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CONTRIBUTORY SOCIAL PROTECTION FOR THE INFORMAL ECONOMY?

Insights from Community-Based Health Insurance (CBHI) in Senegal and Tanzania

Boris Verbrugge, Adeline Ajuaye & Jan Van Ongevalle

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Introduction

Social protection occupies an important place on the international agenda. A growing number of low- and middle-income countries are in the midst of a 'quiet revolution', whereby they are integrating social protection into national development strategies (Barrientos & Hulme, 2009). This evolution is supported by international institutions like the World Bank and the ILO, who, in 2015, launched a global partnership for universal social protection (Zelenev, 2015). Yet in many of these countries, the achievement of universal social protection remains a massive challenge. According to the ILO (2017), only 29 percent of the global population enjoys access to comprehensive social protection, while the remaining 71 percent are not or only partially covered. In addition to being underfinanced and fragmented, existing systems of social protection continue to focus on those in formal employment, while excluding the majority that depends on the informal economy (Alfers et al., 2017). This coverage gap is highly worrisome, because people in the informal economy are disproportionately at risk from employment-related health- and income shocks (Chen, 2008).

Policy responses to this reality have mostly revolved around non-contributory social assistance schemes and cash transfers which are financed by government budgets, and typically target the most vulnerable social groups. Yet in addition to depending on the availability of government budgets, non-contributory schemes may be unpopular amongst the middle class (Martinez Franzoni & Sanchez-Ancochea, 2016), and cultivate an image of people in the informal economy as 'needy poor', instead of trying to mobilize their contributory capacity (Alfers et al., 2017).

Instead, this paper - which forms part of a broader research consortium that looks at domestic revenue mobilization - shifts attention towards the potential of contributory social protection mechanisms that mobilize resources from the informal economy. Specifically, we zoom in on community-based health insurance (CBHI): voluntary prepayment schemes for pooling health risks at the community level. While CBHI has rapidly gained popularity as an alternative mechanism for organizing and financing health care in low-and middle-income countries, CBHI-schemes continue to face important challenges when it comes to reaching out to their target population. For this reason, this paper attempts to address the following research question: *What strategies can CBHI-schemes adopt to improve revenue collection and recruitment in a context characterized by pervasive informality?*

This paper is divided into four chapters. Chapter one provides theoretical background on the challenge of social (health) protection in the informal economy, and presents an overview of selected research on CBHI. Chapter two presents case study evidence from Senegal and Tanzania, two countries where CBHI now plays an important role in national strategies for the extension of health coverage in the rural and informal economy. Chapter three discusses the challenges faced by CBHI-schemes in terms of revenue collection and recruitment, and looks at the strategies they develop to address these challenges. Finally, chapter four makes a number of empirically informed recommendations for external actors that aim to support the development of more sustainable CBHI-schemes.

1 | The challenge of social (health) protection in the informal economy

Box 1: Key takeaways from chapter 1

- Social health protection in developing countries tends to overlook the needs and concerns of those in the informal economy. This creates important barriers on the road to UHC.
- CBHI is one possible mechanism that can help close this coverage gap. However, CBHI-schemes continue to face important challenges when it comes to reaching out to their target population (i.e., the rural poor and informal workers).
- Participation in CBHI is determined by a wide range of factors that play out at different levels. Many of these factors lie beyond the immediate control of those in charge of CBHI-schemes. Instead, this paper focuses on two important albeit understudied factors that can be controlled: revenue collection and recruitment strategies.

1.1 The Coverage Gap in Social Health Protection

One of the key priorities on the emerging global agenda of social protection is universal health coverage (UHC): a situation wherein "all individuals and communities receive the health services they need without suffering financial hardship"[1]. To increase health care coverage, governments typically rely on (any combination of) three strategies (Gottret & Schieber, 2006): develop centrally managed and tax-financed national health care systems; set up social health insurance (SHI) systems that pool contributions from different stakeholders (which typically include workers and their employers); or promote private health insurance. Each of these strategies has advantages and drawbacks, and can contribute to the overarching aim of increasing health coverage.

Yet in low- and middle-income countries with weak fiscal and administrative capacities, none of these strategies offers a quick fix. Instead, existing systems of social health protection are often underfinanced and cover only a limited number of risks. Moreover, they target only a small part of the population that is active in the civil service or in the (mostly urbanized) formal economy, while excluding the overwhelming majority of people that depend on the informal economy (Alfers et al., 2017). Insofar as people in the informal economy have access to health care, they usually depend on costly user fees, a situation that has dramatic effects on their utilization of care (Lagarde & Palmer, 2008). Before proceeding with a discussion of challenges and potential policy responses, we first need to discuss some of the key characteristics of the informal economy.

