalize health insurance as an exception to that traditional rule.

Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures. They also cover or partially cover the cost of

certain prescription, but exclude payment for over-the-counter drugs that are not formally prescribed by a medical doctor. Sometimes the insurers determine what drugs are covered based on price, availability, and therapeutic equivalents. The list of drugs that an insurance program agrees to cover is called a formulary**.** Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, some individual hospitals began offering services to people on a pre-paid basis, which was eventually leading to the development of Blue Cross organizations. This was the predecessors of today's Health Maintenance Organizations originated beginning in 1929, through the 1930s and on during World War II. The Employee Retirement Income Security Act of 1974 regulated the operation of a health benefit plan if an employer chooses to establish one, which is not required. The Consolidated Omnibus Budget Reconciliation Act of 1985 gives an ex-employee the right to continue coverage under an employer-sponsored group health benefit plan.

Through the 1990s, managed care insurance schemes including health maintenance organizations, preferred provider organizations, or point of service plans grew from about 25% US employees with employer-sponsored coverage to the vast majority. With managed care, insurers use various techniques to address costs and improve quality, including negotiation of prices "in-network" providers, utilization management, and requirements for quality assurance such as being accredited by accreditation schemes such as the Joint Commission and the American Accreditation Healthcare Commission. Employers and employees may have some choice in the details of plans, including health savings accounts, deductible, and coinsurance. Additionally, having a high-deductible plan allows employees to open a health savings account, which allows them to contribute pre-tax savings towards future medical needs. Some employers will offer multiple plans to their employees. Health insurance is a crucial sector in measuring health care management among households in the community and has remained in focus for many researchers all over the world. This chapter of the study presents what other researchers have written about health insurance in general. There are various studies which have been conducted on the different aspects of health insurance, but this present research is a study to investigate: “Patterns of Health Insurance schemes among members of the Biyem-assi community” The study covers literature on areas of immediate relevance, including health insurance knowledge and attitudes of community members, relevance of health insurance coverage and health care management among household members, out of pocket payments and health care management among community members just to name a few.

**2.2. Theoretical Framework**

The theoretical framework is a foundational review of existing theories that serve as a roadmap for developing the arguments to be used to support ideas in a research (Sarah, 2022). In a theoretical framework, the researcher explains the existing theories that support the research,

showing that the dissertation topic is relevant and grounded in established ideas. A research in Patterns of health insurance schemes has recognized the contributions of some theorists that shall be discussed in the paragraphs that follow. In many low-income countries, the decision to introduce health insurance is motivated principally by theoretical arguments. Most theoretical frameworks, however, emerged in the context of wealthy countries, in which health providers were effectively regulated, and held accountable for their actions (Witter, 2001). Health insurance builds on the 'law of large numbers', which states that the average behaviour of a group of individuals is more predictable than that of a single individual (Black, 1997). In other words, the tendency to behave more systematically and predictably increases with the size of the group. This is the rationale for pooling individual risks as a key function of an insurance fund.

### 2.2.1. Theory of demand for health insurance

The theory of the demand for health insurance was propounded by Besley in 1989, in an attempt to provide a response to "Why the demand for health insurance exists". In his theoretical framework, he pointed out that the demand for health services is derived from the demand for health; while the demand for health insurance is derived from demand for health services. His framework of the demand for health, health services and health insurance has been built on conventional economic theory of demand.

#### 2.2.1.1. Conventional economic theory of demand for health insurance

The Conventional economic theory of demand for health insurance was propounded by Besley, (1991). According to this theory, people purchase health insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. It also holds that any additional healthcare that consumers purchase because they have insurance is not worth the cost of producing it. Therefore, economists have promoted policies-co-payments and managed care-to reduce consumption of this additional seemingly low-value care. Following this approach, health is a commodity traded-off against other goods (e.g., smoking) and as such, individuals demand for health can be elicited through an analysis of tastes or preferences. Besley continues that individuals maximize their utility within budget constraints, health being one of the many goods contributing to utility. According to this framework, better health is achieved by investing in goods that improve health, which in turn leads to both a consumption gain (i.e. being healthy enables a range of activities to be achieved), and an investment gain (i.e. better health increases lifetime earnings). In terms of demand for health services, apart from the influence of income, education, and health status, other characteristics such as age, aversions to receiving health care, and the availability of health-related information, will each influence demand for health services. Not only is it difficult for individuals to assess the quality of the health service before receiving it, it is also difficult for insurers to assess the quality of the buyers. Two theories have

been used to discuss the relationship within the health insurance market: adverse selection and moral hazards.

#### 2.2.1.2 Adverse selection

In economics, insurance, and risk management, adverse selection is a market situation where buyers and sellers have different information. The result is the unequal distribution of benefits to both parties, with the party having the key information benefiting more. In an ideal world, buyers should pay a price which reflects their willingness to pay and the value to them of the product or service, and sellers should sell at a price which reflects the quality of their goods and services. For example, a poor quality product should be inexpensive and a high quality product should have a high price. However, when one party holds information that the other party does not have, they have the opportunity to damage the other party by maximizing self-utility, concealing relevant information, and perhaps even lying. Taking advantage of undisclosed information in an economic contract or trade of possession is known as adverse selection (Akerlof, 1978).

According to Akerlof (1970), A common example with health insurance occurs when a person waits until he knows he is sick and in need of healthcare before applying for a health insurance policy. For a theory of health insurance markets to spread risks efficiently, several conditions must hold true: First, the probability that insured individuals will fall ill must be known in order to allow the insurer to make reasonably accurate predictions about the number and size of claims, in a given time period. Secondly, these risks must be largely independent of each other. If an event occurs in which all insured individuals, or a significant proportion of them, simultaneously suffer an insured loss, the scope for sharing risks is severely limited and the insurance function may collapse. Thirdly, the probability of an individual requiring medical treatment must be significantly lower than one (i.e. not certain).

Insurers face problems accurately assessing the first and third condition that is the likelihood of an individual making a claim. Where the information held by the insured and the insurer is asymmetrical, the health insurance market may unravel. Akerlof (1970) formalized this phenomenon using the example of second-hand car markets, in which the seller holds more accurate information than the buyer about the quality of a particular car. The potential buyer cannot easily distinguish between good and bad cars and, as a result, prices move towards the average quality of cars in the market. In response, owners of good quality cars remove theirs from the market, leaving poorer quality cars to dominate. Prices fall further to reflect lower average quality, pushing out more good quality cars, until only low quality cars are traded. In the health insurance markets, the problem is essentially the same, although it is the consumer (patient), rather than the seller (insurer), that holds more accurate information, in this case about the quality of their own health. If new customers provide biased information to the insurer, in favor of good health, the

actual number of claims and pay-outs will be higher than predicted. In order to protect profits, the insurance agency adjusts premium up wards.

Indeed, where the insurer expects new customers to provide biased information, the premium may already be loaded, or upwardly adjusted. In both cases, individuals in relatively good health may leave the market, increasing the average risk of those remaining in the insured pool. Of course causing a Premium rise further in response, increasing the incentive for lower risks to leave the pool, and for high-risk individuals to provide biased information about their health in order to lower the premium offered to them. A vicious circle of increasing average risk and increasing premium ensues. This process of unraveling describes the "adverse selection" theory, which violates the third condition for insurance markets to operate efficiently. There are two common approaches to setting insurance premium. Profit-maximizing insurers set premium according to an individual's health status, adjusting for the probability of a claim being made. In contrast, non-profit schemes typically offer the six theoretical insights into the development of health insurance in low-income countries same premium to all members, based on the average risk of the group. In this approach, individuals in poor health are not excluded, or discriminated against, through higher premium, consistent with the policy objective of protecting access to services amongst the poor.

Adverse selection is more likely to be a problem when all consumers face the same premium. Whereas for high-risk individuals a premium based on average risk is low, relative to a risk-rated premium, for healthy individuals the average premium is relatively high. Individuals with poor health are thus more likely to purchase insurance and where possible, more of it. To summarize, adverse selection is likely to be a problem in all health insurance schemes based on voluntary membership, whether motivated by profit or social concerns. In a private market, the insurer may eventually go out of business if adverse selection is not dealt with and, typically, will further price discriminate in response. In non-profit schemes, such discrimination is rarely used as a policy tool, often creating pressures for greater public subsidy.

**2.2.1.3 Moral hazard**

The pioneering work into this issue moral hazard was conducted by Pauly (1968). Moral hazard is an increase in the probable frequency or severity of loss due to an insured peril that arises from the character or circumstances of the insured. It is the tendency for an insure individual to decide to increase consumption of healthcare because he has health insurance coverage. Moral hazard portrays two types of behavioral change as a result from insurance: the ex-ante moral hazard and ex-post moral hazard.

**2.2.1.3.1 Ex ante moral hazard**

As pointed out by Cutler (2000), ex-ante moral hazard is predicted by the classical economic theory, suggesting that health insurance coverage reduces an individual's incentive to

take preventive efforts to remain healthy or a change in lifestyle which increases the probability of needing more expensive curative services. For example, if as a result of being insured, an individual feels less worried about the financial implications of falling ill, they may decide to forego certain preventive, health-improving actions. Reducing consumption of immunizations, for example, significantly increases the risk of illness but the full costs of not taking care of one's own health can never be fully compensated for by an insurance scheme (i.e. in the case of death, or disability). Ex-ante moral hazard refers to the situation prior to an illness, which is different from Arrow (1985), referring to the less judgmental and more informative term hidden action.

**2.2.1.3.2 Ex-post moral hazard**

This refers to the increased consumption of health services once an individual has already fallen ill. In health insurance markets, the marginal cost to the patient of accessing care is lower than the marginal cost to the provider of supplying care. The insurer pays the provider a price, which is sufficient to cover the marginal cost. The extent, to which the reduced price to the patient leads to increased consumption, depends on the extent to which they are price sensitive. In some circumstances, patients may also be able to influence the cost of care received, for example by demanding the best quality of treatment available. Where increased consumption is considered a problem, insurers respond by shifting part of the cost of care back on to the patient, for example through co-payments and deductibles. Referred to in the literature as "supplier-induced demand", providers may, for example, conduct more diagnostic tests on a patient than might otherwise be considered necessary. In higher income countries, one response to this problem has been to remove third-party payers, and integrate the insurance and provision functions.

In many Less Income Communities, where the decentralization process has increased the autonomy of individual health facilities, revenue from patient user charges tends to be retained, creating an incentive for supplier-induced demand. Whilst much of the literature focuses on the detrimental effect of moral hazard, (Zweifel, 2000), point out that there may also be benefits, as some amounts of moral hazard may be deemed beneficial for two reasons. First, to the extent that physicians wield a collective monopoly, the quantity of medical care consumed falls short of the optimum. The increase in quantity caused by the moral hazard effect of insurance can be efficiency-enhancing in this situation. Secondly, moral hazard may encourage the use of a more cost-effective medical service at the expense of a less cost-effective one within an insurance scheme. Thus, the optimal amount of moral hazard is positive rather than zero**.**

Conventional theory holds that health insurance is purchased because consumers are averse to risk, and that all of moral hazard is inefficient. Nyman's model holds that insurance is purchased in order to obtain an income transfer in the ill state. This income allows for the purchase of additional healthcare when ill, efficient moral hazard. Health insurance is also purchased because it

often allows consumers to gain access to healthcare that they would not otherwise be able to afford. This access value of health insurance is an important reason for the demand for insurance.

The conventional insurance theory therefore suggests that all of moral hazard generates a welfare loss, and that the magnitude of this loss can be represented by Marshallian demand (Pauly, 1968). Most moral hazard either generates a welfare gain in its entirety or a combination of a gain and loss, and that the magnitude of most of these losses is smaller than the tax subsidy would complicate this analysis considerably loss that would be represented by a Marshallian demand response. Thus, conventional theory has dramatically overstated the loss and understated that gain from health insurance.

**2.2.2. Health Insurance Theory: The Case of the Vanishing Welfare Gain**

This theory was propounded by John Nyman in 2003. The main argument here is that a large source of value is completely missing from the conventional theory of the demand for health insurance namely, the effect of the transfer of income (from those who purchase insurance and remain healthy to those who purchase insurance and become ill) on purchases of medical care. Conventional theory has focused on the effect of the income payoff on increasing purchases of other goods and services, and on the effect of price on purchases of medical care. The effect of the income payoff on increasing purchases of medical care is real, but has completely vanished from conventional theory. This is an important omission and one that changes the value of insurance dramatically. Without recognition of this income effect, the voluntary purchase of health insurance at traditional coverage parameters appears to reduce welfare (Feldstein, 1973), because all the additional medical care purchased is assumed to be in response to the willingness to substitute medical care for other goods and services as relative prices change. As such, it could only mean that the additional care purchased with insurance is not worth the cost of producing it. With recognition of the income effect, however, not only is much of the welfare loss under conventional theory eliminated, but furthermore, it is replaced by a welfare gain. This welfare gain is due to the fact that with the additional income from insurance, the consumer would be willing to pay an amount that exceeds the cost of much of moral hazard. This gain is very important because it is often derived from those major medical procedures that would otherwise be beyond the consumer's liquidity constraint.

There is evidence that, when the spurious losses are eliminated and true gains are accounted for, (1) the value of moral hazard far exceeds the costs of producing it, (2) the gain from moral hazard represents an important reason for purchasing health insurance, and (3) the voluntary purchase of health insurance generally increases society's welfare (Nyman, 2003). Recognition of the income effect also dramatically changes the focus of public policy. Without this income effect, public policy has been directed at reducing consumption of medical care at the margin in order to

reduce costs. Over the last 30 years or so, economists have promoted cost-sharing and managed care as efficient cost-containment policies. With recognition of an income effect, policy becomes more complicated because it is necessary use cost-containment policies that distinguish efficient from inefficient moral hazard. Co-payments and managed care should only be directed at the inefficient portion of moral hazard that is generated by a pure price effect. Moreover, policies to reduce monopoly pricing of medical care, once thought of as being counterproductive because high prices counteracted some of the moral hazard welfare loss of insurance (Pauli, 1995), must now be considered legitimate ways to limit medical care spending (Nyman, 2003). The ideal insurance policy is also different with the new theory.

This theory suggests that once the consumer becomes ill, it makes little sense to impose co-payments to limit consumption. Office visits for chronic diseases (such as, diabetes, asthma, chronic obstructive pulmonary disease, and others) and expensive procedures that are deemed to be standard treatments for common ailments (such as, hip replacements, treatment of trauma, and others) should have "first dollar" coverage. If cost sharing is imposed, it should only be with regard to any care that responds to relative prices, such as, days in the hospital in excess of the standard stay. This theory also suggests the current "managed care backlash" is due to managed care's denying coverage for procedures that the consumer would gladly be willing to pay for with the income transfer from insurance. It may also explain (at least in part) why so many elderly in the U.S. (about 90 percent) have supplemental insurance designed to reduce Medicare cost-sharing to zero.

Finally, the new theory provides a solid theoretical justification for insuring the uninsured and for implementing national health insurance. Under the conventional theory, the sole source of value of health insurance is derived from satisfying the consumer's preference for certain (as opposed to uncertain) financial losses. Under the new theory, the benefits of insurance are 26 largely derived from the access that it provides to care that would otherwise be beyond the ill consumer's liquidity constraint. Providing access to care for those who are ill would be a source of external benefit for many in society and would justify either tax subsidies of health insurance, or the implementation of a national health insurance scheme.

To summarize, conventional theory analyses the consequences of health insurance on other goods and services separately from its consequences on medical care. The gains from health insurance are determined by the effect on utility of spending on other goods and services only, and are seemingly derived (because of the specification conventionally used to model the insurance decision) from exchanging the payment of a small amount of income (that is, other goods and services) with certainty (that is, the premium) for a payment of a larger amount of income with uncertainty (that is, the income reduction from medical expenditures if ill). Because certainty could

not be achieved if the income payoff resulted in the purchase of additional medical care, income effects on medical care are totally excluded from the analysis."

The implication is that any additional purchases of health care can only be due to a price (substitution) effect, but this implies that health insurance can generate only welfare losses from its impact on medical care consumption. Thus, an important welfare-increasing component of health insurance is completely excluded from Conventional theory holds that health insurance is purchased because consumers are adverse to risk, and that all of moral hazard is inefficient. Nyman's model holds that insurance is purchased in order to obtain an income transfer in the ill state. This income allows for the purchase of additional healthcare when ill, efficient moral hazard. Health insurance is also purchased because it often allows consumers to gain access to healthcare that they would not otherwise be able to afford. This access value of health insurance is an important reason for the demand for insurance. Nyman (1999) argues that as much necessary care is unaffordable, the purchase of health insurance is often simply motivated by a desire to access certain services, rather than risk-aversion. Whilst it is debatable how relevant many of these theoretical frameworks are for Less Income Communities, Nyman's argument appears particularly relevant, given the context of high health needs coupled with low levels of service usage. In other words, higher levels of consumption are desirable, and insurance may help to generate demand. Careful analysis is required, however, to establish whether or not any additional care consumed is necessary.

### 2.2.3. The interpretive theory of culture and health insurance

The interpretive theories refer to a relatively broad general category that includes analytical perspectives and theories, covering the fields of communication, sociology, anthropology, education, cultural studies, political science, history and the humanities at large. Interpretive theories, sometimes called interpretativism or philosophical interpretativism, are orientations to social reality based on the goal of understanding. Thus, we can define interpretivist theories as ontological and epistemological tools used in research that is aimed at understanding how individuals and groups create meaning in their everyday practices, communication and lived experiences. Interpretativists are in part researchers who are interested in how communities, cultures or individuals create meaning from their own actions, rituals, interactions and experiences; researchers who wish to interpret local meanings by situating them in a broader historical, geographical, political, linguistic, ideological, economic and cultural milieu; researchers who study the meaning of texts, codes and rules (Vannini, 2009). According to the interpretive theory, interpreting is a process of conveying the sense.

The Interpretive Theory, also known as the sense-based theory, came into being with the publication of the doctoral dissertation of Danica Seleskovitch in 1968 with rich experience in

conference interpreting. Seleskovitch is therefore regarded as the pioneer of the Interpretive Theory. The essence of the Interpretive Theory is that what the interpreters try to understand and interpret is not the linguistic form of the source language, but the sense and idea the speakers want to convey, so the basic task for the interpreters is to be verbalized, so that the meaning of the source language can be grasped. Seleskovitch (1970) argued that in a communication, people show great interest in the information that the other party transmits and the thought that the other party expresses. The interpretive theory sometimes referred to as interpretivist or philosophical interpretivist and is orientated to social reality based on the goal of understanding. Thus, the interpretive theory can be defined as ontological and epistemological tools used in research and concerned with understanding how individuals and groups create meaning in their everyday practices, communication and lives experiences.

The interpretive theory of culture and health insurance can be used to explain the patterns of health insurance scheme among community members, first and foremost, by establishing an understanding of rules and regulations guiding community activities and benefiting rules. Scholars are interested in the way communities, cultures, or individuals create meaning from their own action, rituals, interactions, and experiences. Patterns of health insurance schemes are experiences among community based groups, whose members believe are guided by the activities, roles and regulations for membership and participation. The payment of a registration fee is interpreted as membership commitment to a community group. Once a member, activities including regular and prompts contributions to provide assistance to other members who have health crisis to benefit from the scheme. These benefit structure is however, based on the notion of reciprocity, in the sense of give-and-take (Shipton, 2017). In any case, members who fail to make contributions to assist other members in pain shall not receive any form assistance when they are also in need. Reciprocity explains a situation where two or more people or nations have equal exchange of goods or services and enjoy an equal benefit from the relationship. In a reciprocity-based relationship, no person is a permanent giver. Individuals who lend money do so knowing that they will be borrowers in the future. Additionally, individuals who had received loans provide loans to their former lenders as a way of repaying the social debt they owe, although the "monetary" loan had been repaid. It is due to this notion of social debt that (Shipton, 2017), argued that loans and repayments do not cancel each other out. Similarly, according to the principle of reciprocity, monetary gifts from relatives and friends have to be repaid when the occasion justifies. This is because a gift calls for a counter-gift (Shipton, 2010). The only uncertainty is related to the time when the gift will be repaid, but the gift will certainly be repaid. Thus, in a reciprocity-based environment, loans and monetary gifts from relatives and friends are viewed as debts. The findings, therefore, demonstrate that notions of reciprocity and debt are essential to understanding how low-income populations finance healthcare.

Arguably, it is also due to the principle of reciprocity that people received interest-free loans from family and friends. As people take turns as lenders and borrowers, it makes sense for people not to charge interest on loans given to one another. Again, according to the notion of reciprocity, people who provide interest-free loans have at one point been recipients of interest-free loans or will be recipients of interest-free loans in the future.

Due to a strong social relationship, a close friend approached for a loan may be uncomfortable asking the supplicant friend to pay interest on the loan, as it may mean that they are perhaps taking advantage of a desperate situation for economic gain. Charging interest on a loan may be viewed by people in the communities as not being sensitive to people's situations. Being sensitive to people's economic situations is part of the process of managing social relationships (Nelson, 2000). It is against social norms in these local communities for people to charge interest on loans given to kin. According to social norms, people are expected to help those in their kin network and not make economic gains from them. The concept of reciprocity is also applicable to the parent-children relationship. Parents take the position of "givers" by sending their children to school, ensuring that they learn a particular trade and providing food for their nourishment as they grow, in addition to shelter and healthcare. Based on the foregoing, children have a "debt" to repay their parents, as in a reciprocal relationship no person is a permanent giver or receiver. When children become adults and have income-generating activities, they take the position of "givers", hence, they are expected to assist their parents in various ways, including paying their healthcare bills. The principle of interdependence in the parent-child relationship is also embedded in the concept of reciprocity. Interdependence entails complementary relations between parties (Servet, 2007). There is a complementary relationship between parents and their children, as each party takes turns in assisting the other in times of need. However, people do not rely on a single mechanism to finance healthcare.

### 2.3. Conceptual Framework

A conceptual framework sets forth the standards to define concepts in research to connect them with concepts that present a pictorial or narrative format in the research (Swaen, 2022). For a better understanding of this research, some concepts that make up the title of the research have been defined in the following paragraphs, including the following; health insurance, health literacy, health management just to name a few.

#### 2.3.1. Health insurance

Health insurance is an economic system by which one or more insurers guarantee, after the signature of a contract binding the insurer(s) with a subscriber and according to the conditions appearing in the contract, one or more insured against the pecuniary consequences linked to the occurrence of a harmful event that has damaged the physical integrity of said insured(s), and

requiring medical intervention to try to restore the claimant(s) to the situation in which they were before the occurrence of the loss. Health insurance has therefore been set up to allow people to take out a contract that reimburses them for the share of treatment costs not covered by social security. It is therefore intended, as its name suggests, insuring people against the economic consequences of a state of health requiring treatment.

A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (that is an employer or a community organization). The contract can be renewable (annually, monthly) or lifelong in the case of private insurance. It can also be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national (health policy) for public insurance needs such as the research study described in this document, may support the idea of an individual as an agent of change, rather than the traditional top-down approach that is characteristic of many health literacy reports and efforts (Huber, 2012). While some view health literacy as a set of individual capacities, others view ability as a dynamic state dependent upon “the characteristics of both the individual and the group.

**2.3.2. Out-of-pocket-expenditure for healthcare**

Out-of-pocket expenses are costs that an individual is responsible for paying that may or may not be reimbursed later. The term is most often used to describe an employee's work-related expenses that the company later reimburses. It also is used to indicate a health insurance policyholder's non reimbursable share of medical expenses such as deductibles, co-pays, and coinsurance. Out-of-pocket payments on medical expenses not fully covered by private or public insurance occur in all health systems, to a varying degree. “Most countries try to address this, especially when out-of-pocket payments are high, According WHO (2008), the biggest challenge is to ensure reductions are targeted to the most vulnerable, and countries are not simply reducing out-of-pocket payments on average and as an overall share of the total expenditure.

Direct payments for health can limit access to healthcare options and could force people to choose between health and other essential spending, the Organization for Economic Co-operation and Development (OECD) has warned, a result known as ‘catastrophic health spending’. The cost of living crisis is intensifying the problem, as more struggle to pay for basic needs and services such as food, energy and medicine. In health insurance, the deductible is the amount paid each year for covered costs before the insurance coverage starts. When the deductible is met, the policyholder "shares" the costs with the insurance plan through coinsurance. With an 80/20 plan, for example, the policyholder pays 20% of the cost while the plan picks up the remaining 80%. The amount paid for coinsurance, as well as the co-pays and deductible all count towards the out-of-pocket

maximum for the year. When the insured reaches the out-of-pocket maximum, the plan pays 100% of covered costs for the rest of the year. Some plans have higher deductibles than others.