1.2 Whither the informal economy?

For a long time, the informal economy was seen as a marginal phenomenon; as a remnant of traditional societies that was bound to disappear with economic progress. It was only in the 1970s that anthropological research in sub-Saharan Africa revealed that the informal economy was not only remarkably resilient, but also much more dynamic than widely assumed[2]. In subsequent decades, rather than a unilinear evolution towards a more formalized economy, numerous countries underwent a process of informalization (Meagher, 1995). More precisely, in response to economic crisis and skyrocketing unemployment - caused at least in part by the structural adjustment reforms

1 See http://www.who.int/mediacentre/factsheets/fs395/en/.

2 For a concise yet informative overview of existing debates on the informal economy, see Chen, 2008.

that were championed by international lenders - a growing number of people started looking for opportunities outside the formal economy.

1.2.1 The size of the informal economy

For different reasons - including a lack of official data and definitional disagreements - measuring the informal economy is a gruesome task. Still, its importance cannot be overstated. According to the ILO's, nearly 70 percent of the global workforce (including those employed in agriculture) is now part of the informal economy (ILO, 2018). The importance of the informal economy varies across regions: while less than half of the workforce in Europe and Central Asia is now employed informally; in the Arab states, Africa, and Asia-Pacific this is a majority; while in Africa this figure reaches a staggering 85 percent. Over the years, the growth and persistence of the informal economy has attracted the attention of scholars from different disciplinary backgrounds. They have tried to make sense of, amongst others, the composition of the informal economy, the structural processes underlying its continued expansion, its implications for poverty and wellbeing, and the different options policymakers have to confront it. While an exhaustive review of this literature would lead us too far, a few important insights should nonetheless be retained for the purposes of this paper.

1.2.2 Definitional questions

The meaning of the informal economy has changed over time, and has been the subject of intense debates. Depending on the intellectual and ideological tradition, scholars and practitioners either adopt a narrower definition that emphasizes self-employment in small firms (e.g. the World Bank), or a broader definition that also includes wage employment in unprotected jobs (e.g. the ILO). We identify with the second option, by adopting the simple yet comprehensive definition of WIEGO[3], which defines the informal economy as "the diversified set of economic activities, enterprises, jobs, and workers that are not regulated or protected by the state." (WIEGO, 2017).

1.2.3 Diversity

For a long time, the informal economy was approached from a dualist perspective, which sees the economy as divided between a modern and mostly urban formal economy; and a traditional and mostly subsistence-oriented informal economy (Chen, 2008). In reality, the informal economy is extremely diverse, with activities ranging from mining and e-waste recycling, over various forms of agriculture, to commercial activities and a wide range of services. Moreover, while the informal economy is often associated with self-employed individuals, in many parts of the world informal wage employment is gradually becoming the norm, both in rural and in urban areas. Finally, the informal economy is not only a survival economy, but also offers opportunities for accumulation, particularly for those who have the capital to invest in high-earning activities (e.g. Verbrugge, 2014).

1.2.4 Precarity

While not all those involved in the informal economy are poor, and while informal work may carry advantages for some (such as increased flexibility), it also harbors important risks. On average, people in the informal economy are more exposed to employment-related health- and income risks than their counterparts in the formal economy (Chen, 2008). The position of women is especially precarious, because they tend to be over-represented in informal economic activities with below-average earnings and above-average risks.

3 WIEGO is a network of scholars and activists who work on the informal economy, mostly (but not exclusively) in developing countries.

1.2.5 Informality is not anarchy

Finally, it is important to emphasize that informality and a lack of formal social protection does not necessarily imply that people have no access to social protection whatsoever. Instead, in the absence of effective state regulation, social protection often becomes informalized itself, with informal institutions and social structures such as family networks, informal credit arrangements, mutual support schemes, religious associations, and informal business networks fulfilling key roles in the regulation of 'work and wellbeing' (Harriss-White, 2010).

1.3 Challenges and Policy Options

In short, given the precarious position of many people in the informal economy, there are good reasons to strive for their inclusion in social (health) protection systems. However, the sheer diversity and dynamism of the informal economy militate against easy, one-size-fits-all solutions. Based on the preceding discussion, we can already identify some of the more pressing challenges that policymakers face when attempting to extend social protection to the informal economy.

Box 2: The challenge of social protection in the informal economy

- People in the informal economy are unregistered, and often lack clear representation (e.g. in the form of labour unions) (Bonner & Spooner, 2011). This greatly increases transaction costs for identifying and monitoring the target population. Transaction costs can be increased further by the geographical dispersion and mobility of informal workers (Annaer et al., 2013).
- Due to low and irregular incomes, people in the informal economy are often unwilling or unable to contribute to social protection schemes that do not always meet their priority needs (van Ginneken, 1999).
- Due to the sheer diversity of informal activity, these priority needs vary substantially between different (categories of) people.
- In the case of informal wage employment, employers may be reluctant to cooperate, because they have an interest in persistent informality, and want to avoid the costs associated with social (health) protection (Chen, 2008).
- Finally, the existence of informal social protection mechanisms poses both opportunities and challenges. When trying to set up social (health) protection schemes for the informal economy, the way in which these interact with these informal mechanisms can be of crucial importance for their effectiveness.

Despite these challenges, a growing number of developing countries are undertaking careful steps to extend social health protection to the informal economy; often as part of a broader campaign aimed at achieving UHC. To do this, they can rely on (any combination of) different strategies (van Ginneken, 1999; 2003):

1. A first strategy is to adapt existing systems of social insurance so that they better reflect the needs and concerns of those in the informal economy. Yet in addition to problems of affordability, the legal and administrative overhaul of existing systems of social insurance poses various challenges.
2. A second strategy is to promote medical assistance schemes for vulnerable groups like informal workers. In recent years, a growing number of developing countries - especially in Latin America (Barrientos & Santibáñez, 2009) - have put in place non-contributory social (health) protection schemes. Yet in addition to depending upon the availability of fiscal resources, a one-sided reliance on non-contributory schemes risks overlooking the dynamism and contributory capacity of the informal economy, and cultivates an image of people in the informal economy as 'needy poor' (Alfers et al., 2017).
3. In an environment characterized by pervasive informality, limited fiscal space, and institutional weakness, a growing number of governments in low- and middle-income countries are experimenting with a third strategy: to promote and foster contributory CBHI.

1.4 CBHI: A golden bullet for the informal economy?

CBHI is a broad term, which covers a wide variety of schemes that vary substantially in size and scope. For this reason, CBHI is usually defined on the basis of a number of key characteristics.

Box 3: Key characteristics of Community-Based Health Insurance (CBHI)[4]

- CBHI is an autonomous prepayment scheme, whose primary purpose is to pool health risks and financial resources at the community level.
- This 'community' is seen as the primary vehicle for mobilizing, pooling and allocating financial resources for health care.
- CBHI is contributory, which means that it depends at least in part on contributions made by beneficiaries (typically a flat rate).
- With few exceptions, affiliation to CBHI is voluntary.
- CBHI operates on a non-profit basis, and instead refers to community values such as equity and solidarity. For this same reason, CBHI-schemes are typically managed by voluntary staff –although this trend was also encouraged by donors that were looking to minimize costs.

While proponents treat CBHI as an ideal instrument for reaching out to excluded groups, critics point out that the uptake of CBHI-schemes amongst the target population (i.e., the rural poor and informal workers) remains extremely low (Jakab & Krishnan, 2004; Ekman, 2004). Even in rare cases where CBHI-schemes do succeed in attracting a sizeable membership base, drop-out and the non-payment of membership premiums remain pervasive problems. Ultimately, these problems can undermine the sustainability of CBHI-schemes, because the risk pool and the resource base are simply too small.

A growing body of research has attempted to identify the factors that determine people's willingness and/or ability to participate (understood here broadly as to enroll and remain in CBHI-schemes, and to regularly pay premiums) in CBHI. In the remainder of this section, we provide a (non-exhaustive) review of this growing body of evidence[5]. Based on our own reading of this literature, the discussion is best structured along the lines of four (interconnected) levels of analysis: the individual/household level; the community level; the level of the CBHI-scheme/health care system, and the broader political context. The results of this review are summarized in figure 1.1.

1.4.1 Individual/household level

- While **demographic variables** such as age, gender, health status and household size do matter, evidence on their impact on participation in CBHI-schemes is mixed.
- Virtually all studies agree that **income** is a critical factor determining participation in CBHI. In general, wealthier people are more likely to participate than their poorer counterparts. Unsurprisingly, therefore, the height of premiums is also an important factor.
- **Education and financial literacy** also have an impact on people's decision to participate. In general, the better people understand the functioning of CBHI-schemes, the more likely they are to participate in them.