**Conclusion**

In this chapter, the researcher presented literature that was reviewed contextually, thematically and theoretically. Much literature was geared towards a review of what other writers have written about health insurance, beginning from its definition of the concept and evolution of health insurance. Contextually, the researcher presented literature on the perception and attitude of community members towards health insurance coverage and its effects on access and use of health care facilities. Thematically, literature was reviewed on important terminology out-of-pocket-expenditure, the Anthropology of health insurance coverage; just to name a few, where the presentation of ideas from other writers could best explain concept and functioning of health insurance to the reader. However, with the theoretical framework, we used the conventional economic theory, propounded by Thomas Besley in 1991, Health insurance theory and the vanishing welfare gain, propounded by Nyams in 2000, and the interpretive theory of culture and health insurance by Seleskovitch in 1968. All theories and models used to better explain the concept of the health insurance and its functioning to the reader's attention.

The end of chapter two introduces us to chapter three, which is all about the perception of health insurance coverage among people of the Biyem-assi community. According to most respondents, health insurance is a saving scheme for healthcare needs. With this in mind, community members try as much as possible to register and participate in the community insurance schemes where they carry out most of their livelihood activities. We were able to identify and classify community based scheme into faith based, professional based, ethnic based, standard based insurance schemes, just to name this few.

# CHAPTER THREE: THE PERCEPTION OF HEALTH INSURANCE AMONG THE PEOPLE OF BIYEN-ASSI IN YAOUNDE

## 3.0. Introduction

This chapter is an elaboration of findings on the perception of health insurance coverage among community members. Perception is the ability to see, hear, or become aware of something through the senses. Thus this section will demonstrate the belief or opinion of people about this coverage and how it facilitates access to healthcare among the indigenes of the Biyem-assi community in Yaounde. The research hypothesis suggests that the people of this community perceive health insurance as a scheme of savings for their healthcare needs. Therefore the researcher's objective here was to explain the perception of health insurance among the people of Biyem-assi in Yaounde, by drawing their opinions using experiences from community interactions to confirm the way they see and hear about the coverage, which is based on what they have observed, witnessed and even discovered by virtue of being registered to community based groups carrying out health insurance schemes activities to assist members healthcare.

## 3.1. Perception of health Insurance coverage among the people of Biyem-assi in Yaounde

According to these findings, people perceive health insurance as a savings scheme for healthcare. Community members continue to contribute to these schemes by participating fully in community activities. According to these understandings, a health insurance scheme is any community based group bringing community members together to benefit from a pool of many. Community members therefore register and participate in the activities of such groups in order to contribute and assist members who are in need, and also become future beneficiaries as the case may. Some of the most frequently mentioned community based groups during the data collection process included amongst others groups from the faith based insurance schemes, Ethnic based insurance schemes, professional based schemes, standard based schemes just to name this few. These schemes reflected different works of life and so carried out relevant activities to benefit member's healthcare and wellbeing. That is why membership was differentiated by member's livelihood activities, so almost all informants had a form of health insurance scheme where they make their contributions and hope to benefit from groups assistances as the care maybe . While the Informal sector populations flooded the ethnic based and faith based health insurance schemes, formal sector populations where into the prestigious standard based and professional based health insurance schemes.

The concept of health insurance is almost always interpreted by many community members to mean the standard based insurance scheme, which refers to the activities of the public and private health insurance companies. This traditional health insurance coverage is relatively new in Africa and is hardly well understood by many. It remains unclear how this functions in communities where the majority of the population work outside the formal sector. In a number of communities where health insurance is largely regarded as a pro-poor intervention, enrolment is much lower than

projections. Factors such as poverty, poor perception of health insurance, lack of knowledge of health insurance terminology, inadequate information on its functioning, perceived poor quality of healthcare to clients on insurance, a large number of people in the informal sector, low levels of education, inefficient institutional coordination, lack of trust among others have been documented as responsible for the low enrolment onto health insurance in many low-income communities (Paul, 2020).

Following our study objectives, research was carried out in the Biyem-assi community of Yaounde to access the patterns of health insurance schemes in that community. Many informants did not belong to any form of health insurance scheme, but reported that they were aware of health insurance coverage, with at least one form of health insurance scheme which had operated in the study area or elsewhere. Based on this view, Mary who is 32 years and a mother of 04 said that:

> *There has been a lot of community based groups scheming for health insurance coverage in my home town Njinikom in Bamenda. The facilitators for the main mutual health insurance scheme and BEPHA operating in the area were always at the Njinikom hospital center either to assist already benefiting members or to register new ones to the programs. Mary Bih, Hair dresser, Round point Express May 2023*

Participants expressed different opinions of their first encounter with health insurance information. Apart from Roses experience, Jackeline, a mother of 04 children, narrated that, it was at the bank that she heard of health insurance for the first time. It was introduced to her as part of the requirements to open an account at the bank. A subscription form was provided which she filled the details and declared her current health status. Questions relating to her contracting certain non-communicable diseases like diabetes and hypertension for the past three to six months or a year were asked. Special attention was given to these diseases since there were not included in benefit packages of the bank. An annual subscription fee for an insurance policy covering diseases like malaria and typhoid was to be deducted from her account. People who travel abroad for different activities required health assistance. Mr Nelson, who is a father of 03, also had his perception of health insurance and so during the interview he explained that he was travelling to Germany to attend a seminar, and one of the documents requested by the embassy was a traveling health insurance policy. To him, that was the first time he heard of health insurance. However, the person who received him at the insurance company gave him further explanations of how the policy functions, and how it is different from all other health insurance policies, after which he was provided with a form to fill in some important information, including information for my passport, date of departure, date of return, country of destination, purpose of travel, just to name a few.

Some respondents who already had their car insurance policy said that they have heard about health insurance coverage, but did not have the details of the policy. Most participants who expressed lack of knowledge of health insurance terminology and its functioning attributed this to

limited efforts made by insurance facilitators to promote the product. Moreover, insurance facilitators have failed to properly educate the public about the necessary information required to understand the health insurance policy. Yvonne, 34 years old and mother of 03, a community member who has been embarrassed once with such terminology said that: In the insurance company where she renews her car insurance yearly, the customer service lady told her about health insurance coverage and said it was important for her to register her family members to benefit from the coverage. She was given a document containing questions she has to fill following the requirement for a quotation. She needed to understand some of the terminology in the questionnaire before completing it, but since she was in haste to attend another meeting, she had to postpone for a later date. Others informants thought that informal sector workers cannot benefit in such private insurance schemes, where membership is mostly for the rich and enrollment is by formal employment. Claudette, 34 years old, and father of 02, explained that:

> *There are people who know about health insurance, but it is small percentage. Those who do not know are not ignorant…, but there has been no attempt to have a comprehensive campaign to create awareness. The few who know about health insurance are those who have travelled and become exposed to this information. Most of the people here are petit traders and are not very exposed. The ones who are aware are mostly those who are formally employed. Due to being at work, they do not have the time to share [information about health insurance] with the other people* (Claudette, Nurse, Acacia May 2023).

Some others informants thought that commercial agents of private insurance companies have been trying to sell the product to the public, but the information they give is not always sufficient enough to make people understand exactly the functioning of health insurance. The officials of the CBHIs have also been trying to educate people about health insurance scheme through various channels, including churches, funeral grounds and other social gatherings, but this information did not always reach everyone in the community. Martha, 38 years old, mother of three, and who met many insurance agents said that:

> *I have heard most of this information in the Catholic Church especially when I was still in my home town back in Bamenda, when officials of BEPHA always come around after mass to sensitize the congregation about the advantages of the scheme to the population and their families. I think the idea of CBHI must have originated from there and promoters usually come there almost every other Sunday. That is all I know since I am not a member of any health insurance scheme* (Martha a farmer, Biyem-assi Carrefour May 2023).

Even at funeral programs, participants could learn about health insurance, Mr. Peters, 40 years old and father of four had a unique encounter and had this to say:

> *I can say that I learned about health insurance coverage about two years ago when I was invited as a member of a funeral organizing committee of a boy who had died. As we were brainstorming about the hospital bill since the boy had been ailing for some time, […] some insurance official told us*

> *not to worry about the hospital bill and the funeral expenses as the boy already had health insurance coverage from his employment with such extension coverage for his funeral expenses* (Johnson, motor mechanic TKC May 2023).

Respondents demonstrated an understanding of the role of health insurance coverage, but they did not always know how these schemes function, with many equating them to 'merry-go-rounds' (rotating savings groups, that are very common among women) "njangi". Most people reported that the main aim of health insurance is to help members to meet costs of treatment when they fell ill. This was important because of the uncertainty associated with illnesses and the high costs of treatment. The role of health insurance was described in various ways: being covered for healthcare when ill; saving money for illness; and protecting oneself from unexpected events. In most cases, respondents linked their understanding of the role of health insurance to their past experiences, or those of their friends and relatives. James, 37 years old, and father of two said;

> *My brother got ill and was referred to meet a specialist doctor in one of the big clinics in town, there after the consultation, he was admitted. It was a very expensive clinic and most patients admitted there had health insurance coverage, especially workers insurance provided by their employers, then I was told that if he had health insurance coverage, they would have cleared his bills* (James, carpenter, Tam-Tam weekend, May 2023).

### 3.1.1. Perception of the insured about health insurance coverage

Majority of the respondents who have once been enrolled in health insurance schemes reported that scheme membership was open to all regardless of socioeconomic status. However, joining the scheme depended on an individual's willingness, preferences and ability to pay. People of high socioeconomic status and those who are in formal employment were more likely to acquire health insurance coverage. According to World Bank (1994), private health insurance covers almost exclusively the formal sector populations, and therefore achieves a coverage rate of not more than 10 percent of the total population. The majority of low-income populations, including informal sector workers do not have access to this kind of social protection. As a response to the lack of social security the negative side-effects of user fees and the persistent problems with healthcare financing, various types of community financing, especially for urban and rural self-employed and informal sector workers have been recently proposed as a way forward (WHO 2001). Based on these, Kiya, 39 years old and father of 03 said that:

> *I think some households do find it easier to acquire health insurance coverage than others. For example when my wife was employed a Non-Governmental Organization,, she benefited from a group health insurance coverage plan in a private insurance company and she told me that the children and I were also beneficiaries. I do not think I would ever have joined an insurance scheme with my kind of self-employed activities I do. So an employed person may find it easier to join a health insurance scheme than an unemployed person. So in my view those without good income are*

*unlikely to register in such groups.* (Kiya, Taxi driver, Superette, May 2023)

Some informants emphasized that while CBHI schemes were open to all, they were specifically targeting the poor populations. The private insurance companies for the high class 'rich' members of the society, though none of the schemes had any arrangements to waive or subsidies contributions for the poor population. However, it was reported that CBHIs and private insurance companies had different packages to care for people of different socio-economic status: some packages costing less with some exclusions to the health coverage, while other packages costing higher with wider health coverage. Access to benefits largely depended on the package, with those contributing more, enjoying more benefits. Cletus, 32 years old participant explained that "There are different packages so that all socio-economic groups can benefit. For example, some time back I could hear my brother who was employed discussing about private wards in a very expensive private hospitals where a patient can have their own room. I can compare those who paid 75 000fcfa per night to those who could use private wards in very expensive hospitals, while those paying 3 000fcfa and 8 000fcfa are the ordinary people who consult and get treated at public and conventional hospitals". The quotes above explain that insurance schemes packages are in different categories and can benefit each social class even done to the lowest category of people in the community. It is needless refusing to get a subscription on the grounds that insurance is expensive and restricted to the higher income people. Stephen, 33 years old and father of 04 reiterates this understanding as he reveals that:

> *I think it goes with the package or health insurance scheme one is able to pay, which in turn depends on financial status. I might be able to pay less for a smaller package according to my ability. Another person is better off and is able to pay the package that allows him or her go to more expensive hospitals. So if my financial ability allows me to pay for the public hospital that is where I will go* (Stephen, Catapiller driver, Tam-Tam weekend May 2023).

Some respondents reported that, ill health could be a strong motivating factor to make them want to belong to a health insurance scheme, while others did not see the reason of making contributions towards health insurance when they were in good health. Private insurers reported that since their main aim of operating is to make profit, they have employed all mechanisms to avoid such bad risks (people who want to buy insurance because of poor health conditions) in the health insurance portfolio. Insurers avoid adverse selection by insuring in groups, so that some people's good health may subsidize for others who may get sick often. Most participants did not understand the terminology and so wanted to enroll to an insurance policy only to their convenience, as Clement, 43 years old, and father of four had this to say:

> *According to some participants "the reason why some people think that they can join the health insurance schemes is only when they or their family*

> *members are sick. Those who are healthy do not think of joining health insurance. Now you are telling us to contribute this money and we do not see who is receiving treatment but it is for keeping aside for the future that cannot work* (peter, Builder, Biyem-assi, May 2023).

That is why Roland an insurance agent, 35 years old and father of two tried to explain his opinion on participant's misinterpretation of the health insurance policy:

> *There is also something else I see the people consider. Some people may also for instance see that a member of the family has an illness that is deteriorating with time. You find such a person seeking to gather information to purchase a health insurance policy, or when someone has a plan to travel abroad for treatment. I do not know how they manage to pay but I have observed that such people strive to join probably because they know the burden may become overwhelming* (Roland, Insurance agent at Acacia, May 2023).

### 3.2. Perceptions of non-insured about health insurance coverage

Respondents could express different opinions for not belonging to any health insurance scheme. While most informal sector participants complained of lack of finances, they concluded that the private health insurance coverage which to them is much formalized was mostly linked to the employer's plans, allowing many formal employee workers to meet payment conditions. Apart from the fact that their finances can cover up for the costs of such policies, they can also get coverage through the employer's plan. Informants reported that health insurance policy subscription does not allow premium payments in installments, making it difficult for low-income households to subscribe to any health insurance scheme on their own. Respondents also complained that health insurance terminology such as deductibles and coinsurance was difficult for them to understand, so that at any point in time, they will required the assistance of the insurance facilitator to break down such terminology in the simplest terms. Almost all explanations that were given to them by health practitioners or insurers were never enough for their understanding. That is why some people cannot purchase something without a clear understanding of the functioning. Actually, benefiting from a health insurance policy requires some steps that the insured must follow to the end in order to facilitate the reimbursement procedure, or copayment of the health provider. Following an interview with Evaristus, 32 years old insurance staff and father of 03, he explained that; "the prospective insured is given a questionnaire (see appendix 01) to fill in some necessary information required to propose a good quotation (see appendix 02). When the client is comfortable with the quotes, he does the payment and his contract is established, indicating all coverage's and limits. Then a list of the network hospitals from the insurer is given to the client to facilitate him benefit from the policy, but the insured may visit any doctor of choice and ask for reimbursement from the company. The insured has to take with him a health declaration form (see appendix 03) which must be signed by the doctor and which the insurer needs to provide a care voucher (see appendix 04)

that should serve for the insured's Laboratory tests, medication and or hospitalization, as the case may be". According to this informant, the insured that does not show proof of doctor's consultation with a health declaration will not receive a care voucher, and may have to pay for treatment out-of-pocket. In order for the insured person to obtain a care voucher, he must return to the health department of the insurance company after consultation or doctor's visit. This procedure was never welcome by most people, thus they complained bitterly each time they had the least opportunity.

Some respondents expected the promise that their premiums have to be refunded at the end of the insurance year in case they did not fall sick, or better still that the payments made during the last insurance year be forwarded to the next insurance year if no reimbursements were made. Some orders viewed the health insurance premiums as savings that should attract an interest. Once these could not be the case, they considered it a waste of opportunity contributing money that 'just laid idle' for the duration that they were in good health and therefore could not benefit from the scheme. Following this perception, it is clear that the informant did not understand the health insurance terminology of risks pooling and spreading of health risks, which actually means that health insurance premiums never 'laid idle' and does not have to be refunded even if some people did not get sick during the insurance year. This is a health insurance terminology which simply means that the premium of people who do not fall sick in a pool is used for the treatment of people who fall sick within the insurance year. Based on this scenario, Hilary who is 42 years old, and father of 05 expressed his ignorance of this basic insurance terminology as he thinks that if contributions are made for a year and insured's do not get ill, it means that they are just helping other people and therefore they have to stop paying, unless the insurer has to promise a refund if there is no reimbursement.

Some experiences of insured persons that are linked to perceive poor quality of health services to the insured persons, especially those that have to do with arrogant staff at accredited health facilities, inadequate benefit packages and high co-payments also hindered people from subscribing to health insurance coverage. Poor service provision was exemplified in some network hospitals by lack of laboratory equipment and x-ray machines, long waiting times, corruption (and conflict of interest), and discrimination of patients according to scheme membership or perceived socioeconomic status. Other complaints included poor hospitality, rude hospital staff and inadequate ward facilities (overcrowded wards, inadequate bedding, worn-out patient uniforms) and poor diet. A participant, Maxwel, 44 years old and father of 03 said that;

> *The hospitals where some health insurance companies work with [meaning those accredited to provide services for insured's] do not treat clients well at all because they found out that hospital staff do not treat with such attention required. It is either there is no network to enable insured's use their health cards, or a certain medication is not available even if it is there. Some of the doctors just ignore insured patients with health cards and*

> *rather attended to patients who would pay cash at that moment. This makes it difficult for insured's to renew their policies upon expiration. It is important for officials to monitor quality of services so that people can be encouraged to join the schemes. (*Maxwell, Taillor, Montee Jouvance, May 2023)

In the same vein, Arianne, who is 37 and mother of 02 explains her dissatisfaction with the functioning of some public health providers to insured persons. 'They do not provide good care to patients especially when hospital staff knows they are insured, even though it may have to do with different providers. Patients are expected to buy the drugs to be used even if the policy covers then 100%. They can also tell you they will order for you some drugs…but the drugs belong to the hospital…they tell you they are giving you drugs that belong to another patient and you are expected to pay later on.

There are some inconveniences following the health insurance contract signed between the insurer and conventional hospitals that do not favor the insured. Contracts which do not cover all care services in the same health facility, so upon admission, movements between health facilities are usually burdensome and not welcoming to patients. Yves, 43 years old father of 03 explained that *the* health insurance policy helps people when they are admitted in the hospital but at times one may become ill and is prescribed for some drugs, needs to have an X-ray taken and other tests….and all these is not covered by the health insurance policy in the particular health facility, making the patient to move from one facility to another for lab tests or to buy drugs, which is too burdensome to the patient and the care giver. Hence, most patients would like the health insurance policy agreement to cover all these at one facility'.

Health insurance schemes were perceived to have many advantages by both members and non-members, including offering financial protection to members, making members feel at ease when their relatives were in hospitals and building on solidarity to help other community members. It was reported that in the future, community members would be reluctant to contribute towards helping families to clear hospital bills due to the harsh economic conditions, and health insurance will be the only way of ensuring that such people can pay for health care.

According to Stella, 30 years old and mother of 02, health insurance coverage is a very good idea because if one does not have money and a family member is admitted at the hospital for treatment, the health insurance policy will pay the bill and hence the patient will not be detained in hospital'. So, the whole idea of health insurance thinks that; health insurance is good and can avoid certain embarrassments to the patient. For instance, in some hospitals, if the hospital bills are too high…., say hundred thousands of francs CFA, the patient may be retained at the hospital, forcing family members to sell some of their assets, including household equipment, which will help to settle the hospital bills. That is why people join health insurance schemes because even when an illness strikes, a member will not feel anxious about the hospital bill'.

Fabian, a 42 years old man with 04 children, who does not benefited from any health insurance policy, explained the inconveniences of not being insured. According to him, he has not been a beneficiary of health insurance, so each time a member of his family falls sick; it disturbs other family activities, forcing him to use money invested in a family business for healthcare. He further explained that sometimes he even goes to the extent of using money meant for school fees to settle health bills. He said that at one moment he rushed to the hospital with his three years old child and spent money meant for his "Njangi" contributions for the coming Sunday to help relieve his son at the hospital. To him, all this destabilizes him so much that he keeps worrying about how to make up for the money he already spent to settle hospital bills'. Talking with this respondent, one could better understand the importance of insurance to family's income. The absence of this coverage destabilizes the home because income which was reserved for other investments would be used to pay for health bills.

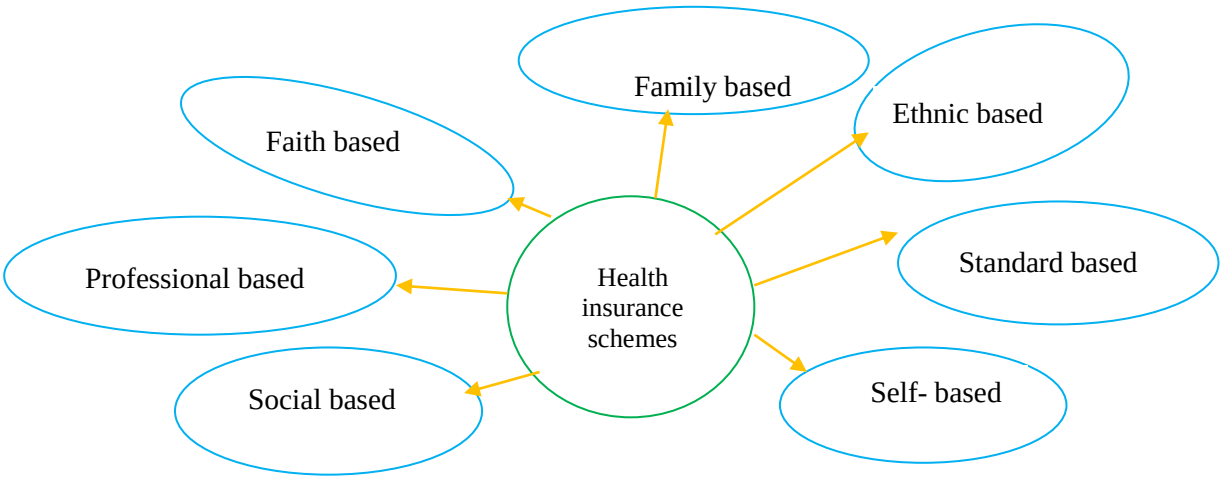
**3.3. Classification of health insurance schemes**

According to most participants during the interview process, there are several health insurance schemes in the community that are classified following the socioeconomic activities of community members. Following our fig 01 below, health insurance schemes were classified as follows: Faith based health insurance scheme, Professional based insurance scheme, standard based insurance schemes, family based insurance schemes, ethnic based insurance schemes, just to name this few. Most community members perceived health insurance as a saving scheme for healthcare. This probably explains the reason why almost all informants during the data collection process indicated that they belong to a health insurance scheme. Every individual is different in life style and carry out different activities for a livelihood, therefore has a unique set of needs. A single health insurance scheme is not enough to cover every person's individual requirements in a community mixed with people of the formal and informal sector. This is precisely the reason why different informants cited different health insurance schemes that they belonged to, so there are a number of different types of health insurance schemes available in the community. Our research findings revealed the health insurance schemes in the Biyem-assi community included; Faith based health insurance scheme, Ethnic based health insurance scheme, Professional based health insurance scheme, Standard based health insurance scheme, Social based health insurance scheme, family based health insurance scheme and self-health insurance scheme.

The diagram below is an illustration of the distribution of health insurance schemes in the Biyem-assi community. Discussing with informants during the data collection process, it was revealed that each one of them belong to a health insurance scheme which is based on their livelihood activities and interactions in the community. In this light, people who spent time doing church activities identify in their different church groups including: the CWA, CMA, Choir groups

, CWF, prayer groups, action groups, small Christian community groups, just to name a few. This church groups usually come together to continue the work of God either through prayers, singing or assistance services. Apart from carrying out God's services in the church, there were also activities meant to assist each order in the group like praying for members in need etc. Once a member in a group, they have to participate with a registration and all forms of contributions that are meant to provide assistances to any group member in need, with the hope of receiving such level of assistance in future.