1.4.2 Community level

- **Cultural barriers** may discourage people from participating. In some environments, saving money for health shocks may be uncommon, or may even be seen to contribute to disease. Other possible barriers are related to perceptions about modern medicine as opposed to traditional medicine.
- The **prior existence of (informal) risk-sharing mechanisms** can facilitate the implementation of CBHI-schemes, because people are already familiar with the practice of risk-sharing, and because

4 This definition is based on Ekman, 2004 and the definition found on the website of the World Health Organization, see http://www.who.int/health_financing/topics/community-based-health-insurance/key-characteristics/en/

5 Key references include Carrin, 2003; Jakab & Krishnan, 2004; De Allegri et al., 2009; Defourny & Failon, 2011; Acharya et al., 2013; Boidin, 2014. Where deemed appropriate, we will still refer to specific authors.

they can provide an institutional entry point. On the other hand, the existence of other social protection mechanisms may make participation in CBHI obsolete (Jowett, 2003).

1.4.3 CBHI-scheme/health care system

- **Trust** in CBHI-schemes affects people's decision to participate. A first important factor determining trust is effective and transparent management. Another one is community involvement in CBHI-schemes and (perceptions of) local ownership.
- Another crucial set of factors is broadly related to **supply side-issues**, prime amongst which the benefits package that is being offered by CBHI-schemes, and the (perceived) quality of health care services. Here, a wide range of factors may come into play, including the state and proximity of health care infrastructure, the availability of specialized practitioners, waiting times, the availability of medicine, the mentality of medical staff, …
- Some authors pay attention to the question of **payment modalities**, i.e, how, when, and where premiums are collected[6]. In general, more flexible systems of revenue collection that are able to adapt to local realities are considered to be more appropriate than rigid, one-size-fits-all approaches. One important question is the extent to which CBHI-schemes can accommodate the irregularity of income flows, especially in rural environments where seasonal income variation is higher. We return to this question of payment modalities in more depth in our case studies.
- Finally, there is the question of **recruitment practices**. For one, overly complicated enrollment procedures may scare away potential members. There seems to be disagreement between different authors on the optimal unit of enrolment: while some are in favor of individual enrollment; others argue that households or even larger units (e.g. associations or even entire villages) should serve as units of enrollment. Another observation is that surprisingly little attention has been paid to actual recruitment strategies, and how CBHI-schemes reach out to their target population. The few authors that do discuss these strategies mostly refer to door-to-door recruitment as the most straightforward strategy for enrolling new members.

1.4.4 Political and institutional context

While most existing research on CBHI ends here, for the purposes of this paper we will add a fourth level of analysis, which all too often remains largely overlooked: the broader political and institutional context. One of the key findings that emerged from the first phase of this research project is that social protection it is not simply a technical or financial question, but also a profoundly political one (Vaes et al., 2017). Here, we discuss just some of the questions that arise when looking at the broader political context:

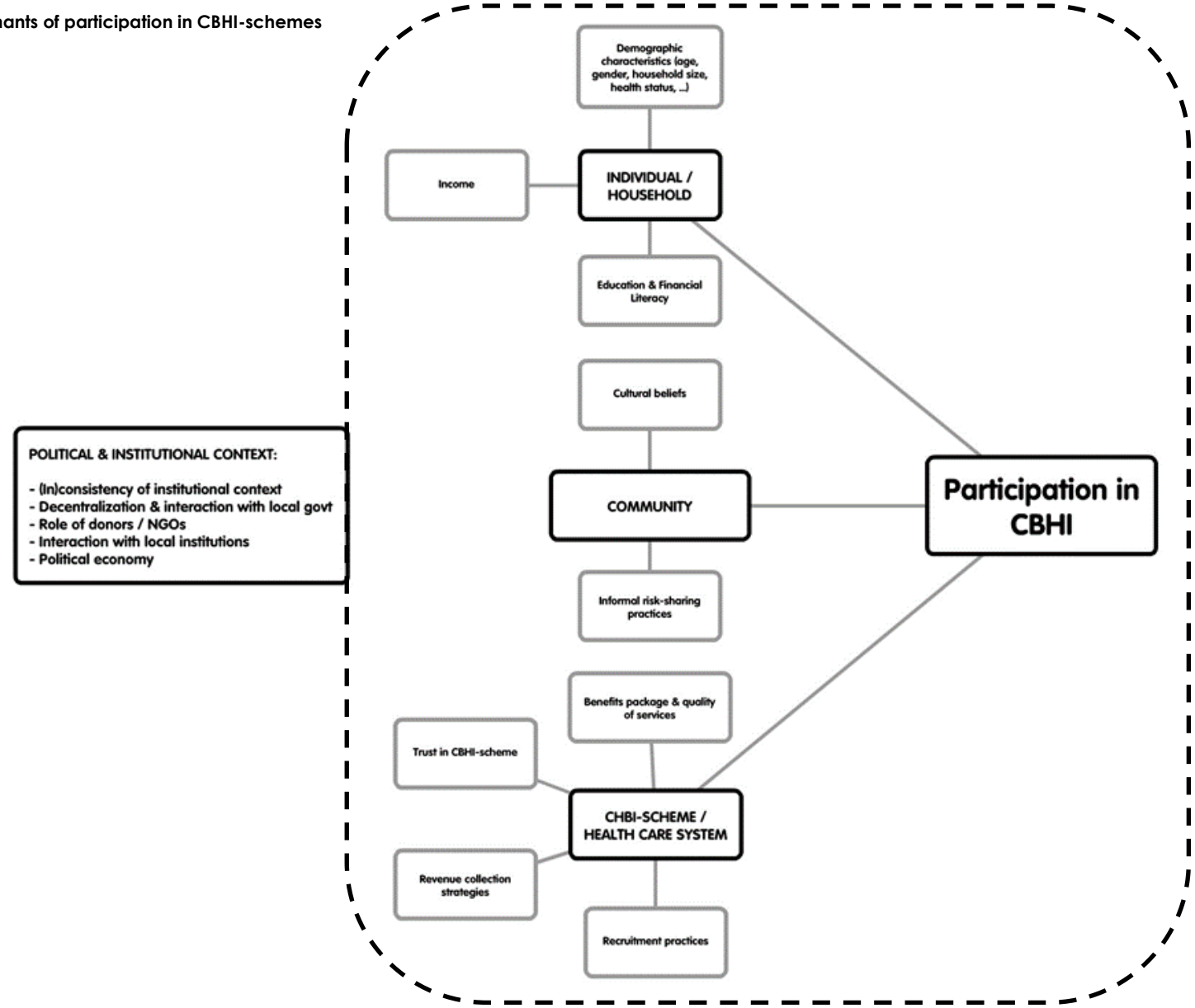
- a first set of questions relates to the **(in)consistency of legal frameworks and policies**. Social (health) protection in developing countries is often characterized by fragmentation. For example, according to Barrientos and Hulme (2009), social protection systems in sub-Saharan Africa are best described as "*a patchwork of colonial schemes and aid-financed social assistance programs (focused on humanitarian support), NGO initiatives and under-funded, fragmented and partially implemented social insurance institutions for civil servants.*" (446). Ideally, social protection follows an integrative approach that exploits complementarities-, and *"avoids opposition, duplication, and competition between different schemes"* (Schremmer et al., 2009: 27);
- this problem of fragmentation may be exacerbated by **decentralization**. According to Guanais and Macinko (2009), decentralization may lead to *"increased fragmentation of services, management practices that provide political or financial gains for local authorities, weakening of central ministries of health, and increased*

6 For an interesting discussion on premium collection in the case of (private) health insurance in developing countries, see McCord et al., 2006.

inequities in health care among regions" (1128). Moreover, it raises important questions with regards to the interaction between CBHI-schemes and local government structures;

- another factor that may lead to increased fragmentation is the **involvement of donors and other external actors (such as NGOs)**. As will be illustrated in chapter 4, external actors often have competing views on how to support social protection schemes such as CBHI, or may even be driven by institutional competition. Without questioning the benevolent intentions of these external actors, they often work alongside or even compete with each other (or with host governments), rather than working together towards a shared goal (Freedland, 2013);
- at the local level, there invariably exist a range of **other institutions** that operate with varying degrees of formal recognition, and fulfill vital functions in various domains of life. Important examples include agricultural- and credit cooperatives, women's groups, or religious associations. The way in which CBHI-schemes interact with these institutions can have a decisive impact on people's willingness to participate;
- finally, CBHI-schemes, like other social protection schemes, are part of a broader **political economy**, wherein different actors are engaged in a constant bargaining process over the distribution of (political) power and resources (Hickey, 2008). For this reason, any attempt to understand their functioning should also pay attention to how the creation and functioning of CBHI-schemes intersects with this bargaining process.