**Diagram 1**: Health insurance schemes distribution in the Biyem-assi community




**Source:** Ndum Clauris, January 2024

### 3.3.1. Faith based health insurance scheme

A faith-based health insurance scheme is a scheme whose values are based on faith and beliefs, which has a mission based on social values of the particular faith, and which most often draws its activists (leaders, staff, volunteers) from a particular faith group. The faith the organization relates to does not have to be academically classified as religion. The term "faith-based organization" is more inclusive than the term "religious organization" as it also refers to non-congregation faith beliefs (Bielefeld, 2013). Religious values and practices are often deeply entwined in the fabric of daily lives. They tend to grow from and build on faith communities' belief that they have a moral imperative to help those in need and improve the human condition. FBOs usually focus on issues of morality such as rules of family life and the spiritual basis of disease. FBOs' ability to ground their work in religion can enhance their influence with communities, as it enables them to call on people's moral duty. Every day FBOs work to better the world and their communities by caring for those in need. They play an enormous role in providing health information and healthcare all over the world. FBO hospitals and clinics are often the most respected and trusted health care providers in communities of all sizes.

Christian Women's Fellowship (CWF) remains a vibrant movement of the Presbyterian

Church in Cameroon (PCC). It started 45 years ago and has grown to over 910 groups and over 50,000 members. In all congregations of PCC, women outnumber men; they represent 70% of PCC members with 30 women ordained pastors (PCC 2006). Unequivocally, the increased number of protestant clergy being female enables PCC to better connect with huge population of female worshippers. On the contrary, with Catholic, Baptist and Muslim clerics, priests and pastors are mostly male. In a context of deepening poverty and economic hardship, these religious organizations are a sanctuary, enabling a fusion of a gospel of spirituality, compassion and basic support. Within fellowship groups, visits to those unwell and old are carried out and a token contribution offered. This approach is commonplace amongst CMF, Christian Men's Fellowship (CMF) Catholic Women's Association (CWA), Catholic Men's Association (CMA), and Baptist Women's Association of the Presbyterian, Catholic and Baptist Churches respectively. An elderly Christian woman stated: 'Participation in church activities is spiritually fulfilling and psychologically stabilizing as one prepares for transition to the other world. We need to rely on God, renew our covenant with him and in return; we receive spiritual fulfillment. Religion is about faith building and it is the bread of life itself as it gives us hope'. Support with bereavement remains a major support mechanism. A man who was interviewed recounted that:

> *I belong to Catholic Men's Fellowship. We contribute when a member is in trouble. If a member dies, we take part at the wake. We carry the coffin and we sing at the burial site. We contribute ranging from 500 to 1000 CFA to assist the family. When a member loses any of the immediate family such as wife, father, son, daughter, we statutorily contribute 3000 CFA. For the extended family, we condole with the member and contribute 500 CFA towards 'mimbo' for members who show up* (Romeo, Food stuff seller, May 2023, TKC).

As discussed earlier, periodic offerings were collected to assist vulnerable people. Contribution boxes (mostly wooden) are circulated and the box is split and its contents disclosed on a designated Sunday service. Based on the contributed funds, averagely 100,000 frs CFA, usually inadequate to meet the needs of those unwell and frail. Allocations are made in sealed envelopes and visits are paid to beneficiaries by designated church elders. A female elder, aged 75 years indicated that she benefited once from the scheme when she was hospitalized, and when she unveiled her envelope, she got 150 000 CFA. Frail older Christians are usually supported with foodstuffs and firewood for cooking, which exemplifies the existentialist function of religion.

Support for sick people varies within the different religious inclinations. For the Baptist, contributions are often done on specific worship days, three times a year. It is an initiative of Deacons Board of the church which extends a helping hand to disadvantaged groups in the church. The church carves a box (plank safe) which is brought into house of God. The box is split quarterly and whatever has been contributed is put together and based on the amount raised, old and sick people are assisted. In Presbyterian Church, church groups like CWF, CMF and Hallelujah Choir

are predominantly comprised of older women and men who easily fall sick. In order to cater for its members, self–help schemes provide ground-up ways of pooling cash as a form of insurance. An informant made mention of Presbyterian Self Help Fund (PESH). Every worker with Presbyterian Church can save and obtain loans from the fund.

Interviews with some Muslim clerics proved that there are no equivalent schemes with Islam. As Muslim clerics survive on largesse of community and endowments pooled from Zakat and sadaqa. Existentialist doctrine resonates with widows who find solace within religious organizations and choir groups. A constraining cultural context that imposes a double burden on most widows, taking care of children and other dependents with diminished resources is a difficult task. Various religious groups provide a safe haven for widows and widowers. A widow related her spirituality and belonging in a church group as:

> *A life-blood relationship without the church, I would have long accompanied my husband to his resting place. When my husband died, I had nowhere to turn to but the church. When I attend prayer sessions early every morning, church service on Sundays and the weekly meetings on Wednesday, my life is restored and my burden is lightened. The songs speak to me; the gospel pierces my heart; it gets to my soul and it's like I hear the voice of God telling me that he is keeping watch over her flock. Within the group, we also visit one another if someone is in poor health. We sing together, pray together, study the bible together and show love and compassion for one another* (Fadimatou, Acara business, white house, May 2023).

Statements lend credence to religious and existentialist ethos of keeping faith, displaying love to your neighbor as you would do to yourself and being your brothers'/sisters' keeper. This philosophy of helping 'the poor and needy' squares with centrality of religion; not only perceived as communion but relevant in pushing across solidarity and acting for common and general good (Welker 2003).

### 3.3.2. Ethnic based health insurance scheme

A group of people who share a similar culture (beliefs, values, and behaviors), language, religion, ancestry, or other characteristic that is often handed down from one generation to the next. They may come from the same country or live together in the same area. It is a group of people who identify with each other on the basis of perceived shared attributes that distinguish them from other. The Institute of Medicine (IOM), in a 1999 report edited by Haynes, M.A. and Smedley, B.D., defines ethnic group as how one sees oneself and how one is "seen by others as part of a group on the basis of presumed ancestry and sharing a common destiny…"Common threads that may tie one to an ethnic group include skin color, religion, language, customs, ancestry, and occupational or regional features. In addition, persons belonging to the same ethnic group share a unique history different from that of other ethnic groups. Usually, a combination of these features identifies an ethnic group. For example, physical appearance alone does not consistently identify one as

belonging to a particular ethnic group.

Ethnic group, a social group or category of the population that, in a larger society, is set apart and bound together by common ties of race, language, nationality, or culture. The Ethnic based groups were also represented and carried out financial obligations to assist members who get sick to access healthcare facilities. Different ethnic groups perceive health insurance differently. For example the Kom ethnic group in Biyem-assi represented by NADECO women refers to health insurance fund as “ngvaah”, while the Ndekong ethnic group of Bafmeng refers to health insurance as “ngwah” and the great Bamileke ethnic group also refers to health insurance contribution to mean “tontins”. The Professional based groups are identified by their different business activities and workers in the same company. For example “bayam sellam” women's association at the Acacia market, who refer to the health insurance scheme in their group activities as “Njangi”. The standard private insurance companies have more formalized insurance activities and work to maximize profit. Especially the private health insurance subscription which is not for all, as only the “relatively rich” formal sector members of the community can afford it, while the majority low- and middle-income populations cannot afford this kind of insurance coverage. Low and middle income class populations most often get their coverage through community based health insurance scheme. There is also the Public health insurance scheme which represented by the NSIF and most often insures workers of both government and private sectors in the country.

**3.3.3. Professional based health insurance scheme**

A Professional based group is made up of members of a particular work or business class, who may decide to come together to carry out activities that are beneficial to member’s welfare and improve access to healthcare facilities. Professional based groups could either be represented by formal sector or informal sector working class. A formal sector group is a designated work group that is defined by an organization based on its hierarchical structure, with designated tasks related to its functions in the workplace. It can be the finance group or the human resources group. A formal group is one where people come together to accomplish specific goals and objectives. It has particular structures and roles where responsibilities of members of the group are defined. Activities carried by this formal group have specific guidelines, which members are supposed to adhere to and follow to ensure good coordination. The practice of members of a formal group is governed by specific rules and regulations, which are usually formulated at the inception of the group. All members of the group are supposed to adhere to the rules and guidelines that define the group. Moreover, formal groups have a defined leadership structure where there is an official leader who ensures that the group is in line to achieve its goals while at the same time enforcing rules among members. Formal group associations are usually most often made up of employees of a company and usually benefit from an employment group health insurance.

Employment group health insurance includes health insurance schemes covering employees of a company. Insurers often offer group insurance as a separate category of insurance with a different pooling and pricing structure, often offering different benefit packages as well. An example of a formal group association benefiting from group health insurance are members of the APEZ (Assocoation du personnels des Employeurs de Zenithe), which is open to all workers of the Zenithe Insurance Company. When a member gets married and when a member puts to birth. Employees who are not registered members of this association do not benefit from it but may welcome assistance from individual colleagues in the company.

Sometimes formal sector workers may not be opportune to benefit from an employee's health insurance plan and may require to subscribe for a private health insurance policy, referring to an insurance schemes that are financed through private health premiums, which are often (but not always) voluntary. Although the government sometimes regulates this type of insurance, the pool of financing is not usually channeled through the general government. It is important to note that there might be out-of-pocket payments such as co-payments, deductibles and co-insurance in both public health insurance and private health insurance schemes. For example, public health insurance members might be required to make co-payments. In Korea, co-payments in public health insurance represent a share of up to 50% for outpatient services and 20% for in-patient care.

The professional based insurance scheme was also represented by people who carry out informal sector activities known as informal associations. An informal group is formed when two or more people come together to accomplish a specific task which is mainly socially geared. The main idea behind the establishment of the informal group is the satisfaction of both personal and psychological needs. Informal groups are not subjected to any rules and regulations as in a company, and the members of this group willingly belong to this group. However, there are some explicit guidelines that govern the operations of an informal group, usually included in the group's constitution. The behavior of an informal group is governed by the expression of members, norms, beliefs, and the values that members adhere. The "bayam sellam" women's association of the Acacia market is a typical example of a professional based group we encountered in the study area. This association is identified with bi laws and activities that keep members together.

Members of informal groups are made up of workers of informal sector activities and do not usually have the finances to benefit from a private formal groups health insurance policy. Most members who have an insurance health policy are registered in a community-based health insurance schemes. Members who were from Catholic Church had once experienced an enrolment with the BEPHA (the Bamenda Ecclesiastical Province of Health Insurance) scheme. The idea of the BEPHA scheme came from the Bishops who after observing that children of God live under deplorable condition, are stricken by poverty, and are unable to afford quality health care. Many

people who visit the health centers or hospitals when they are sick are stranded since they can't pay their medical bills and are sometimes forced to work in the Health Units to settle the bills. Some people resort to selling household items or borrowing – for which they are often exploited; others do not seek medical care at all; other people try to treat themselves (auto-medication); while some others people delay at home hoping for some improvement and most often only go to the hospital for treatment when their condition has aggravated; many other people resort to traditional practitioners or road-side drugs for cheaper treatment – which is very dangerous to their health; and still others resort to prayers with the hope of a miracle from God. The result of the above has often been that the patient suffers for a longer period and the family ends up spending more money, energy and other resources; or the person dies rather prematurely.

### 3.3.4 Standard based health insurance scheme

Health insurance is a part of personal insurance and the purpose is to protect the insured against the risks associated with illness, or more precisely, against all events leading to medical intervention. The standard based health insurance scheme is the formalized public and private health insurance schemes operating in study area.

#### 3.3.4.1 Public health insurance schemes

These are schemes that are financed by the government payroll contributions to social security schemes. Social security schemes are statutory programs financed mainly through social security contributions, which are usually a share of earnings, i.e. income-related. These are mandatory for defined categories of workers and their employers and protect insured persons and their dependents against, among others, loss arising from sickness/illness. The government is the ultimate guarantor of benefits, and usually directly participates in the financing of the scheme. Mandatory health insurance includes schemes where individual participation is compulsory by government through legal stipulation, whether there is a unique system or a choice among scheme/insurer. The mandate can apply to the entire population or to groups within it.

The Cameroon's social health protection system is based on two systems, the government's civil servants scheme and the National Social Insurance Fund (NSIF), more popularly known by its French acronym of CNPS (Caisse Nationale de Prévoyance Sociale). Government civil servants scheme refers to civil servants being able to access public medical assistance with limited finances as it is financed by the state budget. NSIF is directed at workers under the Labour Code and is mandatory for civil servants but not for other laborers. Many laborers, however, do not recognize health as a priority hence; do not participate in social insurance plans. Workers found outside of the formal sector, where a majority of the workforce is concentrated (estimated at 7.3 million people), remain uncovered as NSIF is optional for them (2020). The 10% of the population covered by CNPS benefits from standards set by the International Labor Organization (ILO, 1952). In a study

concerning community-based health insurance (CHI) conducted in the urban cities of Cameroon, Yaoundé and Douala, family size, health priority, and household income were determinants of willingness to join an insurance scheme. In this study, an increase in household income was shown to also increase the desire of a household to subscribe to a health insurance scheme. When sampled on the opinion of community members that could favor a decree to that effect, here is what Henry, 43 years old and father of three children said:

> *We have heard about the NSIF but I think it is only the national state workers who can benefit. Information about its enrolment requires some payments. You are asked to pay money when you cannot even make ends meet, then where will you get the money. If someone asks you for two thousand francs when the last time you had a thousand francs in your house was more than a week ago. I may be willing but I cannot afford* (Henry, call box attendant, Biyem-assi May 2023).

Some participants expressed concerns about how the NSIF functioned, arguing that even when someone is willing to join, most of the offices are located in the central town leading to high transport costs, and follow a lot of bureaucracy which may be difficult for the ordinary informal sector population to follow it up. Alexandre, 40 years old mother of three children explained that:

> *The problem that we have is that NSIF offices are far and have a lot of order to follow before entering there… So you can see one has to pay transport to and from the office. If one was to make contributions every three months, transport costs end up being higher than the cost of the premium, but if the offices were near a person can even track to the offices to make payment or for other services* (Alexander, Business man, TKC, May 2023).

Most household heads responded in preference of the implementation of a compulsory national health insurance scheme in Cameroon in a view towards universal health insurance coverage, where the government was the most preferred revenue - collecting and purchasing organization for such a scheme, without which health insurance coverage can never be obligatory. The Private purchasing institutions were hardly preferred maybe because it is too expensive for informal sector households. Most participants reported that if is a National Health Insurance which is made compulsory, they would prefer to join for various reasons including: to be supported during the period of illness, to ensure that they are protected since the costs of illness are unpredictable; to access high quality health care promptly and the fact that a NHIS would contract more health care providers than CBHIs and private commercial for profit insurance companies, thus better choice of health service providers. Others reported that unlike private providers, who were motivated by profit, and who sometimes promise patients' welfare by providing incorrect treatment, government facilities contracted under the NSIF were unlikely to over diagnose patients.

On overall design, informants revealed that the community would prefer a NSIF that provided comprehensive inpatient and outpatient services, and should include all costs associated

with treatment including drugs, surgery and ambulance. Before implementing the NSIF, in as much as respondents would encourage a NSIF, the government has to work towards improving quality of services in public health facilities to ensure a constant supply of medicines and equipment, adequate personnel and reduced waiting time. Also emphasize was made for the urgent need to have good interpersonal skills among health workers to ensure that people are treated with respect and dignity and to eliminate corruption. Fred, 42 years old father of five children said that: "*The basics….they should treat people with dignity and provide all required treatment. The contribution rate would not matter much as long as they treat people well and tackle corruption because that is what has led to bad services in most public hospital centers"* (Fred, Tam-Tam weekend, May 2023). Based on these facts, Nixon, 44 years old and father of two children said:

> *Another thing is that you may find a person who is admitted being told to go and buy drugs outside the facility, then at the same time turn around to introduce the same drugs for you to buy them privately, while another person is being provided same drugs from the pharmacy in the same hospital. That corruption should be addressed* (Nixon, Builder, TKC, May 2023).

Closed to half of the household survey respondents favored a progressive contribution structure in case the government considers a NSIF in the country, where the richest contributed a larger share of their income towards an NSIF while the poorest population should be exempted from contributing, even though some respondents still preferred everyone to contribute equal amounts. Majority of the respondents showed that the community would want to have their preferences considered in the NSIF design if Cameroon finally decides to consider it, especially on issues regarding contribution rates and benefits package in order to ensure that the set rates were affordable to the majority of the population and that the needed services were provided. However, caution was expressed regarding setting contribution rates too low at a rate that would make service provision difficult. Other suggestions included setting rates according to income levels in society, ensuring that the rich cross-subsidies the poor; the government should use taxes to fund the scheme and should it be on a contributory basis, the poorest population should be subsidized through tax funding. Beatrice, who is 38 years old and mother of 03 confirmed this by saying that:

> *If the opportunity is given, people have to be careful not to propose very low amounts that may close down a facility especially if the payments are unable to sustain the salary of the workers there. So I would suggest we give a figure that can be able to sustain the provision of services at our facilities* (Beatrice, Business, Superate, May 2023).

#### 3.3.4.2 Private health insurance schemes

Private health insurance refers to insurance schemes that are financed through private health premiums, which are often (but not always) voluntary. It is important to note that there might be out-of-pocket payments such as co-payments, deductibles and co-insurance in private health

insurance schemes. In Cameroon, as elsewhere, private health insurance effectively participates in the financing of healthcare and their contribution cannot be underestimated. The private operators are not intended to cover the entire population, not even the majority as subscription is mostly open to the "relatively rich" members of the society. The motivations of the insurers may well be noble without making them philanthropists. Indeed, even in the field of healthcare, private health insurance professionals absolutely intend to make a profit. This way private health insurance is optional and exclusively available only for those who can afford it. It excludes the poorest and those who cannot or do not contribute. It also always excludes the most vulnerable and so is a consumer product of the middle classes and the rich. This situation, which prevails today in the absence of a universal health coverage system, will always be perpetuated when this system is set up because governments cannot declare health insurance compulsory for all overnight; they will always start with insured salaried employees in the private and public sectors, the adhesion of the latter being facilitated by the fact that the amount of their salary is known.

While the vast majority of the population is already excluded from health insurance due to their low incomes, the financial factor continues to be a serious handicap in the capacity of private health insurance to finance healthcare in Cameroon. Indeed, under the relevant provisions of the CIMA Code, in particular article 13, which makes the taking effect of the insurance contract subject to the payment of the entire premium by the subscriber of the insurance contract, it is not possible to finance the health insurance premium gradually or progressively. This constraint, which handicaps individual's as much as small businesses, and even large companies, is not likely to favor the density of health insurance operations.

Private health insurance can either be subscribed individually or the cover can come as part of a group, for example as an employment provision. In the Cameroon, the majority of insured's in to private health insurance schemes are covered by employer-based voluntary health insurance, while the self-employed and non-working people or those ineligible for employer-sponsored insurance can buy voluntary individual insurance form CBHIs. The distinction between group insurance and individual health insurance is important because the former can bring important social elements into the private cover. Premiums under group insurance are often lower because insurers bear lower administrative costs and the size of the pool is greater. A simplified classification of health insurance schemes is proposed. Employment group health insurance includes health insurance schemes covering employees of a company. Insurers often offer group insurance as a separate category of insurance with a different pooling and pricing structure, often offering different benefit packages as well.

**Conclusion**

The objective of this chapter was to understand the perception of health insurance coverage

among community members in the Biyem-assi community. Most of the informants thought that health insurance translates to a savings scheme for future healthcare. That is why members come together in a pool to contribute and assist other members who are in need, hoping to be beneficiaries in future. Savings here could mean a lot, including time, friendship, care, understanding, just to name this few, where relationship between group members was simply reciprocal. In this case members can only assist other members who make an effort to assist others in their times of need. In order words, if a registered member is sick, other members have to contribute money and provide assistance for their healthcare. To this effect, people who do not contribute for other people in time of trouble may not expect any form of assistance when they are also in need. Some group members who cannot contribute financially were allowed to contribute in kind; providing foodstuffs, services or physically present at the hospital to help the sick person.

We now move to chapter four where community members explain the mechanisms they use to finance healthcare. Findings of the research revealed that each of the health insurance scheme identified above constitute different activities, most of which group members use them as mechanisms to finance healthcare in their households. According to our research finding, some of these activities included the following; registration, contributions, savings, loans, monetary gifts, just to name these few. It is therefore various activities of health insurance schemes that help members to finance their healthcare. Given that health insurance is a benefit policy, some community members could do everything to belong to more than one health insurance scheme, where they contribute in cash and kind to secure their health insurance coverage.

# CHAPTER FOUR: PATTERNS OF HEALTH INSURANCE SCHEMES IN THE BIYEM-ASSI COMMUNITY OF YAOUNDE

The chapter four of this research presents findings on the patterns of health insurance schemes in the Biyem-assi community. The objective of this chapter was to investigate the mechanisms used by the Biyem-assi people to finance healthcare. Data was collected to answer the following research question; "what are the mechanisms used by community members to finance healthcare?" and to confirm the research hypothesis that people belong to community based schemes whose activities include healthcare financing mechanisms. Findings revealed that people navigated across health insurance schemes in the form of insurance scheme shopping to meet their healthcare needs.

**4. 1. Health insurance scheme shopping**

The health Insurance scheme shopping requires the availability of insurance scheme organizations set up to create more organized and competitive markets for buying health insurance. They offer a choice of different activities, certify plans that participants can be provided with information on in-person assistance to help members understand the options in community groups and apply for membership. In the community level, individuals and families can shop for membership in community based groups if they need health insurance coverage. Contributions based on livelihood activities are encouraged and cost sharing subsidies are available through the community groups to make coverage and assistance to members affordable for individuals and families. People with very low incomes are eligible for membership and healthcare assistance through family and self-health insurance plans. Self-health insurance is a situation in which a person that is liable for some risks does not take out any third-party insurance but rather choose to bear the risks. This may have to do with self-funded healthcare, where the individuals make health payments out-of-pocket. In the company, an employer for example provides certain health benefits to employees and funding claims for specified pools of assets rather than through an insurance company as the term is traditional used.

Data collected revealed that, members of the community navigated across health insurance schemes in the form of insurance scheme shopping to meet their healthcare needs: in our fig 02 below, data collected revealed that community members understanding of health insurance as a savings scheme for healthcare has encouraged people to navigate across health insurance schemes in the form of insurance scheme shopping. Some denominational Christians who were also employees in multi-national organizations were also devoted and committed members of their ethnic group associations in the study area. As committed Christians, some members in church group's activities were assured following constant contribution and participation in church Christian groups including (prayer groups, choir groups, and Liturgy and action groups in church). Besides benefiting in all church groups, some of the participants benefited from private insurance

coverage as employees of a company, and could also benefit from their ethnic based health insurance scheme as members of a defined ethnic group.

**Diagram 2:** Health insurance scheme shopping among the Kom community in Biyem-assi


**Source:** Ndum Clauris, March 2024

The Diagram above is an illustration of health insurance scheme shopping. Amongst other ethnic group's activities in the Biyem-assi community, our scenario is an illustration of the Kom community experience of health insurance schemes shopping. Originally, the health insurance schemes are the Faith based, professional based, Standard based, Ethnic based, Family based, Social based and Self-health insurance schemes. Health insurance is normally a benefit policy that should respect the role of reciprocity. In this respect, the more people are conscious of the benefits of belonging to more than one health insurance scheme, the more the enrolment. Following our fig.

02 above, some people in the community had the opportunity to enroll and benefit from several health insurance schemes. Following a discussion with an informant Mrs Mukam Riser, who is a Christian of the Catholic faith based health insurance scheme, she is also the president of the Catholic Women's Association (CWA) in her church community. She thus benefits from her CWA health insurance scheme, and since she is a member of the St Michael Choir group and the blue army prayer group in church, when she falls sick she also receives healthcare assistances from the church group's membership. She is an active member of the NADECO Women's group and equally participates in KOMCUDA activities of the Kom Ethnic group, also receiving healthcare assistances as a devoted member. She is a staunch member of the Sisters keeper social group in that community and following bi-lows of the meeting, she is entitled to an assistance amount from meetings trouble fund and a freewill donation from the meeting members. Mrs Mukam works with Plan international Cameroon whose workers benefit from an employer's health plan at Zenithe insurance company. She hails from a very large family where she has introduced a health insurance scheme that can assist family members with their healthcare. Apart from a registration amount, each of the health insurance schemes activities requires reciprocal commitment from the members of the group to sustain the schemes objective of assisting one another during difficult moments, especially healthcare.