Figure 1.1 **Determinants of participation in CBHI-schemes**



2 | Evidence from Senegal and Tanzania

Box 4: Key takeaways from chapter 2

In both Senegal and Tanzania, CBHI no longer qualifies as a purely community-based scheme. Instead, national governments (together with external partners) are undertaking attempts to scale up CBHI, and to integrate it into the broader health care system. In Senegal, the DECAM is trying to streamline the work of local mutuelles, which have been brought together in an overarching institutional structure. Still, the mutuelles enjoy substantial autonomy, and the DECAM emphasizes the importance of local ownership. In Tanzania, on the other hand, the government is firmly in control of the CHF, and sees it not simply as a mechanism to expand health care coverage, but also - and arguably more importantly - as an instrument for domestic revenue mobilization.

In both countries, increased government involvement in CBHI has also led to the introduction of a non-contributory element, in the form of government subsidies that are meant to increase the viability and attractiveness of CBHI. Yet there are major problems with the payment of these subsidies, and CBHI-schemes are forced to rely on their own capacity to recruit members and collect their premiums.

In the following chapter, we will therefore take a closer look at the challenges that CBHI-schemes in Senegal and Tanzania are facing in terms of recruitment and revenue collection, and at the strategies they are using to address these challenges. Because many of these challenges are similar, we bring together evidence from both countries, rather than discussing each one separately.

2.1 Methodological note

One of the authors of this paper (Boris Verbrugge) conducted exploratory field research in Senegal in January 2018. 17 key informant interviews were conducted with various respondents, including government officials; civil society organizations in Belgium and Senegal; officials from 5 mutuelles de santé (4 in the region of Thiès and 1 in the region of Kaolack); officials from the regional union of mutuelles in Kaolack; and staff from the Union Départementale d'Assurance Maladie (UDAM) in the region of Foundiougne. Respondents and mutuelles were identified in collaboration with key resource persons inside Senegal. While the selection of mutuelles was influenced by logistical and practical concerns, we have tried to obtain at least some degree of variation in terms of geography (urban versus rural context) and history (older versus newer mutuelles). The decision to include the UDAM of Foundiougne was made during a meeting with staff from the Belgian Technical Corporation (now EnaBel), who suggested that the UDAMs harbor important lessons for donors.

The field research in Tanzania forms part of the ongoing PhD-research of Adeline Ajuaye, which deals with voluntary social security mechanisms for informal workers. The focus of the research lies on recent attempts to improve the operation of the Community Health Fund (CHF), the largest health insurance scheme for informal workers in Tanzania. Data were collected in two phases. During a first, exploratory phase, key informant interviews were conducted with national government officials (10); staff from international organizations (2), NGOs (4), and a trade union (1). Based on this first phase, two regions (Dodoma and Kilimanjaro) were selected for a second phase of research. During this second, more in-depth phase, the best and least performing districts of each region were studied using household surveys (N=669); focus group discussions with members and non-members (10); and key informant interviews with local health providers and government officials.

2.2 Senegal: The mutuelles de santé under the DECAM

2.2.1 Senegal at a glance: political and economic overview

Since its independence from former colonial power France in 1960, Senegal has enjoyed a fairly high degree of political stability. Despite 40 years of Socialist Party dominance (until 2000), it remained one of the most liberal countries in Sub-Saharan Africa. The election of opposition candidates Abdoulaye Wade (in 2000) and Macky Sall (in 2012) reinforced the country's status as one of the more advanced African democracies. Despite these democratic credentials, patron-client relations continue to play an important role in Senegalese politics (Beck, 2008), while religious institutions (particularly the muslim brotherhoods) exert significant influence over the outcomes of the electoral process (Gifford, 2016).

Since the 1970s, the Senegalese state has initiated different phases of decentralization, resulting in a gradual devolution of power to local governments (collectivités locales), prime amongst which the communes. These communes are presided over by elected mayors, who hold powers in various domains, including health care. However, decentralization has also contributed to a seemingly inconsiderate process of territorial fragmentation, and is not matched by the resources that would allow local governments to fulfill their tasks (Sané, 2016). Moreover, rather than contributing to increased accountability and transparency, in many localities local politics is now characterized by factional divisions between political networks knit together by kinship ties (Juul, 2006).

Economically, after decades of sluggish growth, the Senegalese economy has recently registered more impressive growth rates of around 6-7 percent (Houeninvo et al., 2017). The industrial (23% of GNP in 2016) and services sector (58% of GNP in 2016) contribute most to Senegal's GNP, followed by the agricultural sector (19% of GNP in 2016). Still, nearly four fifths of the population is employed in agriculture, which makes the country extremely vulnerable for external shocks such as climatic disasters and market fluctuations. Moreover, these macroeconomic data conceal that 80-90 percent of the population is currently employed in the informal economy (Benjamin et al., 2012). According to the latest official survey (2011), almost half of the Senegalese population lives in poverty, and economic inequality remains extremely high.

In an attempt to address these challenges, in 2014 president Macky Sall adopted an ambitious national development strategy, the Plan Sénégal Émergent, which seeks to earn Senegal the status of emerging economy. In addition to a series of structural economic reforms and measures to strengthen the country's institutions, the PSE has an elaborate human development dimension, which includes a commitment to achieving UHC.

2.2.2 Overview of the Senegalese health care system

In line with the situation in many other developing countries, Senegal has a very fragmented health care system that consists of a plethora of mandatory and voluntary insurance schemes, and various medical assistance schemes that target different groups[7].

- The Senegalese health care system has long revolved around employer-based mandatory health insurance. Health care costs of civil servants are covered by the general government budget, whereas private sector employees are covered by Social Health Insurance Institutions overseen by the ministry of labour. Retired civil servants and retired private sector employees are covered by IPRES, a pension fund. In addition to facing structural financial problems, these mandatory schemes provide only limited protection. Moreover, they cover less than 20 percent of the

7 The following overview of the health care system is based mainly on the strategic plan for universal health care in Senegal (Ministère de la santé et de l'action sociale, 2013).

Senegalese population, and exclude the majority of households that depend on the informal economy.

- Over the years, the Senegalese state has created a system of medical assistance, which includes a selection of free health care services (gratuités) and special provisions for low-income groups. While this system of subsidized medical assistance has improved access to health care, it is limited in scope, and similarly faces a number of financial and administrative challenges.
- Finally, Senegal has an elaborate system of voluntary and contributory CBHI, which is centered around mutual health organizations (mutuelles de santé). While the history of the mutuelles can be traced back to the mid-1980s, it was only with the election of president Macky Sall (in 2012), and the government's subsequent push for UHC, that they started to play a more prominent role in the Senegalese health care system (Mbengue et al., 2014).

2.2.3 Towards UHC through the DECAM

During his inaugural speech in April 2012, president Sall launched an ambitious plan to achieve UHC, an ambition which was reiterated in the Plan Sénégal Émergent. Specifically, the president pledged to increase health care coverage from 20 percent in 2012, to 75 percent in 2017. Acting on these promises, in September 2013 the ministry of health and social action adopted a strategic plan for achieving UHC, which devoted central attention to the inclusion of the informal and rural economy. Specifically, the plan had three strategic objectives: (1) Reform mandatory health insurance for the private sector; (2) expand existing- and create new medical assistance schemes; and (3) strengthen the role of the mutuelles, as the primary vehicle for extending coverage to the informal and rural economy. In 2015, an agency was created (the Agence de la Couverture Maladie Universelle or agence CMU) with the specific purpose of assisting the government in its efforts to achieve UHC. Furthermore, the ministry of health and social action has initiated the DECAM project (Décentralisation et Assurance Maladie), which has the aim of reinforcing the mutuelles through a combination of institutional engineering and subsidization. With the DECAM, the Senegalese government made a clear choice for a model based on voluntary and contributory CBHI, as the primary mechanism for extending social health protection to the informal economy.

Before proceeding with a discussion of the major institutional and financial tenets of the DECAM, it is important to note that the DECAM was accompanied by efforts to improve the performance and quality of health care services. While no documents could be identified that provide a clear overview of these efforts to improve health care services, some indications can be found in existing policy documents[8]. Between 2006 and 2013, the health care budget was raised by 60 percent (UNICEF, 2016[9]), with a particularly strong increase in 2012, when President Macky Sall came to power. These government efforts to improve health care services were also helped by donor programs, such as the USAID 2010-2016 health project, which has a budget of about 300 million USD[10]. Yet overall, the impact of these efforts to improve health care services remains limited, which also affects efforts to develop the mutuelles de santé. Notably, Seck et al. (2017) note that the overall increase in the number of mutuelles is being hampered by poor levels of improvement in terms of health care quality.