The unique scenario of Mrs Mukam's health insurance scheme shopping is a way to demonstrate how health insurance as a benefit policy can encourage people to belong to more than one group. Each group has as obligation for members to contribution and assists other members who are sick, with the hope of benefiting in future. Belonging to and contributing to many groups translates to the fact that she can benefit as much when the need arises. It is possible that she might never have to treat health out of pocket because of the many assistance packages that Mrs Mukam may have to receive if she falls sick. There were equally other informants whose commitments were never as much, but were sure to receive a certain level of assistance for healthcare from their social based health insurance scheme and/or ethnic based health insurance schemes that may be completed out-of-pocket. Research findings revealed that, most informants do well to belong and participate in community membership activities where they stand to benefit from a pool of many.

**4.2. Community based health insurance schemes activities**

Based on our research findings, the people of Biyem-assi identified a number of community based schemes where they belong and depend on certain activities to finance their healthcare. The interactions of each member of the community could easily push him or her to belong to a certain health insurance scheme, where roles and regulations are used to define the activities of the group to the advantage of the members. The different schemes identified on our figure 02 above included the faith based, ethnic based, social based, professional based, family based health insurance

scheme, whose activities could finance health insurance and assist members through difficult times.

**4.2.1. Faith based insurance scheme activities**

The Christian Women's Fellowship (CWF) remains a vibrant movement of the Presbyterian Church in Cameroon (PCC). It started 45 years ago and has grown to over 910 groups and over 50,000 members. In all congregations of the PCC, women outnumber the men. They represent 70% of PCC members with 30 women ordained pastors (PCC 2006). Unequivocally, the increased number of protestant clergy being female enables the PCC to better connect with huge population of female worshippers. On the contrary, with Catholic, Baptist and Muslim clerics, priests and pastors are mostly male. In a context of deepening poverty and economic hardship, these faith-based groups are a sanctuary, enabling a fusion of a gospel of spirituality, compassion and basic support. Within fellowship groups, visits to those unwell and old are carried out and a token contribution offered. This approach is commonplace amongst CWF, Christian Men's Fellowship (CMF) Catholic Women's Association (CWA), Catholic Men's Association (CMA), Baptist Women's Association of the Presbyterian, Catholic and Baptist Churches respectively. These faith-based groups build the members spiritually and give them hope. The major support mechanism is the bereavement. Apart from the spiritual benefits of the faith based groups, members also contribute when a fellow member is in trouble. For example, if a member dies, the other members contribute between 500FCFA to 1000FCFA to assist the family, partake in the wake keep, carry the coffin and then sing at the burial site. When a member losses any of the immediate family members like a wife, father, son, daughter, they statutorily contribute 3 000 CFA each. For the extended family, they condole with the member and contribute 500 CFA towards buying of drinks 'mimbo' (could be beer, palm wine or sweet drinks) to entertain members who show up'.

Members also extend a helping hand to do some periodic offerings and collections to look after the vulnerable populations. Contribution boxes (mostly wooden) are circulated and the box is split and its contents disclosed on a designated Sunday service. Based on the contributed funds, averagely 100,000 frs CFA is usually found in the box, which at time is inadequate to meet the needs of a sick person, but the important thing is that the beneficiaries can access health care services at least for consultation and initial drugs. Allocations are made in sealed envelopes and visits are paid to beneficiaries by designated church elders. A female elder, aged 75 years indicated she benefited once from the scheme when she was hospitalized. When she unveiled her envelope, she got 150 000 CFA. Frail older sick members of faith-based groups are usually supported with foodstuffs and firewood for cooking, which exemplifies the existentialist function of religion. Some faith base group members also contribute greatly to the education of Christians in church. The president of the CWA, and 'As an elder', she works for Justice and Peace Department in the Catholic Church. She has been involved in the education of old people and men by making them

understand that bride price is a hindrance to social development; it makes marriage arrangements for boys and girls very expensive, cumbersome and frightening times. This message is important because many young girls are forced into prostitution and eventually contract sexually transmitted diseases and HIV/AIDS because of prohibitive marriage demands. They also educate other old people on mutual living and sharing between those who are better-off and those who are lacking'.

Support for old people varies within the different religious inclinations. For the Baptist, contributions are often done on specific worship days, three times a year. An initiative of Deacons Board of the church, it extends a helping hand to disadvantaged groups. The church carves a box (plank safe) which is brought to church. The box is split quarterly and whatever freewill contributions is put together and based on the amount raised, old and other needy people are assisted. In Presbyterian Church, church groups like CWF, CMF and Hallelujah Choir are predominantly comprised of older women and men. In order to cater for its members, self–help schemes provide ground-up ways of pooling cash as a form of insurance. An informant made mention of Presbyterian Self Help Fund (PESH). Every worker with Presbyterian Church can save and obtain loans from the fund. There is also Social Assistance Fund (SAF) mainly for retired pastors. Pastors are expected to save compulsorily approximately 1000 FCFA and when they retire, savings can help them make transition into retirement.

During an interview with the Imam and other Muslim clerics, we were made to understand that, there are no equivalent schemes in Islam as Muslim clerics survive on largesse of community and endowments pooled from Zakat and Sadaqa. Existentialist doctrine resonates with widows who find solace within religious organizations and choir groups. A constraining cultural context that imposes a double burden on most widows, taking care of children and other dependents with diminished resources is a difficult task. Various religious groups provide a safe haven for widows and widowers. A widow narrates her spirituality and belonging in a church group as: 'a life-blood relationship'. Without the church, I would have long accompanied my husband to his resting place (grave). When my husband died, I had nowhere to turn to but the church. When I attend prayer sessions early every morning, church service on Sundays and the weekly meetings on Wednesday, my life is restored and my burden is lightened. The songs speak to me; the gospel pierces my heart; it gets to my soul and it's like I hear the voice of God telling me that he is keeping watch over her flock. Within the group, we also visit other members in poor health condition. We sing together, pray together, study the bible together and show love and compassion for one another'.

Statements lend credence to religious and existentialist ethos of keeping faith, displaying love to your neighbor as you would do to yourself and being your brothers'/sisters' keeper. This philosophy of helping 'the poor and needy' squares with centrality of religion, not only perceived as communion but relevant in pushing across solidarity and acting for common and general good

(Welker 2003). Church ‘njangi’ groups are being fashioned to take care of economic dimension of support. CWF, wealth creation and compassion wealth creation and religious networking is mediated through church ‘Njangi’, prevalent networks of generating additional capital within religious organizations, vital in securing livelihoods. The elderly who are penniless and cash-strapped rely on ‘Njangis’ and other solidarity schemes fashioned and factored within faith organizations. For instance, the activities of the CWF highlighted in this section range from weekly meetings for Bible study, prayer sessions, and religious rallies. Their Bible study materials include not only biblical material but information that can empower women to build better lives for them and their families. Lessons include skill-building for income generation, family life issues, HIV/AIDS information, and manufacture of basic goods like detergents, needlework and craft.

In redressing social security equation, group lessons tackle concerns around importance of having a marriage certificate. Most people enter into traditional marriages that do not involve a legal certificate. Thus, if the husband dies, the widow is stripped of her inheritance. In the case of polygamy, if one wife (usually the first) has a certificate, she stands to inherit almost everything and others are left to ‘scramble on leftovers’. Many widows and their children end up destitute, powerless and disempowered. Women are empowered to seek for redress and to challenge obnoxious customary laws that transgress on succession and inheritance, through help of female jurists and administrators within the movement.

In its evangelization drive, CWF meets weekly, every Wednesday to reinforce its spiritual dimension and to push forward the mutual support and solidarity agenda. The group has a membership of 700 members with about 35% of the members made up of older women and widows. In this connection, mutual support entails home visits and prayer sessions for members who are ill. A ‘njangi’ component involves annual contribution of 1,000 CFA (90 pence) into ‘trouble fund’ annually, seen as a buffer against unforeseen contingencies, ‘born house’, husband’s day celebration, weddings and support with bereavement. When a member dies, group gets in touch with the next of kin to sort out funeral arrangements. CWF district in locality assist with burial dress and cash contribution of 50,000 FCFA, drawn from trouble fund. At the level of the neighborhood where the member was resident, every CWF member resident in that neighborhood contributes 100 CFA, money which is directed towards food and entertainment during funeral.

Sick and hospitalization visits are commonplace because if a member is unwell and is receiving treatment at home, a delegation is constituted to visit the person sick, offer prayers and spiritual support. Names of all persons who are ill are inserted into Sunday services prayer slots for intercession. In case of hospitalization, a delegation is constituted and assigned to visit the sick member with a thin of milk worth 3,000 FCFA from the annual sinking fund. For assistance with births (born house), members who have delivered a baby are grouped following a period of two

years. Every CWF member contributes 200 FCFA and sum total is used for the purchase of buckets and washing soap. The President I interviewed indicated that during 2010- 2011, babies delivered came up to approximately eighty. New born babies, usually accompanied by their parents and God parents share whatever assorted traditional dishes, drinks and other gifts are prepared. Husband's death celebration is organized in almost same manner as 'born house'. Female members buy a shirt and other garments. Items are parceled and members hand over wrapped parcels to spouses of CWF members invited to church on designated days.

Group support in connection to weddings cements the solidarity directed to members. When a members' son/daughter is getting married, the group withdraws 5,000 CFA from its sinking fund. Money raised is used for purchase of a present that is handed to couples on their wedding day on behalf of the group by delegated members. However, individual members who receive invitations for weddings are free to buy gifts for the couple. During presentation of gifts, delegated members lead the group and other individual members follow suit to present their individual gifts. Such gestures are compatible with Welker's (2003) analysis of Christian solidarity, sharing and concern for the other. Organizing educative talks and short training programs is a frequent activity of CWF. Members are drilled in micro projects such as animal raising and livestock production, gardening, marketing skills, house craft, tie and dye of dresses, making of detergents for home and commercial purposes, tailoring through the Women's center, basketry and weaving, knitting and stitching. Educational talks are held on topics such as building peace and harmony within families, responsible parenthood and household budgeting. Health talks are also organized on various aspects including good meal preparation, proper hygiene and sanitation, control of water-borne diseases, fight against HIV/AIDS and its de-stigmatization. Following along the lines of central tenets of Christianity, Islam relies on internal mechanisms of alms giving and wealth redistribution as prescribed by the Koran. Islamic doctrine of wealth sharing (Zakat/Sadaqa) Social security within the Muslim faith follows a symmetrical structure with the Imam and chiefs of the Hausa and Mbororo communities determining the support and assistance to be given to the needy. It is interesting to note that social security within Muslim religion is centralized and hierarchically fashioned.

The Imam of the central mosque in separate stated: Imam's discretion in consultation with senior clerics guides nature, form and rationing of assistance received. This is based on fundamental principle of zakat- act of giving to cleanse your wealth: 'Whoever denies giving to zakat is deemed as a non-believer and must repent, for giving to charity is like cleansing your sins just as water extinguishes fire'. Funds are solicited from well-off Muslims to help older people and other needy groups – women and orphans. After every Friday prayer, alms collected are later distributed to disadvantaged people. The Imam sees Islamic tenet of sharing food and system of

open feeding undertaken in Muslim neighborhoods as a social safeguard for older people. Some elderly Muslims survive on this form of solidarity and benevolence. Muslim feasts such as Ramadan and 'barka de sallah' gives room for affluent to redistribute their wealth through huge donations to puff up zakat funds. As disclosed by Imam, social security is feasible through contributions received for zakat and sadaqa which is one of the five golden pillars of Islam. Sadaqa represents commitment of funds to meet needs of the poor while zakat raises the status of a Muslim as 'charitable ventures do not decrease one's wealth'. Sadaqa addresses directly the needs of the poor including older people while payment of zakat is a direct offering to Allah; believed to raise the status of a Muslim. Rather, zakat is considered to bring about growth and expansion of wealth. Zakat is offered annually as prescribed by Koran- a good Muslim must give sacrifices once a year.

The offering constitutes donation of a fraction of wealth as a sacrifice. Substantiating the mechanism, the Imam explained: 'if someone has 40 cows, he might sacrifice one cow every year as zakat'. Alternatively, for a business person, for each 1000 that makes up ten million, he receives 25 CFA, so 25 CFA pulled out of 10 million represents the percentage that is given as sacrifice (endowment). These contributions enable Imam to function and to provide for poor and needy. According to Imam, Islam requires Muslims to give 2.5 percent of their wealth and assets to the poor every year. Much more is given in voluntary `sadaqa'. But that money is usually donated in small amounts at local levels to feed the poor, help orphans, or build mosques. Muslims say many of them give, almost without thinking, to fulfil a religious 8 obligation. Drawing from the Koran, Imam disclosed: 'if you wash your clothes, you throw the dirt away. A true Muslim believer washes his wealth and possessions as a blessing. Zakat is a means of sending your wealth before death. Beware of the fury of the poor and your neighbor. You have to prepare your way to paradise'. The Imam I interviewed re-iterated there is 'no formula' in sharing what comes in as Zakat funds. He summons other clerics and those eligible to receive what has been offered. This takes the form of prayers and thereafter, the beneficiaries are presented with their own quota of the sacrifice. Joining up and sharing with others remains the fundamental precept of the Koran. The Imam stated that his compound is a place of sharing for all Muslims but was worried that present economic hardships have drastically reduced number of potential contributors to zakat funds.

**4.2.2 Ethnic based insurance scheme activities**

Findings from this research revealed that, most community members do well to identify themselves with their Ethnic group's activities at the locality. As earlier mentioned, the Njinikom Development Cooperation (NADECO) women hosts the largest ethnic group represented by the Njinikom women in Yaounde. The executive body has been assigned to bring together all women and wives of the Njinikom area. However, every member who indicates interest of membership is placed under an observation period of three months before the president approves a registration

with the sum of 1 000fcfa for new member and a renewable 500fcfa for old members. Upon registration, members become eligible to contribute and benefit from the groups financing activities as the case may be. At the beginning of every calendar year, members are expected to contribute or replenish all the sinking funds of the group. After an initial registration, all members are expected to pay in 3 000fcfa membership yearly insurance fees, a development fee of 3 000fcfa and a socials / trouble fund amount of 2 000fcfa each.

The insurance fund is used to assist members' health crisis during the year. Once a member has completed registration and paid all sinking funds, she is eligible to benefit from the insurance fund if he or she falls sick and is hospitalized. The victim usually sends words to the meeting president reporting her ill health and hospitalization and at once, the president commissions the financial secretary to make available funds (usually 30 000fcfa in an envelope) to assist the member at the hospital. Reports may reach the meeting house later on the meeting day, and then some members would be delegated to visit the sick member at the hospital to show solidarity. All members benefit from sick assistance once in a year, so if a member is reportedly sick more than once, the second assistance shall be a free will donation on the day of the meeting, at the end of which the amount raised is sent to the victim through a delegation from the meeting.

The development fund contributions are forwarded to the home village following a development initiative at hand. However, where there is no developmental project at hand, the executive committee organizes an outing for members at the end of the year to win and dine together. Sometimes when there are plans to change the meetings uniform, member who have already contributed the 3 000fcfa are only required to make us with an additional sum to complete for the payment of the new uniform. The trouble fund amount contributed is used to assist fellow members during the death of their first line relationships (husbands, wives, children, mothers and fathers). Once a death announcement is made at the meeting, and if the member's situation is up to date, an envelope of 100 000FCFA is immediately put together to be taken to the victim by some delegated members. Members however have to replenish the trouble fund by a significant contribution of 1 000FCFA each. The trouble fund amounts do not cover death members, because, all members are expected to contribute 10 000FCFA each following the death of the meeting member. When the contributions are completed, 300 000FCFA is given to the family of the deceased, and a dress for the deceased member is bought by the meeting still from the contributions. All members are expected to accompany the corps to the home town for the burial procedures. Before the burial procedures, meeting members are expected to observe a wake the previous day, where the meeting makes arrangement for food and drinks still from the contributions made.

Other activities including the wedding of a member and the birth of a child are handled differently. Until the member concerned sends an invitation, fellow members may never react as a group. So if a meeting member sends an invitation inviting members to 'born house' of her child, all meeting members are expected to contribute 1 000fcfa each to buy a gift for the child, and 2 cubes of CCC Savon which shall be handed to the beneficiary. At the 'born house' proper, members are entitled to food and drink. They are also in charge of singing and dancing to animate and entertain other invited members to the occasion. It goes the same when a meeting member is getting married. Once she sends an invitation to the meeting, all other members are expected to contribute 2 000FCFA, which will be used to buy a wedding gift for the beneficiary. Of Course, members present during the wedding ceremony will be entitled to food and drink. Members may have to present their gift to the couple while singing or dancing to the tune of the music that is available.

Apart from the above mentioned usual group activities, other activities carried out by the NADECO women include a well-functioning system of a saving and loans scheme, which allows members to save, withdraw and borrow money when the need arises. Loans, monetary gifts, personal resources, micro-insurance, arrangement with hospital institutions, meeting groups, church groups, knows your neighbor etc.

**4.2.2.1. Loan**

A loan is anything that is borrowed, especially a sum of money that is expected to be paid back with interest. According to Alan, (1987) a loan is a form of debt incurred by an individual, either from another individual, group or corporation. The lender usually advances a sum of money to the borrower, in return, the borrower agrees to a certain set of terms, including interests, repayment dates, and other conditions. The term medical loan is a form of personal loan that can be avail of in the event of a medical emergency. The amount obtained can be used to cover several costs such as hospital bills, surgery costs, prescription bills, chemotherapy costs and any other medical related expenses. A medical emergency can put people in great dilemma. Following a steep rise in the cost of quality healthcare and coupled with the restrictions on medical insurance coverage, which can put a strain on family finances, many participants reported a case of getting a medical loan. Village savings and loans association, which constitutes between twelve and thirty people usually contribute money in an annual cycle in order to provide loans to members. Disintegrated through development initiatives since the year 2000's, they have become an accepted part of the financial landscape across the global south (Pegie, 2013). In our discussion with some participants at the field, many members of the NADECO women's group have actually benefited from loans in the group to get themselves or members of their family treated. For instance, Mary, 34 years old, a mother of four children, said:

> *I borrowed money from my family member because my child was sick, so I used the money to cover the hospital expenses. Last year when my first son was sick and had to undergo a surgical operation, I had to borrow money from our village meeting because the amount required was much, which required repayment with interest. It took me quite a while to repay because of lack of finances, and the interest too was growing* (Eileen, Farmer, Round point Express, May 2023).

The only worry that members have borrowing money from the group for healthcare is the interest that accrues on the loan. Others however requested for interest free loans from friends and neighbors for the same purpose. When asked whether he borrows money from friends to cover healthcare expenses, Martin, a 34-year-old father of two, responded: "*Yes, I borrow money from a friend and repaid him later. I used 100,000 FCFA I borrowed from a friend to take care of my child who was sick"* (Martin Tam-Tam Weekend May 2013). Along similar lines, Suzan, a 43-year-old farmer and mother of two said: " *I turn to my neighbor when I have financial difficulties. When my wife was sick, I explained the situation to him and he gave me a loan to deal with the situation and I repaid it later"* (Suzan, acacia Market, may 2023).

Participants who decide to borrow money out of their ethnic group meeting take into consideration the economic situations of lender before requesting a loan from them. For example, when asked whether he gets a loan from a relative or friends, Johnson, 40 years old and father of two, said: "*It depends: a family member may be struggling to make ends meet at the time of the loan. In such a scenario, I prefer to borrow money from a friend than a family member"* (Johnson Biyem-assi round about, May 2013).

When asked whether loans from friends, relatives and neighbors had to be repaid with interest, all participants insisted that loans from these sources were interest-free. For instance, Quinta a 39-year-old woman and mother of 04 who sells fresh fish at the Acacia market, said: "*I do not repay the loan with interest when I get it from friends; I repay a loan with interest when I get it from the meetings saving and loan scheme* (Quinta Acacia May 2023).

As indicated by Jane, participants also used loans from informal financial institutions to finance healthcare. By informal financial institutions (IFIs), we refer to rotating savings and credit associations (ROSCAs) and accumulating savings and credit associations (ASCAs) (Jutting, 2004). As IFIs are pervasive in the community, it is easier to obtain a loan from these institutions, but these loans have to be repaid with interest, as noted by Eteba, a 38-year-old father of four who sells clothes at a local market: *According to his point of view*

> *When someone in my household is sick and I do not have money, I get a loan from the njangi [IFI] and use the loan to pay for the medical bills. The loan has to be paid back with interest, but the interest is very low, that is, 10 FCFA [0.02] per 1000 FCFA. The last time I borrowed 200 000FCFA from*

> *the njangi, I repaid 204 000FCFA after one month* (Kennet, builder, Acacia Market May 2023).

Participants reported the tendency of using business loans provided by their ethnic group reunion or a microfinance institution (MFIs) to pay healthcare bills. In several cases, the business loan was used because it was provided during the period that the loan recipient or someone in their household was sick. For instance, Matilda, a 48-year-old mother of six who sells basic foodstuff (such as rice, beans, plantains etc.) at the Biyem-assi round about, said: "*I fell sick during the period that I received my first loan from the meeting, amounting to the sum of 100,000 FCFA and I was admitted at the hospital. So I added the loan to the money I had to pay my hospital bill"* (Matilda, Acacia Market, May 2023).

The use of business loans to pay medical bills was not restricted to men. Women equally used this mechanism to settle hospital bills of their household members, thus indicating the pivotal role they play in the household. For instance, when asked what she did with her business loan, Julianne, a 46-year-old woman who sells corn beer, responded:

> *I used 50,000 FCFA to pay the hospital bill of my child who was in the hospital, which was part of a loan I asked to top up my business during end of years meeting activities. When he was finally discharged, I also gave him some money to take to school. That is how the money which I borrowed for my business finished and worse of all I have to pay with interest* (Julianne, Business, Acacia Market, May 2023).

#### 4.2.2.2. Savings

Savings is the money one has set aside especially in a bank or an official scheme. Savings represent individual's unspent earnings. According to Nikiforos (2015), savings is an amount of money that remains after meeting the household and other personal expenses over a given period of time. It can be keeping aside money on monthly bases, which goes the same for informants who participate in their ethnic groups meetings. Meeting days are sleeted once every month, and since savings is usually a part and parcel of the meetings activities, members are encouraged to safe frequently because a savings can help in meeting financial commitments at future dates, and can enable an individual to stand against unforeseen emergencies which can arise at any time and due to any reason. Savings can also be used to increase income by investing through different investment avenues. As health shocks are unpredictable, some informants indicated that they sometimes used their savings as a self-insurance device. For instance, Elodie, a 55-year-old mother of three who runs a firewood business, said: "*The general principle of saving money is to use during difficult moments. So, money for healthcare comes from savings not our capital, because the business will fall if we use our capital"* (Elodie, TKC May 2023).

Some participants who did not save money at their meeting houses for one reason or the other saved with MFIs and IFIs or simply at home. In times of sickness or health shocks, they used their savings to cover the healthcare costs, as expressed by Jean-Pierre, a 48-year-old father of two:

> *I save money at the IFI so that when a person of my household falls sick, I withdraw some money and add to the money I get from the sale of sand, then I go to the microfinance institution and withdraw the money I saved there, since I saved the money to deal with illness* (Jean-Pierre, Accountant, Round Point Express, May 2023).

The above quote shows that people tend to use multiple saving mechanisms simultaneously. The interviews indicate that simultaneous use of multiple savings was motivated by two major factors. First, it enabled people to manage risk. Participants noted that MFIs in the country have a record of closing down, causing their clients to lose their savings. Thus, in terms of savings, people avoid relying exclusively on meeting houses or MFIs. Second, the use of multiple saving mechanisms was one way of managing social relationships. Participants indicated that having one's savings in multiple institutions made it difficult for people to be aware of their financial standing; hence, one may not receive multiple requests for financial assistance from people in one's community.

#### 4.2.2.3. Monetary Gifts

A monetary gift is a transfer of money or a financial instrument that has liquid value from one person to another, without receiving or expecting to receive anything in return. Giving gifts is a way of showing care and concern towards the receiver's present and future situation. Participants acknowledge having received monetary gifts from their group members through a freewill donation, children, friends, family, aquatints, to finance healthcare.

##### 4.2.2.3.1. Monetary gift from ethnic group members

Many informants acknowledged that they have received monetary gifts from their fellow group members. One of the principles that bind the NADECO women together is the art of giving. Members are encouraged to assist each order during difficult moments. There is usually an announcement item observed in the agenda of the meeting. Members are allowed to make announcement concerning good or bad experiences in their lives. Group's activities however cover some of the experiences that might come up during the announcements page. Once the victim received the envelope of assistance from the meeting house, other members usually still extend a hand to support the individual, based on the type of celebration or tragedy announced. For example, all sickness assistance envelopes from the NADECO women's group to beneficiaries is 30 000fcfa no matter the type of sickness announced. In most occasions, this giving is in respect of reciprocity between members. Reciprocity is a process of exchanging things with other people to gain a mutual benefit. The norm of reciprocity (sometimes referred to as the rule of reciprocity) is a social norm

where, if someone does something for another person, he/she then feels obliged to return the favor. Reciprocity is a crucial aspect of how people interact and live in society but researchers who study these interactions have often overlooked its importance (Molm, 2010).

Reciprocity, as a fundamental principle in social psychology, revolves around the concept that individuals tend to respond to the actions of others in a manner that mirrors the positive or negative nature of those actions. It involves a mutual exchange of behaviors and reactions, where individuals reciprocate the same type of behavior they have received from others (Molm, 2007). People's choices in how they behave are mostly based on what they can gain from others in return, while feelings of trust, liking, and togetherness are strongly influenced by the idea of giving and receiving equally. Following a discussion with mama Theresia, a 55years old woman said that she has benefited a lot from meeting when she was sick and hospitalized. Following an announcement of her ill health, the financial secretary disbursed 30 000fcfa for her support, but she was surprised that at the end of the day, she received financial gifts from other meeting members, which amounted to another 66 000FCFA, a gesture that offered her great help throughout her stay at the hospital.

**4.2.2.3.2. Monetary gift from family**

Some meeting members after receiving their usual support from the NADECO, including monetary gifts from meeting members, still received additional monetary gifts from their family members. Participants stressed the value of monetary gifts from relatives in times of sickness and in terms of it general reciprocity, which involves exchanges within the families in which case there is no expectation of a returned favor. Instead, people simply do something for another person based on the assumption that the other person would do the same thing for them when the prime comes. Remond, a 40-year-old father of two, said: " *I spent 150,000 FCFA for the medical bill of my child, who died of meningitis. My relatives gathered money and bought medicine. They provided financial assistance because they wanted her to be well"* (Raymond, Round point Express, May 2023).

The above statement shows that people view health emergencies as a collective affair, which require family members to pool their resources together to help their kin in need. Participants insisted on the importance of sharing the healthcare costs among family members. For instance, Javice, a 34-year-old farmer with two children, said:

> *When a family member falls sick, we handle it collectively since we are our brother's keeper. So, we put our hands together. A relative was seriously sick and was at the Biyem –assi Health District Hospital, so we all provided financial support and, thank God, he is well. Every person contributed the amount of money they could afford* (Javice, Fruits seller, Tam-Tam weekend, May 2023).

Participants also reiterated health care costs shared to the family is responded positively only when the person concerned has also been of assistance to others as well. For example Paul, 43

years old father of three mentioned: "*When my friend's brother made an accident last year, he was almost abandoned at the hospital because relations did not provide any financial assistance for his health care. I was worried and asked why and my friend said that his brother always refuses to assist others in need"* (Paul, Tam-Tam weekend, May 2023).

From the above quotes we realize that health care assistance provided at all levels is reciprocal and any family member who is not ready to assist cannot receive assistance. Meanwhile, most families have decided form a formal family reunion with a written text of activities, where all family members have to obligatorily belong to the reunion and pay yearly dues, from where, all forms of assistance from the family union will come from as explained by Peter, 38 years old butcher and father of three:

> *Last year my wife was very sick when she miscarry our second baby. We paid medication bills up to 200 000fcfs monitory gift we received from the family reunion. At the beginning of the year, each family member has to reregister with 1 000fcfa and then pay yearly dues of an amount that reflects his or her socioeconomic status; for all family members who have employment and receive a monthly salary, they pay (15 000fcfa), for all successful business members(10 000), for all members not working, (5 000fcfa). We call this insurance which is used to assist family members within that year for issues relating to joyful events, sad events and sickness* (Peter, civil servant, Tam-Tam weekend, May 2023).

By implication, the above quotation shows that, the family reunion can only send a monitory gift to a registered family member who has completed his yearly family dues. For example, Romeo who is a taxi driver and father of 03 revealed.

> *My family did not register in our family reunion last year, so we did not expect any monitory gifts of any sought from the reunion. So we did not know it was going to be a difficult year and it was actually one because almost every member of my household fell sick and spent much money for treatment. A situation that we should have had at least 200 000fcfa for each person's health care. However, we have registered this year, and hopefully if there is any health issue, we shall receive our package.* (Romeo, white house May 2023).

Reciprocity therefore is important to the family financial gift exercise between members…a give and take, otherwise; only individual family members can consider a free will donation based on sympathy to the situation at hand and or personal affection.

**4.2.2.3.3. Monetary gift from children**

Some participants also received monetary gifts from their children. For example, when asked where he gets money to pay his medical bills, Mzami, a 42-year-old father of 04, said:

> *Money comes from the farm and my children. My children are grown-ups and are working, so they send me money when I need to go to the hospital. I am preparing to undergo a surgery and while making preparations with the doctor, I updated my children on all financial obligations so that they should send me money* (Mzami, Superrette, May 2023).

Accounts of the interviews indicate that participants are of the view that their children have an obligation to take care of them, including paying their healthcare expenses, as expressed by Zelot, a 70-year-old father of 09: "*I am of aged now. My children are now adults; I sent them to school. Well, that is to say that sometimes I depend on my children. They also helped me by buying my medication"* (Zelot, Superrette, May 2023).

The above quote suggests that children have a "debt" to repay their parents. One way of repaying that debt is by paying the healthcare bills of their parents. Perhaps this explains why all participants declared that they received monetary gifts from their children, and not loans. Some participants express the joy of the responsibility of taking care of their parents needs especially health care. Remond who works at the Ministry of Finance, father of 04 said: "*My parents are my first responsibility; I pay them a monthly allowance for their personal needs and send them to do checkups every 03 month. I am thankful to God for blessing them with good health all these years"* (Remond, White House, May 2023).

Following the above quote, it might be easy to conclude that children with good financial backing are delighted to provide for their parents financial needs and health care as required. It is different for those children who are still struggling in life, as they find it a burden, especially if the parents are such that fall sick often. For Kenneth 33, years old Yams seller with 2 children said: "*Life in Yaounde is very difficult. With the small money I get from selling yam, I have to take care of my family and my sick parents. I try my best, but sometimes it is really difficult to meet up. One thing is sure, that is each time when they are sick, I must struggle to provide medication"* (Kenneth, Yam seller, Acacia Market, May 2023).

**4.2.2.3.4. Monetary gifts from friends**

Some participants also counted on monetary gifts provided by friends to pay their medical bills. For instance, talking to Justina, a 44-year-old farmer and mother of 03, she recounted that, when her child was sick, she received a lot of financial assistance from friends and neighbors. They helped me because it was a sad situation and God so kind, her son regained his healing. People associated financial assistance received from diverse sources with their ability to build social relationships with those in their communities. Participants emphasized the importance of establishing strong social relationships with members of their communities, as these relationships facilitated the flow of financial assistance in times of need. For example, when asked where she got the money to pay her medical bill, Eileen, a 46-year-old mother of five, said:

> *As you know, people cannot lack anything when they have a good social relationship with other people. When my husband made an accident, I received financial support from many people: I received money from friends at least 200 000fcfa; and relatives, I received almost 290 000fcfa. This was much money that was used to add up to buy medication for my husband's*

> *illness that lasted almost 3 months at the hospital. Even though he is well now, we still receive some financial gift from friends who did not have the information at the time* (Eileen, Tam-Tam weekend, May 2023).

Interpersonal relationship is therefore a very good mechanism to receive financial gifts for healthcare needs, which to the best of my knowledge also has to be reciprocal. It should be a give and take process because even the 'rich' people who give 'much' to people who are in need also like to receive even 'small' when they have crises too.

#### 4.2.2.4. Personal Resources

Although participants had access to financial assistance from diverse sources, they used their personal resources to cover their healthcare expenses when possible. For instance, Teresina, a 30-year-old mother of two who sells foodstuff at the local market, said: "*When a person of my household falls sick, I use the little money I get from the business to pay for the medical expenses. Sometimes when the illness persists, I use up the little savings I have just to make sure that the person is well again"*(Teresina, Biyem-assi Round point, May 2023).

When money from income-generating activities was insufficient to cover healthcare costs, some participants sold their assets to meet the shortfall, as expressed by Ryan, a 34-year-old man who has two children and makes a living by selling firewood:

> *I get the money for hospital from the sale of firewood which is my regular source of income. I also sell goats to get money for the hospital if the sickness becomes complicated. Last year when my son had an accident in school, they school assisted me with 50 000fcfa, calling it insurance which was very minute. I had to sell off a small plot of land around my house to make up for the hospital bills* (Ryan, Biyem-assi round about, May 2023).

#### 4.2.2.5. Arrangements with Healthcare Institutions

Participants reported that they received healthcare on credit when they had no money. Then, an arrangement was made with the relevant staff of the healthcare institution that provided the service for the bill to be paid later, when the funds were available. This was expressed by Dorothy, a 36-year-old mother of two: "*I normally go to the health centre…Sometimes the health center treats me on credit, and I pay the bill later because they trust me. This happens when I do not have money"* (Dorothy, Round Point Express, May 2023)

Patrick, a 32-year-old father of three, mentioned an almost same situation like Dorothy by saying that: "*When a person of my household is sick, we take the sick person to the health center. When there is money, we use it. When there is no money, we negotiate with the chief of the health center for treatment and when it is done, we pay the bill later"* (Patrick, white house, May 2023).

The foregoing quotes underscore the vital role of trust in the relationship between people who require healthcare services and healthcare institutions. Participants who could not pay the total healthcare bills when discharged worked out a payment plan with the healthcare institution. For

instance, Lucy, a 41-year-old mother of four, noted: "*One of my children had appendix problem and required a lot of money. We had to pay over 160,000 FCFA in order to have it removed which we didn't have the bill was paid by installments. This bill will soon be paid completely"* (Lucy, white house, May 2023).

Again, this account underscores the role of trust in the relationship between healthcare institutions and their clients. The payment plan between Lucy and the healthcare institution may not have happened in the absence of trust, as contract enforcement institutions, in the country, are weak.

**4.2.3. Professional based health insurance scheme activities**

A Professional based group is made up of members of a particular work or business class, who may decide to come together to carry out activities that are beneficial to member's welfare and improve access to healthcare facilities. Professional based groups could either be represented by formal sector or informal sector work activities. A formal sector group is a designated work group, one that is defined by an organization based on its hierarchical structure, with designated tasks related to its functions in the workplace. It can be a finance group or the human resources group. A formal group is formed when people come together to accomplish specific goals and objectives and has particular structures and roles with defined responsibilities of the members. Activities carried by this formal group have specific guidelines, which members of the group are supposed to adhere to and follow to ensure good coordination. The practice of members of a formal group is governed by specific rules and regulations, which are usually formulated at the inception of the group. All members of the group are supposed to adhere to the rules and guidelines that define the group. Moreover, formal groups have a defined leadership structure where there is an official leader who ensures that the group works to realize its goals while enforcing its rules among members. Formal group associations are most often made up of employees of companies and organizations, and usually benefit from an employment group health insurance. Employment group health insurance includes health insurance schemes covering employees of a company that may extend to cover their family members. Insurers often offer group insurance as a separate category of insurance with a different pooling and pricing structure, often offering different benefit packages as well.

**4.2.3.1. APEZ health insurance scheme activities**

APEZ (Association du personnel des Employeurs de Zenithe) is a professional based insurance scheme for formal workers. The association is open to all workers of the Zenithe Insurance Company. To be Eligible to group's membership, one need to be employed to work with Zenithe insurance company. Immediately anyone becomes and employee with the company, he or she shows interest by filling a questionnaire with the matriculation details that is later on handed to APEZ board. Such information is dropped at the human resource manager office, where a sum of 3

000fcfa is deducted from the monthly salary of all members as an insurance payment in the group. Followed by an incorporation of new members name and his/her family members to the company's group health insurance policy where members are insured in a coinsurance apparition of 80/20. The insured and members of his family thus benefit 80% of their health insurance bills, because he pays only 20% of all consultation and general visits to the hospital, including lab tests, hospitalizations and drugs once the visit or consultation is taken at the company's partner facility. The insured, however, has to fulfil certain obligations before benefiting from such coinsurance payments. The health department of the company must deliver a 'bon de prise encharge' (see annex 1) to the beneficiary following a health declaration form signed by the medical doctor during consultation, in which case, the insured patient must return to the health service of Zenithe insurance to show prove of consultation and information relating to either a laboratory requests or a drug's prescription, requiring the patient to go to the pharmacy. In the absence of the signed declaration form, the patient may not be able have receive the approval to access either the laboratory or pharmacy on the policy's apparition rates of 80/20. In the absence of a 'bon de prise encharge' the insured can only pay 100% bills out of pocket and ask for reimbursement from the company. It goes the same way if the patient prefers to visit and consult a doctor or health facility outside the partnership hospitals of the company. Before any reimbursement is effected, the patient must provide a signed declaration form and corresponding receipts. Each member benefits an assistance of 100 000fcfa towards the demise of a first blood relation (Husband, wife, child, mother and father), then marriage of members, birth of new baby in the member's family etc. Employees who are not registered members of this association do not benefit from these but may welcome assistance from individual's colleagues at the office.

Some formal sector workers who may not be opportune to benefit from an employee's health insurance plan are required to subscribe for a private health insurance policy, which are referred to insurance schemes that are financed through private health premiums and are often (but not always) voluntary. Although the government sometimes regulates this type of insurance, the pool of financing is not usually channeled through the general government. It is important to note that there might be out-of-pocket payments such as co-payments, deductibles and co-insurance in both public health insurance and private health insurance schemes. For example, public health insurance members might be required to make co-payments. In Korea, co-payments in public health insurance represent a share of up to 50% for outpatient services and 20% for in-patient care.

The professional based health scheme could also be represented by groups who carry out informal sector activities known as informal associations. An informal group is formed when two or more people come together to accomplish a specific task which is mainly socially geared. The main idea behind the establishment of the informal group is the satisfaction of both personal and

psychological needs. Informal groups are not subjected to any rules and regulations as in a company, and the members of this group willingly belong to this group. However, there are some explicit guidelines that govern the operations of an informal group, usually included in the group's constitution. The behavior of an informal group is governed by the expression of members, norms, beliefs, and the values that members hold dearly.

#### 4.2.3.2. The "bayam sellam" women's association

This group of women of the Acacia market is a typical example of an informal sector professional based group we encountered at the study area. This association is identified with bi laws and activities that keep members together. Each member pays a yearly registration of 1 000FCA accompanied by 5 000fcfa as sinking fund which is used for insurance activities like: healthcare assistance, death of member's first blood relations, birth of members etc. For any member to benefit from the contribution when in crisis, he or she must be up to date with the contributions of the group. Talking to a member of the group regarding the health insurance scheme, he pointed out that all members are expected to have paid their registration fees of 1000FCFA and the sinking fund of 5 000FCFA before the month of March every year. Member's health insurance assistance is taken from the 5 000fcfa contribution and a beneficiary must have been admitted at the hospital before she can benefit from an assistance of 30 000fcfa. Once the announcement of a sick member is made at the meeting, the financial secretary immediately disburses money and three members are sent to represent the group to visit the member in the hospital.

### 4.2.4. Standard based health insurance scheme

By definition, health insurance is part of personal insurance. The purpose of health insurance is to protect the insured against the risks associated with illness, or more precisely, against all events leading to medical intervention. The standard based health insurance scheme is the formalized public and private insurance activities that mostly work with formal sector employers to insure civil servants and workers of private institutions respectively.

#### 4.2.4.1 Public health insurance schemes activities

The Public health insurance scheme is a part of the standard based insurance scheme that is financed by the government's payroll contributions to the social security schemes. Social security schemes are statutory programmes financed mainly through social security contributions as a share of earnings and are mandatory for defined categories of workers and their employers to protect insured persons and their dependents against, among others, loss arising from sickness/illness due to the work they do. The government is the ultimate guarantor of benefits, and usually directly participates in the financing of the scheme.

**.2.4.1.1. The Cameroon National Social Insurance Fund (NSIF) activities**

The Cameroon's social health protection system is based on two systems, the government's civil servants scheme and the National Social Insurance Fund (NSIF), more popularly known by its French acronym of CNPS (Caisse Nationale de Prévoyance Sociale). Government civil servants scheme refers to civil servants being able to access public medical assistance with limited finances as it is financed by the state budget. NSIF is directed at workers under the Labour Code and is mandatory for civil servants but not for other laborers. Many laborers, however, do not recognize health as a priority hence; do not participate in social insurance plans. Workers found outside of the formal sector, where a majority of the workforce is concentrated (estimated at 7.3 million people), remain uncovered as NSIF is optional for them (Thordason, 2020). The 10% of the population covered by CNPS benefits from standards set by the International Labor Organization (ILO, 1952).

The ILO's ultimate objective in the field of social health protection is to achieve universal social health protection coverage defined as effective access to affordable health care of adequate quality and financial protection in case of sickness (ILO, 1952). The NSIF program in Cameroon provides benefits to individuals who have contributed into the program or those whose employers have paid on their behalf. Following the activities of the NSIF, employers do have rights as well as obligations to fulfill towards their employees welfare. An employer is stated to be any individual or public corporation that employs under his authority and direction of one or many persons on a permanent, casual or seasonal basis in return for remuneration. The NSIF distinguishes two categories of employers namely, skilled labor and employers of domestic manpower. Employers are under obligation to register their employees with the NSIF and to offer them necessary protection for safety and health. Any employer who neglects to register an employee under the NSIF is liable to a fine of 50 000FCFA to 500 000FCFA or six months imprisonment.

Following an employment procedure, the employer has the obligation to register this newly employed with the NSIF to pay for the social insurance contributions of the employee, which is declarative. This is done at the nearest office of the NSIF where a registration number is issued, and has to be confirmed within 30 days. The employer is responsible for the calculation of the NSIF dues following the monthly salary of the employee and the percentage provided by the NSIF board, then the declaration which is either by physical presence or online and then the payment to NSIF, where the employer has his share to pay for the employee's NSIF contribution. The employee's share of the contribution is deducted during each salary's or wages pay out. The employer then adds his share of the contribution then declares and pays every month. The employer can declare its staff online and pay their contributions to banks or any other approved financial institutions. Once payment is done, the issued receipt and the copy of the online declaration are then taken to the relevant tax center in order to obtain a receipt for payment of the employee's tax.

Within the framework of the execution of its social mission, the institution's action is geared towards two main targets: The wage-earner and his/her rightful claimants and the employer of skilled labor and domestic manpower. 1) Wage-earner or rightful claimant, the expression wage-earner is used in labor parlance to refer to employee, workman to name a few. The labor code defines a wage-earner or worker in section 1 of the Labor Code as any person, irrespective of sex or nationality, who has undertaken to place his services in return for remuneration, under the direction and control of another person, whether an individual or a public or private corporation, considered as the "employer" and may pay him wages in return for the work done. However, some people may obtain social benefits because they are put in the same category as wage-earners, or because they apply to be covered by the legislation of the social insurance: these are religious authorities and voluntary insured persons. The practices of the institution who have to be clearly defined must know the types of benefits that are opened to them and know how to fulfil some conditions so as to benefit from the rights opened by the social insurance. The rightful claimants of the wage-earners may also benefits from the services of the NSIF. These are persons who depend on the deceased wage-earner and who may continue to receive some benefits that were due to him.The employer of the labour force is stated to be any individual or public corporation that employs under his authority and direction one or many persons on a permanent, casual or seasonal basis in return for remuneration.

**4.2.4.2 Private Health Insurance Activities**

Private health insurance is a contract between a client and a private health insurance company that mandates the insurer to pay some or all of his/her medical expenses as long as the premium is paid (Borrelli, 2019). Private health insurance activities are carried out and executed by defined private insurance companies in Cameroon. We noted the activities of SAAR Insurance Company PLC, Beneficial Life, Zenithe Insurance Company S.A, Activer, just to name a few. The private health insurance procedure begins with a client seeking health insurance advice. The agent administers a designed health insurance questionnaire (see annex 02) to collect relevant information that would be helpful in proposing a quotation. Depending on the information in the questionnaire, the insurer can diagnose weather the request is from a group or an individual, since Private health insurance can either be subscribed individually or as part of a group as an employment provision. In Cameroon, the majority of insured are in to private health insurance schemes are covered by employer-based voluntary health insurance. In any case, the quotation (see annex 3) is usually depended on the information provided by the client. The insurance agent after proving the quotation explains details of what the insurance policy will cover in case the subscription is finalized. The client may consider other options and then asks for a modification of the quotes to favor what is actually required.

Once the quotation is confirmed by paying a premium, a list of the insureds and members of their family is transmitted to the insurance company for subscription to be effected following the quotation that was provided to the client, which indicates the sum insured per person in all the guaranties with extensions and the postulated coinsurance apparition (80/20 or 70/30). A written contract prepared by the company is signed with the client, permitting the insurer to program a visit to the insured for a sensitization of the policy conditions, leaving them with the health declaration form, (see annex 04) which has to be signed by the doctor visit and consultation. The signed declaration form is the only document permitting the insured person to benefit from the policy's hospitalization, laboratory tests, pharmaceutical products, X-rays, reimbursements etc. By implication, the insured person must show prove of a doctor's visit before getting access to a 'bon de prise encharge', which has the coinsurance apparition information and concerned facility for medication, hospitalization and laboratory. The client must always return to the insurance company for a 'bon de prise encharge' after every consultation.

**Conclusion**

**F**indings revealed here that loans and monetary gifts were frequently used to finance healthcare among ethnic based group members in the community. Although both fall into two thematic areas, they are, however, based on the notion of reciprocity, in the sense of give-and-take (Shipton, 2017). In a reciprocity-based relationship, no person is a permanent lender. Individuals who lend money do so knowing that they will be borrowers in the future. Also, individuals who had received loans provide loans to their former lenders as a way of repaying for the assistance received. Furthermore, monetary gifts from relatives and friends have to be repaid when the occasion justifies, because a gift calls for a counter-gift (Shipton, 2010). Thus, in a reciprocity-based environment, loans and monetary gifts from relatives and friends are viewed as debts. The findings, therefore, demonstrate that notions of reciprocity and debt are essential to understanding how low-income populations finance healthcare. Arguably, it is also due to the principle of reciprocity that people received interest-free loans from family and friends. As people take turns as lenders and borrowers, it makes sense for people not to charge interest on loans given to one another. Again, according to the notion of reciprocity, people who provide interest-free loans have at one point been recipients of interest-free loans or will be recipients of interest-free loans in the future. Having concluded with chapter four, let us move to chapter five, where findings relating to the power struggle of health insurance schemes activities to satisfy community members were investigated and documented. Community based group activities use health insurance schemes activities to satisfy community member's healthcare.

# CHAPTER FIVE: POWER DYNAMICS BETWEEN PATTERNS OF HEALTH INSURANCE SCHEMES IN THE BIYEN-ASSI COMMUNITY

## 5.0. Introduction

This chapter shares information on the importance of health insurance to community members and how different health insurance schemes struggle to satisfy people through their activities. We were able to gather this data following the third research question which is "What are the power dynamics that health insurance schemes use to satisfy the health needs of people in the Biyem-assi community?" Based on the above research question, the researcher's objective was to confirm the hypothesis that community based group activities use health insurance schemes activities to satisfy community member's healthcare. The fundamental concept of the different insurance schemes is to strengthen the healthcare financing system, to access healthcare by reducing costly risk-coping strategies. The schemes sustainability and the quality of services provided are highly dependent on the satisfaction of its members. findings revealed that, various schemes activities were designed to improve the quality of care, which impacted member's satisfaction and in turn affected their sustainability (Criel, 2011) It was noted that not only could schemes membership guarantee quality healthcare services, members' satisfaction was also an important indicator of healthcare quality which was often associated with greater adherence to medical technology, health service utilization, and health outcomes (Prakash, 2010). While high satisfaction with any community based health insurance scheme encouraged its scale-up through membership, it was certain that schemes with low enrolment spoke for its self. According to Haile et al. (2022), scheme member's satisfaction was influenced by health insurance literacy about the benefits packages open to each scheme members.

## 5.1. Power dynamics among health insurance schemes in the Biyem- assi community

How much a scheme member continues to pay allegiance is enough proof of satisfaction. The Presidents of based groups try hard to keep members by working very closely with insurance scheme providers. Notwithstanding, given the same circumstances, all based groups apply the principle of reciprocity in participation with other members to provide assistances and care to members.

Findings revealed that, members of the different faith-based denomination were most likely affiliate to scheme activities proposed and implemented by their various church denominations. The members of the Catholic Church after identifying in their various faiths-based insurance schemes and sub-schemes; they proceed for a health policy in the BEPHA insurance scheme. Members pay a Registration Fee of 1.000 FCFA, and an Annual General Assembly (AGM) Fee of 1,000 FCFA; The Annual Contribution for each BEPHA Adherent stands at 4,000 FCFA; Other requirements to facilitate the enrollment process include: two recent colored passport-size photos and photocopy of National Identity Card (NIC) or Birth Certificate for each person in the Household or Group; Number of persons needed to constitute an enrolled Household ranges from 4 to 10. Larger

Households (with more than 10 persons) are attributed two BEPHA policies. The number of persons per groups like the CWA women's group Organizations Institutions, ranging from 4 to infinitum; showed interest to adhere in BEPHA. Everyone in a given Household or Group must be enrolled to avoid adverse selection. BEPHA facilitators avoid individual adhesion into the scheme to avoid a situation where only those who often get sick would tend to belong to the scheme. BEPHA was founded by the Bishops of the ecclesiastical province of Bamenda for the Christians of the Catholic Church and has been implemented by the various hospital facilities of the denomination.

Following an enrolment decision, members were expected to benefit from the following BEPHA coverage: 75% out patient, Hospitalization, Booking, Delivery and surgery, with each service having a limit up to which one can benefit, where out - patients consultation covers 75% up to 15 000FCFA, and surgery covers 75% up to 70 000FCFA. BEPHA however suffers a lot of inadequate financial support, which leads to the provision of poor-quality health services among the health facilities. There was a higher dissatisfaction with member's coinsurance payments at the BEPHA partner hospitals. Reason why most participants interviewed perceived the services as fair, while fewer participants indicated that services were good. There were high user fees indicated at hospital level due to more complicated illnesses that require more procedures, high opportunity costs such as transport in order to access health care in hospitals or high costs for procedures due to the need to meet the overall operating costs such as remunerating specialists. The unemployed were significantly dissatisfied with payments and this is not surprising given the lack of income. Interestingly though, the formally employed were also dissatisfied with the payments for services provided, indicating that they may perceive there is low value for money for services rendered. Additionally, the formally employed might be experiencing a huge burden of paying for the costs of health care for themselves and their dependents, which takes a large share of their household incomes. The study also found that those with post-secondary education were also dissatisfied with payments. Those with post-secondary education are likely to be also formally employed and the same reasons for this might be applicable. The findings on payment dissatisfaction should include exemption policies since the unemployed are not satisfied with charges and this could be due to their lack of income.

Furthermore the professional based schemes were distinguished by the formal sector and informal sector workers with their different professional activities. In our chapter four, we distinguished the informal sector activities of the "bayam sellam" women of acacia market and formal sector activities of the APEZ. Field analysis revealed that these "bayam sellam" women's group, based on their informal activities usually subscribe for health insurance from little community-based health insurance schemes (CBHI) including micro insurance schemes etc, which

was an emerging concept for providing financial protection against the cost of illness and improving access to quality health services for low-income rural households who are excluded from formal insurance. CBHI refers to the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Some research studies show that low-income households are willing to pay for CBHI and in most cases, they can pay the premiums in cash, in a monthly, quarterly, yearly intervals, or in kind (Preker, 2001) such as agricultural commodities. However, the success of CBHI relies on the existence of social capital in the community. According to (Churchill, 2006), CBHI refers to the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. The role of CBHI among others therefore is to help low-income households manage risks and reduce their vulnerability in the face of financial shocks. It is usually based on the following characteristics: voluntary membership, non-profit objective, linked to a health care provider (often a hospital in the area), risk pooling and relying on an ethic of mutual aid/solidarity. CBHI is currently being provided in some rural areas in developing countries and there is ongoing research about its impact on the well-being of the poor in these areas. However, the success of CBHI revolves around the existence of social capital in the community. This social capital in the community can be an asset for the breakthrough of CBHI, thus contributing to the demand for health care at the community level. Social protection is broadly and traditionally defined as "public interventions to assist individuals, households and communities better manage risk and provide support to the critically poor" (Holzmann, 2001).

Group members who moved from the North West Region shared their experiences from the community based Mutual Health Organization, the new experience, which covers metropolitan Bamenda, Boyo and Bui Divisions in the North West Region. Members and their families of at least four members contribute annually into a common fund to solve their health problems and to reduce financial barriers to access to quality health care. The scheme reimburses 25 per cent, 50 per cent, 75 per cent or nothing at all, depending on the nature of care. On the other hand, HIV/AIDS patients receive a maximum of FCFA 30,000 for CD4 Counts and opportunistic infections each year. The scheme covers amongst others, emergency surgeries, hospitalizations, planned surgeries, deliveries and a special out-patient package that covers consultation fees, laboratory charges and drugs in health facilities with which the scheme keeps memoranda of understanding. It is however a no-go scheme for chronic conditions that require regular consultations.

Access to healthcare for scheme members is good, but in view of the low coverage rate of insurance schemes, this does not have a significant impact in the target population. The majority of schemes achieved less than 10% penetration rate, which leads to Mutual Health Organization have

the potential to influence efficiency in the health sector, the majority of schemes does not use the spectrum of available design tools and mechanisms such as mandatory reference, co-payments, deductibles, ceilings on benefit cover, strict checking of members' identity, or an essential and generic drugs policy (Atim, 1998). Many schemes suffer from poor design. Financial and managerial performance is weak to moderate. A condition of improved efficiency is that free preventive and health promotion services are included (MAE, 2000). Schemes which take into account consumer concerns and preferences (choice, availability of drugs, transport, hospitalization etc.), conclude contracts with health facilities with a good reputation for quality and synchronize premium collection with income earning periods, can be successful in attracting a sufficient number of members, and ensure they are up to date with their contributions. However, resource mobilization capacities are modest and limited by the low amount of the insurance premium, low premium and cost recovery, low coverage rates and weak marketing capacity. In feasibility studies people often show interest and willingness to pay defined amounts of premiums, but when it concerns contribution many default or are late with their payments. Insurance premiums are flat rate and are not proportional to income, which is very complex to administrate. MHOs are not a solution for the problem of indigence. The majority of schemes had very little ability to protect the poorest parts of the society.

MHOs can only channel demand from an existing contributory capacity. Government social assistance programs are required for segments of the population that cannot afford premiums (Carrin, 2000). Not many schemes constitute a real counterweight to the health system. Often managers of MHOs lack technical competence and schemes do not function efficiently. Some schemes take up quality issues when negotiating contracts with providers. The study by Atim found that few insurance schemes neither checked provider prescriptions nor monitored the quality of care delivered to their members. For MHO managers, it is difficult to enforce the stipulated quality aspects when providers are not fulfilling their contractual requirements. But schemes may initiate a dialogue between users and providers of health services (Criel, 1999/Huber, 2000). Atim found that many aspects of MHOs impinge directly or indirectly on their viability as institutions. He concluded that while MHOs possess some managerial and administrative skills, major problems remain in the area of institutional development and the skills required for MHO-specific tasks. These tasks included: setting premium rates, determining benefits packages, marketing and communication, using a Management Information System (MIS), determining the appropriateness of care provided and its pricing, contracting with providers, accounting and bookkeeping, monitoring and evaluation and collecting dues.

Still on the professional based insurance scheme activities, formal sector workers were found to subscribe most often to the private business insurance companies. We noted the

experience of APEZ whom as a workers association put their resources together for a group's health insurance policy which extends to their dependents. Most workers of private multi-national companies benefit from a workers group health insurance policy from the private business insurance companies. Even at that, the study revealed that the formal sector insurance covers less than a fraction of the population, usually only workers of private companies and a few formal sector employees of less than 10%. The existing private insurances schemes are often dysfunctional, close to bankruptcy, and plagued by corruption (MAE, 2000).

These systems proved incapable to serve as nuclei for the extension of social insurance to the unorganized sector (Ginneken, 1997). The main reason for this situation is that the administration of a social security system is highly complex. It involves keeping records, ensuring the compliance of employers and employees, and organizing their effective control (Atim, 1998). Governments lack the administrative and management capacity needed to establish and run social security schemes (Juetting, 1999). The average African government often does not have sufficient popular credibility for the organization and management of a nation-wide social insurance system (Criel, 2000). Insurers and providers need sufficient managerial skills, which are often not available. Insuring public and private sector employees have often led to greater inequity. It benefited an already privileged population, increasing their access to both private and public sources of care. In a situation where government health facilities remain heavily subsidized, consumption of their services by the insured implies double subsidy. As a consequence, groups with higher incomes have captured a greater share of public subsidies for health care (Kutzin, 1997).

One of the participants revealed that there is long waiting time in the card room where NHIS enrollees collect their folder before going to see a doctor. Doctor's office is another area where the enrollees also spend time before they see a doctor. This is in line with study of Glory and Dr. Kevin (2014) where the enrollees perceived that delay in attending patient is the second biggest problem observed in the programme: *"……when we went before we will receive our folder card, sometimes we use to spend more time before you get it".* Another alleged that: *"….. You will go to hospital since 8' O clock….. You will not see any one of the doctor….. after 1am before you see the doctor"*.

He added that sometimes the drugs are not available in the health facility and they were asked to go and buy them outside and at that time they don't have money to buy the drugs: *"Sometimes they use to say we went out and buy another medicine…. by that time we don't have money"*.

It is not right for a facility to ask enrollees to buy drugs outside the facility especially towards the end of the months when the enrollees have almost spent their salary. Again, even if

they have money, it is not proper for the facility to do so since government is deducting NHIS funds from enrollees' salary on monthly basis regardless of whether they use the services or not. Another participant opined that service points such as pharmacy, laboratory and others in the facility do sometimes overcharged enrollees during payment:

> *General hospital as I know, the problem is not from the doctors or management of the hospital. The problem is from those that are serving medicine (pharmacist) and cashiers and laboratory. .....when I go to the cashier or pharmacy on the way to calculate or to estimate the amount you are going to pay, they will double or tripled the amount. (Paul N. Montee de soeur, May 2023)*

One of the participants argued that drugs are sometimes available and sometimes not available in the facility:

> *Our problem is that there is no drug and sometimes there are".* Another participant said: *"Also sometimes even with your health insurance policy, they will write a medicine to you maybe that cost more than 10, 000 FCFA or 20, 000 FCFA and definitely they will either tell you that they don't have that drugs, you will have to buy it outside. Instead of them to buy for you they will refuse. But anything 2, 000 FCFA down ward or 5, 000 FCFA downward sometimes if you are lucky, they will be able to give you the drug*. (Mercy, bar owner, TKC, May 2023)

On the other hand, another participant asserted sometimes all the prescribed drugs are there available in the facility: *"The issue of drugs, sometimes if you come you can get the drugs. All of them without any problem"*. The health insurance services in the facility are not 24 hours as revealed by one of the participants: *"So, we are only having this health during working days from 7'O clock in the morning to maybe 4'O clock"* The health insurance services in any facility are supposed to be 24 hours services. In those facilities where the services are not 24 hours, enrollees sometimes find themselves in a very difficult situation because their folders are locked up in a room that is provided for safe keeping of NHIS folders. In this situation, the enrollee has to buy another folder or card before seeing a doctor and this cause them to spend more money as out of pocket expenditure.

**5.2. The health insurance scheme and insurance literacy**

Health insurance literacy, which is "… the degree to which individuals has the knowledge, ability, and confidence to find and evaluate information about health insurance plans, select the best plan for them and their family financial and health circumstances, and use the plan once enrolled (Kim, 2013). Community based members make efforts to understand the basics of their scheme activities and then jointly contribute to its development because having health insurance may not automatically translate into easy or equitable access to health care services as some schemes do not response quickly to member's needs. While some insurance schemes may reimburse members after

each claim, others require a lot of justifications before beneficiaries can access and use the health care services as Michael, 44 years old father of five children explained:

> *When I got employed for the first time, few days after I began work, the human resource manager informed me about the health insurance coverage for all staff members and their families. Even though I did not understand the mission and purpose, I later discovered that it was a formalized kind of health assistance that members of our faith based and ethnic based scheme received upon an announcement of sickness. I fell ill for the first time and expected to use the workplace health insurance plan, but did not succeed because the health provider asked me for a health declaration, a 'bon de prise en charge', which meant I had to go back to the office for all that was required before a consultation, or I may have to pay out of pocket and then ask for reimbursement later on. I was very sick and the only thing I needed at that time was a medical assistance. Only a phone call to my faith based and ethnic group president earned me some monetary assistance which I used for the consultation and medication* (Micheal, Teacher, Jauvance, May 2023).

When health insurance consumers do not have a good understanding of the system, it can lead them to make poor decisions about their care. For example, before choosing a plan based on premium, the person needs to evaluate the possible out of pocket costs, network access, and benefit value. Fortunately, this is a mistake that can be avoided with some basic knowledge and education. The primary focus of health insurance literacy is to understand its relationship with access and use of health services. The first step in effective use of the health care system is awareness of the available resources. Some participants who had been present in at least one presentation about health insurance sensitization were more likely to be aware of such programs.

> *Each registration of a new health insurance policy is followed by a sensitization talk presented to the person or people insured under the policy, during which the insurance personnel explain important insurance terminology, that the insured may need to understand the policy and apply such information during the insurance year, and then the functioning of the policy. The insured are allowed to ask question about the policy in areas which they have doubts* (Helen, Restaurant operator, TKC, May 2023).

Choosing the right health insurance plan has been the focus of much of existing Health Insurance Literacy research. When interviewed, some insurance workers explained how they make out time to sensitize client on insurance products. Nelson, 34 years old insurance worker said:

> *My colleagues and I always go out for marketing of our company's products and we explain the functioning when needed. They explained the different health insurance plans to the potential client at the time he or she enters the office for the first time, to get information about procuring a health insurance policy. Each quotation presented for validation by the client depends on a number of considerations including the health insurance plan that was selected by client in a formulated questionnaire to facilitate the underwriter's work* (Nelson, Insurer, Jauvance, May 2023).

Clients who discuss with insurance workers about health insurance before selecting a plan usually make better choices for themselves, because there is an understanding of some basics about the functioning of the policy. Clementina, 48 years old, and mother of three children explains:

> *I was able to select an insurance plan based on a one on one discussion with the insurance scheme worker. He clearly explained the different insurance plans available and their functioning with each plan in relation to its premium, the deductibles and co-payments required for the policy, examples of the insurance plans we talk of where the 20/80, 30/70, 10/90 or 100% plan. Premium paid was according to the plan in question, with 100% having a very extensive coverage, if compared to 30/70* (Clementina, accountant, Biyem-assi, May 2023).

Insurance employees have been making health insurance decisions for many years for participants with basic or below basic health insurance literacy because their ability to procure appropriate levels of health insurance coverage and interact with the health care system successfully may be limited. This study has shown that health insurance information materials are not written with low-literacy users in mind (Vardell 2013).

> *I benefit for health insurance coverage from the group policy of the company where I serve as a driver. I do not understand how the health policy works. When I go to the hospital, I pay the bill presented to me by the doctor. I have been asking questions to understand better, but my colleagues are usually too busy to explain, so they usually refer me to the worded contract drown by the insurer to explain the policy, which makes no difference since my educational level is low* (Raymond, driver, Tam-Tam weekend, May 2023).

Health insurance literacy also includes more domain-specific tasks, such as completing health insurance forms, calculating cost-sharing, and other insurance-related skills to model the concept. "*The insurance procedure requires a lot of documentation. A doctor's visit is confirmed by his signature on the health form, which permits the insured person to apply for reimbursement or to request for "bon de prise encharge", so the facilitator always cautions me"* (Louis, Acacia, May 2023).

When health care consumers do not have a good understanding of the system, it can lead them to make poor decisions about their care. For example, they may choose a plan based on premium alone, instead of also evaluating the possible out-of-pocket costs, network access, and benefit value. Fortunately, this is a mistake that can be avoided with some basic knowledge and education "sensitization of newly insured persons on the functioning and specifications concerning the health policy. Marcel who is 34 years old shares had this to say:

> *My directors asked us to verify a number of quotations from different insurance companies for our health coverage and report to him. We requested quotes from about three companies with different coverage limits, premium and coverage plans. The premiums varied based on the coverage limits, deductibles and out of pocket costs. We almost went for the lowest cost until the insurer explained to us that the coverage was very limited,*

> *without any extension guaranties to tooth care, eye care and personal accidents, with very high out of pocket costs too* (Marcel, PRO,TKC, May 2023).

Another contribution on this point came from Angela, 28 years old and a mother of 02 said that:

> *Our work place health plan was 20/80 following the budget line of the company for local staff health insurance coverage, but following a report of our consumption at the end of last year, we had a meeting with our insurer and requested quotes for a different plan say 10/90 to make up for the reduction that was previewed due to a drop in consumption* (Angela, secretary, Biyem-assi, May 2023).

Some attention has shifted from the literacy required to choose a plan to the literacy required to use that insurance to gain timely access to needed health care services. Health insurance literacy programs bridge information gaps by helping people understand basic health insurance information. This can empower people to have more control and make better informed decisions about their healthcare. Improved understanding of health insurance terms can also increase health insurance enrollment rates, which improves access to care and, ultimately, health outcomes.

### 5.2.1. Measuring Health Insurance scheme satisfaction

A number of criteria can be used to measure health insurance literacy, including knowledge of terms such as individual's knowledge of health insurance premium, deductible, copayments, coinsurance, maximum annual out-of-pocket spending, provider's network, covered services just to name a few. Most insurers always try to explain the meaning of some important health insurance terminology to their clients after each subscription. The subscribers of the group policy would always advice their employees to understand health insurance basics so that they can become better consumers of the policy. This dose not only helps ensure satisfaction with their coverage, but it also gives them the confidence to evaluate health insurance plans, select the plan that best meets their needs, and, most importantly, to use the plan to its maximum benefit once enrolled:

> *When our company's health insurance policy was drawn, the director invited the insurer for a brief sensitization meeting at the office with all the staff, during which he explained the functioning of our health policy and some important conditions that must be respected. We also had the opportunity to ask him to explain better some terminology that was used in the contract, some including; coinsurance, deductibles, out-of-pocket payments and so on* (Clifford, Administrator, Biyem-assi Carrefour, May 2023).

Other variables to be considered in Health Insurance Literacy measurements may include differences in income levels and educational levels among population settings. Health literacy is consistently lower among people with low incomes and lower educational levels which may ultimately lead to lower health insurance enrolments. In addition, members of low-income

communities have higher rates of uninsured members and gaps in health insurance coverage which in turn decreases exposure to health insurance terminology as Samson said:

> *Understanding health insurance terminology is very important for health insurance functioning. We explain the policy to some beneficiaries with low education almost every time they are seeing a doctor for consultation or request for reimbursement. We have to keep explaining their coinsurance, deductibles and out-of-pocket-expenditure as it was drawn in their policy, since they cannot read, even those that can manage to read lack understanding and require further explanation* (Samson, CA, Tam-Tam weekend May 2023)

Health Insurance Literacy is assumed to be higher among people who are less healthy and needs more healthcare than people who are healthier, as was explained by 42 years old medical practitioner Dr. Laurence:

> *Insured people with bad health conditions are capable of understanding health insurance terminology faster than even healthy and uninsured people. This is because they are very familiar with the health insurance procedure as they require fulfilling certain obligations for health insurance at the hospital before receiving treatment. I always hear most of them talk about proforma, health declaration form which the doctor has to sign 'bon de prise encharge' just to name a few* (Laurence, health worker, Acacia, May 2023).

Age and gender can also be considered as criteria to measuring health insurance literacy. Young insured adults who regularly use health care services reported higher Health Insurance Literacy than people who occasionally accessed health services. Young adults are generally healthy and have more limited interactions with the health system, and therefore unsurprisingly are less likely to respond correctly to knowledge quizzes about Health Insurance Literacy. Leo who is 28 years old explained that;

> *All my life through school I have never witnessed any lessons on health insurance. I just started work and this is the first time I have anything to do with health insurance and the terminology is quite difficult to understand…especially as I do not frequent the hospital"* (Leo, Teacher, Round point Express, May 2023).

Women tend to use more health care services than men, and so were reported to have higher Health Insurance Literacy levels, paradoxically, people reporting poor health status reported lower levels of Health Insurance Literacy. A possible explanation for this paradox is that people in poor health conditions relative to those in good health actually use their insurance policies more often, and so the frequent use increases their knowledge of the complexity of the health plan and the awareness of the terminology of health insurance policies.

Individuals can actually make better informed choices through their employers, particularly when employers provide a short list of options for employees to choose from, as well as provide administrators to offer guidance. (Hanoch, 2015) drive home the importance of providing

assistance with health insurance literacy concerns: To do so, they need a great deal of help understanding and comparing coverage options when making these important decisions". Health insurance literacy concerns also extend beyond selecting a health insurance coverage option. Once individuals are insured, their health insurance literacy levels may dictate how effectively they are able to navigate the health care domain. If an individual unwillingly uses an out of-network physician or hospital, it could cost the person thousands of francs CFA more than selecting health care providers within their insurer's network. As Levitt (2015) underscores "the lack of health insurance literacy has important implications for how effectively people use health care services and their insurance policies"

Besides providing financial protection from the economic consequences of illness, health insurance is meant to improve access (Nyman, 1999). Evaluating the link between health insurance and access and use; most respondents were positive about the significant impact of health insurance on access and use. When respondents questioned on the impact of health insurance on access and use, majority responded positively indicating that health insurance increases access to and use of health services. Milton, who is 38 years old and father of 03 had this to say:

> *Our work place insurance plan has coverage abroad. When I fell on the staircase and sustained a spinal cord injury at work, I was immediately referred to India to access timely and advanced medical treatment which was covered entirely by the health insurance policy"* (Milton, motor park attendant, Round Point Express, May2023)

This finding seems consistent with the results of previous reviews in the developed world, and it seems to confirm what the insurance theory predicts: health insurance reduces the price of health care and thereby promotes access and use of health services (Nyman, 1999).

> *My family's health insurance plan is the 20/80 percent payment apparition, where the insurance scheme covers 80 percent of every hospitals charge and we cover only 20 percent during each consultation, hospitalization and/or laboratory examination tests. The 80 percent charges covered by the insurance company is already a huge reduction of health care charges, which protects the family income from catastrophic health expenses* (Pascal, civil servant, Round Point Express, May 2023).

One might wonder, however, whether the heterogeneity in the social health insurance schemes (in benefits packages, institutional implementation, and so on) evaluated allows for a meaningful cross-country comparison (even after controlling for observable differences such as variations in provider payment mechanisms). In this context several studies find that an aggregate measure of health insurance may cloud the impact of health insurance by not taking into account the heterogeneity in impact across different health insurance schemes.

The impact of health insurance varies across populations but these differences vary substantially across settings. Findings revealed that it is precisely the most vulnerable low-income population groups who benefit most from health insurance access and use of health facilities (Chen,

2007). "*Our health insurance scheme has been receiving a lot of external funding to subsidies the health care of the low income population, often 100% coverage, giving them access and of timely and advanced health facilities (Health insurance scheme facilitator*)"(Innocent, Acacia, 2023).

On the other hand, according to some findings, only the better off high-income populations have increasing access and use of medical facilities as a result of health insurance coverage (Wagstaff 2007). For example, private health insurance worker, Evaristus, father of 03 narrates.

> *I realized that, most families that own a health insurance coverage benefit from an employer's plan. Some few individuals who are relatively 'rich people' also purchase family health insurance for the health care of their families. This way, they are sure to access timely and advanced medical services for checkups and diagnoses, also for preventive care, in order to avoid future catastrophic health expenditure* (Evaristus, nurse, Whitehouse May 2023).

In some instances, the impact on use across population groups varies over time and health insurance settings in the same country. This variability in results certainly stems from unaccounted for designed elements of the programs. "*I realized that the high coinsurance rates mandated in our CBHIs is scaring away membership of most low- and middle-income population from the facility, because, there is no significant increase in utilization among the low income population"* (CB Health insurance scheme facilitator, Constance, Round Point Express, May 2023).

Hsiao (2008) presents a more nuanced picture as they look at considerable heterogeneity in benefit packages, coinsurance rates, deductibles, and ceilings across counties and coverage modes. A modality providing 100% coverage with no deductibles but with ceilings does have an important impact on access and use, especially among the poorest and highest income groups.

> *The facilitator informed us at the beginning of the year that a foreign body had subsidized our health coverage at 100%. We could access very good medical services, and enjoy doctor's referral advice to more sophisticated facilities for expert treatment elsewhere, at no additional cost but as a part of the health insurance coverage* (Joseph, ministry, Round Point Express, May 2023).

The discussion and examples highlight the importance of incorporating the possible heterogeneity of health insurance schemes and the impact across different population groups into the study design and data collection. Typically, household data used to study insurance programs are collected for other purposes and are difficult to use to understand the impact of insurance program design elements.

One interesting question put forward by several participants is related to the limits of the concept of use when evaluating the impact of health insurance: (if health insurance is found to increase use is necessarily good?). However, according to Nyman (1999) "The value of insurance for coverage of unaffordable care is derived from the value of the medical care that insurance

makes accessible." In this perspective and given the substantial access problems in most low- and middle-income countries, observing improved access and use through health insurance will therefore generally be considered a welfare gain. Based on same preoccupation, participants reported that most low and middle income people are grateful for the opportunity to increase access and use health facilities through health insurance, and the value of the cost of health care covered by the insurance plan is converted to family income and used for other investments, as Susan explains with a broad smile that "Family's health is taken care of by the health insurance policy, so they worry about other aspects of life to improve the family's wellbeing, for instance, further education, housing construction and good feeding*".*

On the question of (What if health insurance encourages the overuse of health services?), most respondents indicated that, "The aim of health insurance is to reduce risk exposure and to make necessary health care affordable. Theory suggests that the welfare gains in terms of access must be weighed against the potential welfare loss from demand-side and supply-side moral hazard. Further research is required to investigate the issue of whether the extra utilization obtained through health insurance is medically necessary or not." In our view, it can be safely assumed that in most middle middle-income communities. The population and especially the most vulnerable ones tend to experience severe access problems and thereby underuse rather than waste and overuse health services, the literature does not sufficiently discuss this trade-off between improved access of necessary services and the potential moral hazard issues.

**5.3 Health insurance schemes financial management**

Financial protection is achieved when direct payments made to obtain health services do not expose people to financial hardship and do not threaten living standards. Key to protecting people is to ensure prepayment and pooling of resources for health, rather than relying on people paying for health services out-of-pocket at the time of use. Providing financial protection against the economic consequences of illness lies at the heart of the adoption of health insurance. The question posed on "Why people purchase health insurance?" Many participants answered that it permits purchasers to avoid risks of financial loss. For example Mercy, aged 38, mother of 02, said that:

> *We used to spend a lot of money for health care in the family before my husband got employment in his recent job, where employee's health insurance extends coverage to family members. The health plan is on a 20/80 apparition, where the insurer covers up to 80 percent, leaving only 20 percent to be covered by the insured. The health policy therefore, enable us access timely and advanced medical services at only 20%, while protecting a financial loss of 80%* (Mercy, credit union, Tam-Tam weekend, May 2023).

This part of the research which evaluates the impact of health insurance on financial protection confirms a reduction on both out-of-pocket payments and the incidence of catastrophic

payments, especially amongst the low-income population where the health insurance modality provides 100% coverage (Hsiao and Yip 2008). Some participants could confirm this assertion, for example, Martha, aged 32 mothers of 04, May 2023 explained:

> *I once heard a man in my former neighborhood advertising his landed property for sale at a very affordable price too. I wanted to know more about his decision to sell such a beautiful parcel of land at a giveaway price like that. He was told that his child is very sick and admitted at the intensive care unit, so he needed money for hospital treatment. (Brita, 32Years old, Montee de soeurs,May 2024)*

The informant in his quote above simply explains the importance of a health insurance policy in protecting family finances. Health is such an important issue that cannot be ignored. Once it comes, the victim would be ready to lay down everything in order to have access to money for treatment. Garil, 43 years and father of 03 also contributed to the fact that health insurance provides financial protection by cutting health care costs as he explained: *«if my family was not benefiting from health insurance coverage, one's mind could have been imprisoned with such thoughts of uncertainty about family's health and maybe sale of property which without much investments".* On the same bases of financial protection, Elvis, father of 03, aged 53 said that:

> *My family insurance is not on a 100% coverage plan, but the 20/80 apparition still reduces our out-of-pocket payment for each hospitals visit, laboratory, drugs and hospitalization which is 20% of the total bill. The amount of money paid for this percentage may only get higher if the health situation is actually bad. I am so of grateful for the 80% copayment because that is the percentage of financial protection; we gets from being insured for healthcare.( John B, 45 years old, Acacia, May 2023)*

Health insurance is not a homogeneous concept, and in depth familiarity with the specifics of the health insurance scheme being evaluated is key to interpreting results. Avoiding generalizations across countries and even across settings in the same country seems advisable unless details of the plans can be controlled for, which is difficult if not impossible using existing data and research techniques. Some studies however evaluate the impact of health insurance on financial protection basically since health insurance has reduced out-of-pocket spending and the incidence of catastrophic payments. There is positive evidence that health insurance on financial protection, despite the fact that research use many different indicators to measure financial protection and different model specifications to evaluate them. Follow up questions on health insurance literacy revealed that many respondents were able to answer some basic questions, like when premiums are paid. But questions involving calculations, however, proved more difficult. However, most respondents could determine the out-of-pocket charges for a hospital stay where a deductible and copay were involved, while only a few respondents could calculate the cost of an out-of-network

lab test where the health insurer paid a percentage of allowed charges. Bertha, who is 32 and mother of 03 said that:

> *A list of hospitals, pharmacy and laboratories were given to us after the health insurance policy was established. Each time we visit a hospital outside this network list, we have to pay 100% charges then follow up for reimbursement of our coinsurance coverage of 80%, which most often is not fully paid because a number of items and some medication would be cancelled request application. I am most comfortable when we visit a network facility because the co-insurance apparitions are respected* (Bertha, pharmasist, Jauvance, May 2023).

Given the complexity of health insurance it has become clear that there is health insurance illiteracy. A majority of consumers with employer-sponsored health plans lack the necessary financial health literacy to optimally manage their health plan finances. So, they think that insurers need to sensitize their clients on the most efficient means of optimizing their health insurance policy as a financial protection. According to Christine (2019) health literacy is a fairly new phenomenon because 20 years ago, people did not know what medical treatment cost was, as most respondents could not correctly define even basic insurance terms, such as premium, deductible, and copay. They did not matter because their insurance company just covered them. Today there is much more variation in how benefits are covered and what types of cost sharing may apply. And the growths of tools such as health reimbursement arrangements and health savings accounts have further complicated the landscape.

Research has also shown that health insurance literacy is a factor that contributes to consumers delaying or not seeking care. And that includes preventive care, which is often covered by insurance with no cost sharing with the consumer. Some respondents reported delaying or foregoing health care because of cost. Specifically, those with lower health literacy reported significantly greater avoidance of both preventive and non-preventive services. Understanding the types of services available, what is covered and at what cost, can help individuals use their health plan wisely and obtain recommended health services. This trend toward foregoing care was also reported where some respondents claimed uncertainty over their coverage led them to avoid treatment.

In addition to delaying or avoiding important care, poor health insurance literacy can also lead consumers not to understand the additional costs associated with out-of-network care, remain with the same plan year in and year out when a better alternative may be available and also not to take full advantage of shopping for prescription drugs to save money. The insurance agent Sidoney who is 33 and mother of 03 explains that:

> *Each health insurance enrollment is followed by a list of network hospitals, pharmacies and laboratories that work with the insurance scheme. By implication, the insured normally has to consult with the network medical*

> *facilities, where his coinsurance payment apparitions are respected and the rest forwarded to the insurer for payment. However, the insured has the right to visit a specialist doctor of choice and ask for reimbursements from the insurance scheme. The difference is that visits outside network hospitals are expensive since the insured has to pay out of pocket 100% of all expenses incurred, before forwarding a request for reimbursement from the insurer, which usually follows a lot of bureaucratic and justification procedures.( Sidoney, insurance facilitator, Acacia, May 2024*

To address the challenge of health literacy, a widely accepted measure of consumer health insurance literacy called the Health Insurance Literacy Measure, which represented a self-assessment measure of consumers' ability to select and use a particular health insurance schemes. This measurement is based on a conceptual framework that breaks health insurance literacy into four different components: Knowledge, which recognizes the importance of understanding insurance terminology, information seeking behaviors, which requires an understanding of the questions to ask and where to find the answers, document literacy, which is being able to interpret benefits and explanation and Cognitive skills, which includes an ability to calculate cost sharing and assessing value based on cost and benefits. So according to Anthony who is an insurance staff and father of 01 child;

> *Understanding the functioning of a health insurance policy is a whole school on its own because of the many terminologies and procedures involved. While consulting, the insured has to meet the doctor with a health declaration form, then take a proforma and go back to the insurance company for approval and the signing of the "Bon de prise encharge" for pharmacy, hospitalization or Laboratory procedure as the case may be. Unfortunately, we have to make an effort to understand the basics; otherwise, we may have to takes charges which were normally supposed to be taken by the insurance company, or make double trips to the hospital and back to the insurer just to collect documents which were supposed to be collected only once( Anthony, director, Superette, May 2023)*

By measuring health insurance literacy and recognizing the components that contribute to this phenomenon, we can shape consumer education, policy development, and research around health insurance experiences.

Findings of this research revealed that insured hospitalized patients of the faith-based scheme who prefer to use their confectioner healthcare facilities had significantly higher levels of satisfaction. Apart from acquiring quality treatment, each working day starts with a word of prayer and teachings about Gods love to his children. The faith based scheme is about religious building and it is the bread of life itself as it gives each member hope even in hopeless situations. The teachings in the faith based scheme are all about belief in the will of God, which translates to their healing and the spiritual benefits that come with the word of God. The preaching of the word is what simply keeps the hospital staff on track at service, believing that the service they render to patients is on to God and not onto man. Satisfaction here is the overall level of contentment with a

service experience (Andaleeb, 2007). Meeting patients' expectations is an important step towards providing continuous high-quality healthcare (Buetow, 2007). It has the potential to make patients adhere to the care provider and return for follow up. This is more important in an insurance scheme where dissatisfied patients may refuse to renew their membership in the next year. Thus according to Ashangwa (2019), the Boyo mutual health scheme has the potential of meeting member's expectation both at the schemes level and at the Njinikom healthcare facility where the scheme and the hospital work hand in glove to see that members and patient's needs are met, without which, they may dissuade others from joining the scheme; thereby affecting the overall viability of the scheme. This, along with other measures, like affordable premium, acceptable benefit package, easy administrative procedures and trust in the organization would go a long way in ensuring the success of pattern of health insurance scheme.

Comparatively, insured hospitalised patients of the NSIF scheme were so unsatisfied with the services they received both from the scheme and the government owned hospital healthcare facilities they used. Members of the NSIF scheme usually ask for reimbursement after treatment and may have to show proof of expenses incurred from the time they started treatment. Because of financial constraints, NSIF members usually would prefer to take their treatment with government hospital facilities, but there are problems which include non-availability of staff and medicines as well as the rude behavior and incompetent staffs that do wrong prescription and shout at patients at the hospital units. Recoveries usually take longer than expected because of too many administrative bottlenecks at the NSIF, making some patients to abandon following their bills.

Findings also revealed that the ethnic based insurance schemes most often did not affiliate members to health insurance facilities, but prefer to provide the assistances following the ethnic group's by-laws. Based on these the NADECO women's group insurance desk provide 30 000fcfa to members who fall sick and are up to date with their contributions in the meeting. In fact, these observe a very good health policy as members can be assisted even through money transfer mechanisms, so long as there is proof of hospitalisation. This is also true with the activities of the informal sector professional group of the "Bayan sellem" women of acacia market. Their assistance is by contribution and representation, so that members who could not contribute at the time of need shall simply pay back to the meeting with interest. The total amount of money contributed is handed to the beneficiary by some representatives of the group. The formal professional based schemes were affiliated to the private insurance business companies.

Private health Insurance companies can always improve the quality of care for their client by ensuring that they visit quality healthcare facilities. Based on the schemes activities, managers would prefer to enrol members with a facility which matches their finances and which they can easily work together to provide better services to satisfy their members. Findings of the study

revealed that presidents of all faith-based insurance schemes preferred members to consult and visit practitioners of confectioner hospital facilities because they get their insurance coverage from the BEPHA health scheme. Private insurance schemes which were more expensive can afford to provide private health care facilities to its clients. Quality of care is one of many important determinants of health service utilization. The quality of healthcare in Cameroon hospitals for the private, confectioner and public health sector is unsatisfactory depending on the circumstances. The private insurance companies used the private sector probably because of the reduction in the financial barrier and the perception that the private sector provides better quality of care. Private insurance companies empaneled the providers based on their capacity to provide medical and surgical care, which further negotiates with the hospitals to reduce the fees for insured patients and also provide documents to the patients as soon as possible. Patients felt that the doctors charged higher fees for insured patients. This affected the patient directly, as the patient had to pay 25 percent of the total bill. Hence the patients usually hid their insurance status till the time of the discharge. This should be translated into higher satisfaction levels by patients using the private sector, thus giving a higher probability for a renewal. One of the reasons for satisfaction among the insured was that the staff did not shout at them. Also the insured were seen faster compared to the uninsured patients, and finally, less number of insured patients had to pay informal fees compared to the uninsured, whereas, more uninsured found the treatment costly, the medicines less effective and have no faith in the doctor, the differences were not very significant. Uninsured patients sought care with public health services as both the insured and uninsured patients had similar socio-economic status.

**Conclusion:**

Generally, the organizer of the scheme can negotiate with the provider for ‘better quality of care’ because they control the funds and are ultimately responsible for paying the provider. Yet another mechanism is by empowering community members. In any health insurance scheme, there is an element of ‘service guarantee’. Once the insured pays the premium, the insurer has to guarantee the promised services. This can then give the insured patient the authority to ‘demand’ the services from the provider. Thus, ideally the insured patient can access the care that is required. From the provider side, this would ensure that they receive a steady income over time. Thus, insured patients hypothetically receive better quality of care from these providers in order to improve on the sustainability of the health insurance scheme in their community. Our next section is a general conclusion on patterns of health insurance schemes among people of the Biyem-assi community in the Yaounde – Camerron

# GENERAL CONCLUSION

This dissertation entitled 'Patterns of Health Insurance schemes amongst people of the Biyem-assi community in Yaounde; a contribution to Anthropology of Development' is a research to evaluates the contributions of health insurance scheme activities to members timely access and use of healthcare services. Healthcare is a substantial cost around many communities, yet it is even more so in systems with significant out-of-pocket payments as seen in many lows and middle-income communities. Healthcare costs continue to rise, which prevents many informal sector people from accessing necessary and timely healthcare. Paying out-of-pocket for emergency surgical and healthcare services is often a catastrophic expenditure for many households in the community. Health insurance which can increase healthcare access is still almost exclusively limited to the formal sector population which represents only about 10 percent of the total population in the community. The health service delivery is therefore disproportionately distributed, projecting the healthcare system as discriminatory and has raised concerns about equity and social justice (Kibu, 2019). Members of the formal sector who can afford healthcare can still access the standard health insurance coverage of the private and public schemes because of their employment. The informal sector populations who mostly depend on self-employment are not able to access adequate healthcare, even for members of their family. Access to quality healthcare is thus hampered by factors such as poverty, high costs and out-of-pocket payments which most often prevent them from meeting care requirements for catastrophic health crisis. To this effect, we are tempted to conclude that the informal sector population and low income indigenes of the community do not have health insurance coverage.

These let us to ask the following main research question; what are the patterns of health insurance that enable people in Biyem-assi to access healthcare?, including more specific research questions as follows; How do people of the Biyem-assi community perceive health insurance coverage?; What are the mechanisms used by the people of Biyem-assi to finance healthcare? What are the dynamics of power struggle for health insurance schemes in the Biyem-assi community? Based on the above research questions, a main research hypothesis was developed as follows: The people of Biyem-assi may access healthcare through a complex web of insurance schemes. Including more specific research hypotheses as follows; the Biyem-assi people perceive health insurance as a scheme of savings for healthcare, people belong to community based groups whose activities constitutes healthcare financing mechanisms; community based groups use health insurance schemes to satisfy members healthcare. In line with the above, a main research objective was proposed as follows: to explain the patterns of health insurance that enable the people of Biyem-assi to access healthcare, including specific research objectives as follows: to understand the perception of health insurance among the people of Biyem-assi; to investigate the mechanisms used by community members to finance healthcare; to determine the power struggle among health

insurance schemes to satisfy members healthcare in the Biyem-assi community.

In order to answer the research questions, test the validity of the hypotheses and finally achieve the objectives that were fixed for this research, a methodology was inevitable. Mindful of the fact that our research was to a greater extent exploratory, the qualitative research methods were found to be very flexible throughout the actual research process, which enabled the collection of primary and secondary data. Primary data collection made way for a face to face contact and extensive discussion with informants at the field. The research was conducted in accordance with ethical principles such as respect for participants, no harm to participants, informed consent, voluntary participation, right to withdraw, confidentiality, just to name this few. As tools application, we used the interview guide to collect data on a face to face contact with the informant; observation guide to note only relevant behavioural activities of insured and non-insured patients at the hospitals centres; note books to jot relevant notes during the interviews and observation processes; pens used to note information on the note book; pencils used to emphasis certain jots in the note book; a tape recorder used to record extensive and complicated discussions and observations that could not make notes during the interview or observation process. When the data collection process was over, data collected was analysed by sorting to give meaningful titles for the research write up.

Also, in order to verify the validity of our hypotheses, we mobilised techniques of data collections beginning with secondary data collection from the periods through January to April 2023, where diverse documents were consulted such as; books, articles, dissertations, journals and reports of studies. The documentary reviews and extensive internet search enabled an elaboration of a reading sheet where the contents were used from the beginning to the end of the write up of this dissertation. These secondary data collection techniques, which were mainly documentary research, guided the researcher to acquire some literature review that was used to facilitate the readers understanding of the health insurance coverage and its functioning. Some libraries were visited in the course of the research: the University of Yaounde 1 library of FALSH where we collected information from the work of some academic seniors and friends. These documentary data were used to reformulate the research problem, literature review and to bring out the originality of this research.

The field work was carried out in all the communities that make up the Biyem-assi locality in Yaoundé, mainly Rond-point Express, Acacias, Carrefour Biyem-assi, Rue Saint-Marc, Maison Blanche, Montée des Sœurs, Montée Jouvence, Superette, Tam Tam, and TKC, which constituted the populations of both men and women English speaking people. Participants for the research were gotten thanks to the snowball and convenience sampling technique. From the contacts in the field, we were able to construct a beam of individuals relating to them through the use of

intermediaries for the snowball collection, and for the convenience technique, we took advantage of people we found with previous insurance subscriptions to initiate a discussion for the research. The field research took place from May 2023, where direct observation and in-depth interviews were used to collect data. The data collected was in the form of word verbatim and images. Recorded data was transcribed, coded for identification and categorization of themes was done to draw insights into the data. The analysis process was content based and interpretation, where data collected was given a thorough description to make it meaningful. We used the conventional economic theory, the Vanishing welfare gain of the demand for health insurance and the cultural interpretative theory of demand to discuss the "adverse selection" and "moral hazards" concepts that best explained the functioning of health insurance coverage.

The findings of the research revealed that; people perceive health insurance as being a scheme of savings for healthcare and so contribute to these schemes; the people of Biyem-assi belong to several health insurance schemes including: self-insurance schemes, faith based insurance schemes, ethnic based insurance schemes, professional based insurance schemes, standard based insurance schemes, and contribute in cash and kind to secure their coverage. Also most of the informants during the data collection process had a form of health insurance scheme where they contribute to assist members in need, while hoping to benefit in future. Most people in this community navigate across health insurance schemes in the form of insurance scheme shopping to meet their healthcare needs. This research was limited to qualitative approach but but quantitative and mixed approaches for further research may reveal the trends of subscription for health insurance.

Some other findings revealed that healthcare was financed through mechanisms including; loans, savings, sale of personal belongings and acquisition of monetary gifts from friends, children and family members. Some people could access the micro health insurance given the very best conditions. Community members actually confirmed that loans and monetary gifts were widely accepted means to finance healthcare among members of the community. Although these fall into two thematic areas, they are however, based on the notion of reciprocity, in the sense of give-and-take (Shipton, 2017). In a reciprocity-based relationship, no person is a permanent lender. Individuals who lend money do so knowing that they will be borrowers in the future. Additionally, individuals who had received loans provide loans to their former lenders as a way of repaying the social debt they owe, even though the "monetary" loan had been repaid. It is due to this notion of social debt that Shipton, (2017), argued that loans and repayments do not cancel each other out. Similarly, according to the principle of reciprocity, monetary gifts from relatives and friends have to be repaid when the occasion justifies. This is because a gift calls for a counter-gift (Shipton, 2010). The only uncertainty is related to the time when the gift will be repaid, but the gift will

certainly be repaid. Thus, in a reciprocity-based environment, loans and monetary gifts from relatives and friends are viewed as debts. The findings, therefore, demonstrate that notions of reciprocity and debt are essential to understanding how low-income populations finance healthcare. Arguably, it is also due to the principle of reciprocity that people received interest-free loans from family and friends. As people take turns as lenders and borrowers, lender do not charge interest on loans given to one another. Again, according to the notion of reciprocity, people who provide interest-free loans at one point have been recipients of interest-free loans or will be recipients of interest-free loans in the future. Additionally, due to a strong social relationship, a close friend approached for a loan may be uncomfortable asking the supplicant friend to pay interest on the loan, as it may mean that they are perhaps taking advantage of a desperate situation for economic gain. Charging interest on a loan may be viewed by people in the communities as not being sensitive to people's situations. Being sensitive to people's economic situations is part of the process of managing social relationships (Nelson, 2000). It is against social norms in these local communities for people to charge interest on loans given to kin. According to social norms, people are expected to help those in their kin network and not make economic gains from them.

The concept of reciprocity is also applicable to the parent-children relationship. Parents take the position of "givers" by sending their children to school, ensuring that they learn a particular trade and providing food for their nourishment as they grow, in addition to shelter and healthcare. Based on the foregoing, children have a "debt" to repay their parents, as in a reciprocal relationship no person is a permanent giver or receiver. When children become adults and have income-generating activities, they take the position of "givers", hence, they are expected to assist their parents in various ways, including paying their healthcare bills. The principle of interdependence in the parent-child relationship is also embedded in the concept of reciprocity. Interdependence entails complementary relations between parties (Servet, 2007). There is a complementary relationship between parents and their children, as each party takes turns in assisting the other in times of need. However, people do not rely on a single mechanism to finance healthcare.

The efficiency and dynamics of health insurance pattern was easily measured in the community. Formal sector populations who mostly subscribe for private health insurance were so bitter about their inefficiency in executing this health policy. Apart from the fact that reimbursements were not done on time, insured people often complain how much most hospital staff disrespects them when they visit the hospitals for consultation and treatment. They are kept for longer than expected and are made to buy medication and pay for services which their contracts have covered for 100% and do not allow copayments. It is already well-known that micro health insurance schemes, especially community-based health insurance programs, seem quite effective in reaching a significant proportion of low-income populations who may otherwise have little or no

financial protection against the cost of sickness (Dror, 1999). However, of particular interest is how people's relationships with micro health insurance schemes are framed in terms of gains and losses.

According to the findings, some subscribers of voluntary health insurance schemes who did not make a claim in a year, because they or someone in their household was not sick, said that they 'lost money'. Because they incurred a loss, they decided not to renew their health insurance for the next year. In other words, whether people renew their subscription seemed to depend on whether they perceive that they made a gain or loss. The fact that people did not renew their insurance because they did not make a claim suggests that they have a strong aversion to loss. They seem to gain more utility when their annual premium is not "lost". Our finding that people did not renew their subscription when no payout occurred suggests a lack of understanding of the insurance concept, whereby insurers use the pool of several premiums to pay for the losses of individuals who make claims.

In the midst of the above findings, one thing was certain; the standard based health insurance schemes of the private and public insurance companies were not as efficient in meeting subscriber's needs as the other schemes identified during the research procedure. While costs, bureaucracy and administrative bottlenecks were some of the factors that discouraged enrolments into these schemes, these were mostly open to formal sector workers whose subscriptions were through an employment plan as part of encouragement to the staff. The majority members of the community were informal sector workers who were limited to insurance schemes of the Faith based, Ethnic based, Social based, family based, just to name these few, where apart from the "Trouble Fund" assistance that is given to each registered member who is in need, members can also apply for loans from the meeting, or withdraw from their savings and even obtain 'monitory gifts' from friends and family members in case of very precarious of deteriorating health situations. Most formal sector workers, who because of their social status registered and could benefit from several insurance schemes, given that health insurance is a benefit policy and the more one saves, the more he/she benefits.

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**VI. Oral Sources:**

| N° | Name | Age | Sex | Marital statues | N° of children | Date of interview | Place of interview | Religion | Activity |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Mary Bih Tosam | 32 | female | Married | 04 | May 2023 | Round point express | Presbyterian | Hairdressing |
| 2 | Martin Lyonga | 34 | male | Married | 02 | May 2023 | Tam-Tam weekend | presbyterian | Auto-mechanic |
| 3 | Suzan Tassa | 43 | female | Married | 02 | May 2023 | Acacia | Muslim | Farmer |
| 4 | Johnson Ndikum | 40 | Male | Single | 02 | May 2023 | Biyem-assi round point | Catholic | Bayam-sellam |
| 5 | Quinta Ngow | 39 | female | Married | 04 | May 2023 | Acacia | Catholic | Fish business |
| 6 | Eteba Justina | 38 | Male | Married | 04 | May 2023 | Acacia | presbyterian | Cloths business |
| 7 | Matilda Bihti | 48 | female | Married | 06 | May 2023 | Biyem-assi round point | presbyterian | Foodstuff seller |
| 8 | Elodie Nange | 35 | Female | Single | 03 | May 2023 | TKC | Catholic | Firewood seller |
| 9 | Jean Francise | 48 | male | Married | 02 | May 2023 | Round Point Express | Catholic | Tailoring |
| 10 | Raymond Ndoh Chia | 40 | male | Married | 02 | May 2023 | Round point express | Catholic | Taxi Driver |
| 11 | Javice Kum Tuh | 34 | Male | Single | 02 | May 2023 | Tam-Tam weekend | Baptist | Farmer |
| 12 | Paul Makula | 43 | male | Married | 02 | May 2023 | Tam-Tam weekend | muslim | Caterpiller driver |
| 13 | Peter Adeh Nde | 38 | male | Married | 03 | May 2023 | Tam-Tam weekend | Presbyterian | butcher |
| 14 | Romeo Samson | 60 | male | Single | 03 | May 2023 | Maison blanche | Protestant | Driver |
| 15 | Nzami Michel | 42 | male | Married | 04 | May 2023 | Superette | Catholic | Business |
| 16 | Remond song Bih | 48 | Male | Married | 03 | May 2023 | Superette | Catholic | Builder |
| 17 | Peter Asama | 35 | male | Single | 7 | May 2023 | Maison blanche | Protestant | Capenter |
| 18 | Zelot Bela | 70 | male | Married | 09 | May 2023 | Superette | Protestant | Yam seller |
| 19 | Remond Asaba | 50 | Male | Married | 04 | May 2023 | Maison blanche | Protestant | Accountant |
| 20 | Kennet Nkwain | 33 | male | Single | 02 | May 2023 | Acacia | Presbyterian | Builder |
| 21 | Justina Ataindum | 38 | Male | Married | 03 | May 2023 | Maison blanche | Catholic | Business |
| 22 | Eileen Chinda | 46 | Male | Married | 05 | May 2023 | Tam-Tam weekend | Catholic | Farmer/small business |
| 23 | Teresina Necha | 30 | Female | Married | 02 | May 2023 | Biyem-assi round point | Catholic | Business |
| 24 | Dorothy Ngonga | 36 | Female | Single | 02 | May 2023 | Round moint express | Catholic | Mobile money/credit transfer |
| 25 | Rayan Peter | 34 | male | Married | 02 | May 2023 | Biyem-assi | Catholic | Driver |
| 26 | Patrick Asaba | 32 | Male | Married | 03 | May 2023 | Maison blanche | Baptist | Nurse |
| 27 | Lucy Ndum | 41 | Male | Married | 04 | May 2023 | Maison blanche | Presbyterian | Secretary |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 28 | Christoper Nji | 33 | Male | Single | 04 | May 2023 | Acacia | Catholic | Security guard |
| 29 | Mathias Mbang | 47 | male | Married | 02 | May 2023 | Superette | Catholic | Insurer |
| 30 | Donatus Ngang | 45 | Male | Married | 06 | May 2023 | TKC | Catholic | Business |
| 31 | Hilary Chia | 34 | male | Single | 03 | May 2023 | Tam-Tam weekend | Catholic | Insurance agent |
| 32 | Rose Mary Bih | 35 | female | Married | 03 | May 2023 | Biyem-assi carrefour | Protestant | Business |
| 33 | Jacqueline Akoni | 35 | Female | Single | 04 | May 2023 | TKC | Presbyterian | Business |
| 34 | Nelson Akang | 42 | Male | Married | 03 | May 2023 | Biyem-assi | Catholic | Ministry |
| 35 | Yvonne Bih | 34 | Female | Single | 03 | May 2023 | Round point express | Catholic | CAMTEL worker |
| 36 | Claudette amah | 38 | Female | Married | 03 | May 2023 | Acacia | Catholic | Nurse |
| 37 | Martha Fuka | 38 | female | Married | 03 | May 2023 | Biyem-assi carrefour | Baptist | House wife |
| 38 | Peter Fuoh | 40 | male | Married | 04 | May 2023 | TKC | Protestant | Insurance agent |
| 39 | James Ching | 37 | Male | Single | 02 | May 2023 | Tam-Tam weekend | Presbyterian | Business |
| 40 | Kiya imam | 39 | Male | Married | 03 | May 2023 | Tam-Tam weekend | Catholic | Famer |
| 41 | Cletus chia Neba | 32 | male | Single | 03 | May 2023 | Acacia | Catholic | Business |
| 42 | Stephen Sama | 33 | male | Married | 04 | May 2023 | Tam-Tam weekend | Catholic | Hurker |
| 43 | Clement ndi | 43 | male | Married | 04 | May 2023 | Biyem-assi | Catholic | Business |
| 44 | Roland mbanga | 35 | Male | Married | 04 | May 2023 | Acacia | Catholic | Insurance agent |
| 45 | Evaristus Chia | 35 | male | married | 03 | May 2023 | Biyem-assi | Catholic | Insurance agency manager |
| 46 | Hilary Ngochia | 42 | Male | Married | 05 | May 2023 | Acacia | Presbyterian | Business |
| 47 | Maxwell asang | 44 | Male | Single | 04 | May 2023 | Jauvance | Protestant | Builder |
| 48 | Arianne neng | 37 | Male | Married | 02 | May 2023 | TKC | Presbyterian | CAMTEL worker |
| 49 | Yve Minang | 43 | Male | Married | 04 | May 2023 | Maison blanche | Catholic | Worker |
| 50 | Jean alette | 34 | male | Married | 03 | May 2023 | TKC | Catholic | Farmer |
| 51 | Fabian Muteh | 42 | Male | Single | 04 | May 2023 | Acacia | Catholic | Builder |
| 52 | Henry Ngang | 43 | Male | Married | 03 | May 2023 | Biyem-assi round point | Catholic | Tomato seller |
| 53 | Alexandra Tita | 28 | Female | Single | 03 | May 2023 | TKC | Catholic | Secretary |
| 54 | Fred Atanga | 42 | male | Married | 05 | May 2023 | Tam-Tam weekend | Baptist | Nurse |
| 55 | Nixan Niba | 44 | Male | Married | 02 | May 2023 | TKC | Presbyterian | Hair dresser |
| 56 | Beatrice Tanga | 38 | Female | Married | 03 | May 2023 | Superette | Protestant | Business |
| 57 | Harriet Nachia | 36 | Female | Single | 02 | May 2023 | Maison blanche | Presbyterian | Farmer |

# APPENDIX

1. **INFORMED CONSENT FORM**
2. **INTERVIEW GUIDE**
3. **OBSERVATION GUIDE**
4. **Health Insurance Quotation**
5. **Health Insurance Questionnaire**

# INFORM CONSENT FORM

**TITLE OF STUDY: "PATTERNS OF HEALTH INSURANCE SCHEMES AMONG MEMBERS OF THE BIYEM -ASSI COMMUNITY IN YAOUNDE – CAMEROON: A CONTRIBUTION TO ANTHROPOLOGY OF DEVELOPMENT"**

**PRINCIPAL INVESTIGATOR**

**NAME: NGONG CLAURIS NDUM**

**DEPARTMENT: ANTHROPOLOGY**

**ADDRESS: YAOUNDE**

**PHONE NUMBER: 675 973 079**

EMAIL: ndum.clauris@zenitheinsurance.com

You are invited to take part in a study entitled "Parttens of health insurance schemes among the people of Biyem-assi in Yaounde – Cameroon". This is because you are directly involved as a member of this community, a head of household and or health practitioner and or insurance company staff, which are all elements constituted of the target population.

**INTRODUCTION;**

My names are NGONG CLAURIS NDUM a student of Anthropology in the University of Yaoundé 1. I am carrying out a study on "Parttens of health insurance schemes among members of the Biyem-assi community in Yaounde – Cameroon". While my sample populations are members of the Biyem-assi locality, I am going to give you information and then invite you to take part in this research. Your participation is voluntary. Please take as much time as possible to read the information sheet. You may also decide to discuss it with your family or friends before participating. You will be given a copy of this form which explains the purpose of the study/

We are asking you to take part in this study because we are researching on health insurance coverage, such an important elements in house hold's health care management among members of the community. Given its approved credibility, the study is out to analyse the mechanisms used by community members to finance health care which is a priority element in health care management among household members. We want to know how community member's perception of health insurance can influence the implementation of health insurance schemes in the community.

**PARTICIPANTS SELECTION**: We are inviting everyone especially heads of households, health practitioners and insurance company workers whom we dim to know more about the concept in practice, experience and need to participate in the study.

**VOLUNTARY PARTICIPATION:** Your participation in this research is entirely voluntary and your choices count to, you are not under any pressure to give information that you chose to keep confidential. Your participation or non-participation here shall not change your status in any way. So if there are benefits coming as a result of this study, you shall not be left out for any reason. If

you choose to or not to participate in this study, you will still maintain your social status in all ramifications. You may disrupt the interview and step out of the study at any point in time, and you shall not be held liable for any inconveniences that may come as a result of your absence.

**PROCEDURE:** We shall collect information from you with the use of a notebook, recorder and camera if possible. This study shall be carried out within a period of 2 weeks where information shall be from members of the community. We may come back for more precisions and explanations or verification of information collected from you. At the end of the exercise, this information known as data shall be analysed and interpreted to serve the purpose of our study.

**DESCRIPTION OF THE PROCESS:** During this research, we will keep an appointment on when and where to meet. At our meeting point, you shall be asked questions about the topic above from our interview guide. We may keep another appointment if we do not exhaust our interview guide during the first meeting.

**DURATION:** This research is an academic exercise and given the time constraint I have been authorized to spend at least two weeks on the field. So I will like our appointment to be kept in the earliest time possible.

**RISKS:** There are no anticipated risks to your participation. When you feel some discomfort at responding to some questions, please feel free to ask to skip the question.

**BENEFITS:** knowledge about the subject shared during the interview and discussion period shall be a lot beneficial especially to participants of the study. The overall goal is to understand community member's knowledge and attitudes towards health insurance coverage as a means to improve health care management in the household and to the community in the community at large.

**CONFIDENTIALITY:** Any information that is obtained in connection with this study and that can be identified with you shall remain confidential and shall only be disclosed by your permission or required by the law. The information collected about you shall be coded using a fake name (pseudonym) or initials and numbers for example ABC, 123. The information which has your identifiable information will be kept separately from the rest of your data. The data shall be stored in the investigator's office in a locked file or password protected computer. The data will be stored for about seven years after the study has been completed and then it will be destroyed. Your consent will be asked for audio recording and taping. The principal investigator will transcribe the tapes and may provide you with a copy of the transcription upon request. You have the right to review and edit the tape. Sentences that you ask the investigator to leave out will not be used and they will be erased from all irrelevant documents. When the results of the research are published or discussed in conferences, no information will be included that will reveal your identity. If photographs, video or audio tapes recordings of you will be used for educational purposes, your identity will be protected or disguised.

**SHARING OF RESULTS** knowledge that we get from this research shall be shared with you through academic meetings before it is widely available to the public. Confidential information will not be shared. We may publish the results in order that other interested people may learn from our research.

**RIGHT TO REFUSE OR WITHDRAW:** You can choose whether to be part of this study or not. If you volunteer to take part, you may withdraw at any time without any consequences of any kind. You may also refuse to answer to any question in the guide and still remain part of the study. The investigator may also decide to liberate you from this research if circumstances arise which absolutely require him to do so.

**ALTERNATIVE TO PARTICIPATE**: Your alternative to participate in this study is not to participate.

**RIGHTS OF RESEARCH SUBJECTS:** You may withdraw your consent at any time and discontinue without any penalties. You are not waving any legal claims, rights or remedies because of your participation in this study. If you have any questions about your rights as a study subject or you will like to speak with someone independent of the research theme to obtain answers to questions about the research or in the event, contact the office of head of department of Anthropology at the University of Yaounde 1.

**IDENTIFICATION OF INVESTIGATORS:** If you have questions or consent about the research, please feel free to contact the main investigator, Master's degree student of the Faculty of Arts, Letters and Social Sciences from the University of Yaounde 1, department of Anthropology, NGONG CLAURIS NDUM. CONSENT…… I have red and understood the provided information and have had the possibility to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, even without giving a reason and without course. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature _____ Date_____ Investigator's signature _____ Date _____

## INTERVIEW GUIDE

I am NGONG CLAURIS NDUM, a master degree student of medical Anthropology at the University of Yaoundé 1, carrying out a study on "Parttens of health insurance schemes among members of the Biyem-assi community in Yaounde: a contribution to Anthropology of Development. For me to get the appropriate information to make this study a success, I rely greatly on your participation and responses since you are directly or indirectly concerned with the study, as it targets heads of households, health insurance staffs and hospital staff. You are free to decide to work with me or not. Thank you for cooperating.

1) **DEMOGRAPHIC PROFILE OF INFORMANTS**

- Name of informant
- Age
- Marital status
- Number of children
- Religion
- Village of origin
- Level of education

1. Occupation
2. The main questions asked were; (i) Where do you normally go for hospitalization? (ii) Why do you go there? and (iii) What do you understand by better care?
3. Do you belong to any social group in your community?
4. If yes, what are the mechanisms used to finance health care?
5. Can you briefly explain how the procedure is carried out?
6. What are some of the advantages of health insurance coverage?
7. Do you know of any health insurance facilities operating in this community?
8. Can your health financing mechanisms encourage you to apply for the coverage?
9. What is the importance of health insurance coverage to access and use of health facilities?
10. Has your household ever applied for health insurance coverage?
11. Has your household ever benefited from health insurance coverage?
12. (YES OR NO) If yes, (8-15), if no ( go to 17)
13. How long?
14. How does health insurance work?
15. Are you a member of a voluntary health insurance organization?
16. If yes,
17. Why did you enroll in community-based insurance schemes? If no,
18. Where did you get the money to pay your healthcare bill?
19. Did you receive financial help from friends?
20. Why?
21. Did you receive financial help from family members?
22. Do family members have an obligation to provide financial support when you are sick?
23. Why?
24. How do you manage health care in your household?
25. In your opinion, what hinders the uptake of health insurance coverage?
26. How does lack of health insurance affect health care management in your home?
27. What do you propose should be done to ameliorate this situation?

28. What is ‘out of pocket payment’ on health care management?
29. How does ‘out of pocket payment’ affect healthcare in the household?
30. How does ‘out of pocket payment’ affect access and use of health services in the community
31. How can community members avoid out of pocket payment on Health care management?
32. In your opinion, do you prefer health insurance coverage or out of pocket payment for health care management in your household?
33. How can Health insurance coverage contributed to community development? Economically, Politically,Socially,Psychologically
34. Do you receive patients in your health facility with health insurance coverage?
35. yes/no,
36. If yes, how often?
37. Does your health unit work in connection with any insurance company?
38. If yes, how is the connection
39. How do you treat clients with health insurance files?
40. How does your hospital benefit from treating patients with health insurance file?
41. What are some of the difficulties faced in treating patients with health insurance coverage?
42. How does treating health insurance files benefit your hospital unit
43. Is your relationship with the insurance provider cordial?
44. If no, what exactly is the difficulty?
45. In your opinion, how can this be resolved?
46. Do you think health insurance coverage has improved access and use of facilities in your hospital unit?
47. In your opinion, how has health insurance coverage facilitated patients access and use of health facilities in your unite
48. Do you prefer treating patients with health insurance coverage or patients who pay out of pocket? What is the advantage and disadvantage of each over the other?
49. Do you receive requests for health insurance in your company?
50. Yes/no
51. If yes, is it usually for individual based plans or family based plan or employees based plan?
52. If no, what do you think is the reason?
53. Which of these plans is most likely to subscribe for health insurance coverage after a quote has been provided?
54. How do you treat health insurance files after subscription?
55. Do you work in collaboration with any health provider?
56. What are the terms of collaboration?
57. What does your insurance company benefit from collaborating with a health provider?

58. What are some of the difficulties faced by your company in collaborating with a health provider to treat health insurance files?
59. Is your relationship cordial?
60. If no, what exactly is the difficulty?
61. In your opinion, how can these be resolved?

**OBSERVATION GUIDE:**

62. Observing the activities of patients at the hospitals centers:
63. Handling of health insurance documents at the secretariat
64. Patients with health insurance coverage….their reaction to coinsurance
65. Patients without health insurance coverage…their reaction to huge OOPP
66. Admitted patients without health insurance coverage paying OOP
67. Activities of low income households patients in the face of catastrophic health care costs

# HEALTH INSURANCE QUESTIONNAIRE

## INFORMATION TO BE GIVEN FOR AN INSURANCE QUOTE

- Only the employees of a company or industry or corporate structure or members of a group or an association can benefit from this insurance and could be extended to their immediate family members.
- The health risk is a deficit risk, hence the subscription is subject to the placement of other risks such as (property, motor, group personal accident etc.) at zenithe

**1-Name and surname of the proposer/company name:** ----------
---

**Address:** ----------**P.O. Box:** ----------**Tel.** ----------
**Activities:** ----------

**2-Insured population: Number of adults _____ Number of Children _____**
**For companies**

| | **Directors and Managers** | **Operators** | **Other Agents** |
|---|---|---|---|
| **Employees** | | | |
| **Spouses** | | | |
| **Children** | | | |
| **Sub total** | | | |
| **TOTAL** | | | |

**3-Rate of coverage solicited:** 70 % 80% 90% 100%
**(Encircle your choice)**

**4-Sum Insured (maximum amount of coverage) per person/year in FCFA:**

500 000 – 1 000 000 – 2 000 000 - 3 000 000 – 5 000 000 – 10 000 000

**5-Territorial scope: i-)** Cameroon only--------**ii-)** Cameroon and France-----
**iii-)** Cameroun and abroad excluding Canada and USA---------- **(Tick your choice)**

**6-Medical Centers:** Public/General hospitals------- Public/General and private hospitals-------

**7- Extension of cover: i-)** Dental care--------**ii-)** Eye care-------- **iii-)** Medical Evacuation------ **v-)** personal accidents----------**v)** Funeral expenses----------

**8- Do you have a company doctor?** YES NO

**9-Have you previously had health insurance?** YES NO

- If yes, what year**?** ----------
- By which company? ----------
- Premium paid ----------
- Amount of reimbursements obtained ----------
---

**10-Do you have any Insurance contract with Zenithe Insurance SA? YES NO**
If yes which ones**?** ----------

Done at ……..on…….

**THE PROPOSER** **INTERMEDIARY/CUSTOMER RELATIONS OFFICER**

# HEALTH INSURANCE QUOTATION

YAOUNDE 7th Avril 2022

**VFS GLOBAL SARL**
**P.O Box: YAOUNDE**
**TEL: 672 434 820**

**BRANCH OFFICE: BRANCH OFFICE BASTOS YOAUNDE /KESAM**

O/Ref: ____/ZEN/ADG/DD/DDY//SDT/CNN /04-2022

**Subject: HEALTH INSURANCE PROPOSAL**

Following your request for a quote, we bring to you below, our best terms of coverage and premiums for health insurance coverage.

**OBJECTIVE:**

This contract guarantees the **payment/taking charge or reimbursement** by the insurer of cost incurred during the period of insurance in relation to hospitalization due to an ailment or accident, consultations fees, surgical expenses, pharmaceutical expenses, medical analysis, radiology.

## 1- SERVICE PROVISION TABLE:

| COVER | Key-Lettres | PUBLIC | PRIVATE |
|---|---|---|---|
| • Consultation by a General Practitioner | «C » | 1.000 | 10 000 |
| • Consultation by a specialist | « CS » | 3 500 | 15 000 |
| • Consultation by a Professor | « CP » | 5.000 | 15 000 |
| • Consultation at night, on Sundays or public holidays | « CN » | +1.000 | 10 000 |
| • Check-up by a General practitioner | « V » | 3.000 | 10 000 |
| • Check-up by a General practitioner at night, Sundays and public holidays | « V» | 2 500 | 15 000 |
| • Check-up by a specialist | « VS» | 3 500 | 15 000 |
| • Check-up by a General practitioner at night, Sundays and public holidays | « VS» | 4 500 | 20 000 |
| • Care administered by a nurse | « AMI » | 250 | 350 |
| • Care administered by a physiotherapist | « AMM » | 250 | 600 |
| • Surgery practiced by a medical doctor | « K » | 750 | 1 500 |
| • Current medical practice and minor surgery practiced by a medical doctor | « PC » | 500 | 1 000 |
| • Medical analysis practiced by a medical doctor or pharmacist | « B » | 180 | 260 |
| • Dental care | « D » | 750 | 1 500 |
| • Radiology | « R » | 600 | 1 000 |
| • Day of hospitalization | « J » | 8.000 | 15 000 |
| • HIV | **Following program of Public Hospitals** | | |

**2) COVERAGE LIMITS: 100%**

**3) SUMS INSURED ANNUALLY / PERSON: 2 000 000 FCFA/ year**

**5) ZONE OF COVERAGE: Cameroon only**

**6) GUARANTIES:**

- **Eye Glasses : 100 000FCFA/ per/ 2 years**
- **Dental Care : 100 000FCFA/ per/ 1 year**
- **Maternity :**
  - **Normal delivery: 80 000fcfa**
  - **Delivery by surgery: 100 000fcfa**
  - **Twin delivery: 150 000fcfa**

**7) BREAKDOWN OF HEALTH INSURANCE NET PREMIUM**

| GROUPS | **Designation** | **Net Premium** | Numbers | Total Nette Premium |
|---|---|---|---|---|
| Insureds | Base premium | 160 000 | 03 | 480 000 |
| | Dental care | 18 500 | | 55 500 |
| | Eyes glasses | 16 000 | | 48 000 |
| | Maternity | 5 000 | | 15 000 |
| **Total Nette Premium** | | **199 500** | | **598 500** |
| **Spouse** | Base premium | 160 000 | **03** | 480 000 |
| | Dental care | 18 500 | | 55 500 |
| | Eyes glasses | 16 000 | | 48 000 |
| | Maternity | 0 | | **0** |
| **Total Nette Premium** | | **199 500** | | **583 500** |
| **Children** | Base premium | 80 000 | 05 | 400 000 |
| | Dental care | 18 500 | | 92 500 |
| | Eyes glasses | 16 000 | | 80 000 |
| | maternity | 0 | | 0 |
| **Total Nette Premium** | | **114 500** | | **572 500** |

**7) GLOBALE NET PREMIUM**

| Désignation | TOTAL NET PREMUM |
|---|---|
| INSUREDS | 598 500 |
| SPOUSES | 583 500 |
| CHILDREN | 572 500 |
| TOTAL NET PREMIUM | 1 754 500 |

8) BREAKDOWN OF HEALTH INSURANCE TOTAL PREMIUM

| | |
|---|---|
| Total Nette Premium | 1 754 500 |
| Insurance fee | 25 000 |
| VAT (19, 25%) | 342 554 |
| PREMIUM INCLUDING TAXES | 2 122 054 |

While thanking you for your request and waiting to finalize the contract, Accept sir, our best regards

**FOR THE COMPANY**

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