2.2.3.1 Institutional architechture

Under the new set-up, every commune in the country was supposed to establish a mutuelle. This establishment is taking place in different phases (demonstration, expansion, and consolidation) between 2012 and 2022, and is undertaken in close collaboration with USAID and Abt Associates, a

8 http://www.sante.gouv.sn/sites/default/files/lpsdsante.pdf
9 https://www.unicef.org/senegal/french/ANALYSE.pdf
10 https://www.usaid.gov/sites/default/files/documents/1860/USAID%20Senegal%20Health%20Redacted%20PAD%20DRAFT%2011-August-2015%20%28FRENCH%29%20final.pdf

consulting firm. As of late 2017, a total of 676 mutuelles were established throughout the country, although many were still in the early phases of implementation[11]. It is important to note that the history of the mutuelles did not start under the current government, and that some regions (notably Thiès) already have a decades-long experience with mutuelles de santé. Different respondents indicated that it is important to distinguish between older (those created before the DECAM) and newer mutuelles (those established after the DECAM, usually with the help of Abt Associates and donors such as USAID and JICA). While the former are seen as truly community-based initiatives, the latter are perceived by many respondents as artificial institutions that were created in a top-down manner.

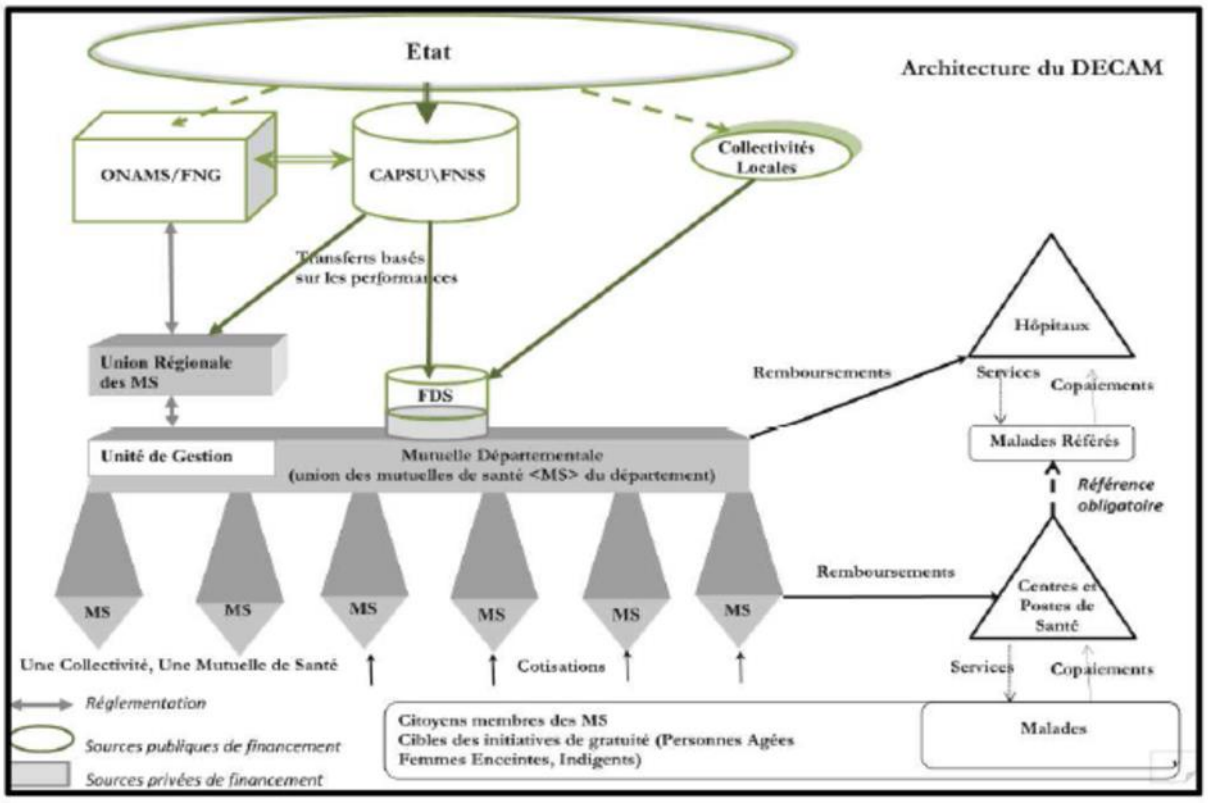
The main responsibilities of the mutuelles are the recruitment and registration of beneficiaries, the collection of contributions, negotiating with local health care providers, and the payment of beneficiaries' health care costs. They have a structure designed to guarantee transparent and inclusive management, which includes a general assembly, an administrative council, an executive council (with a president, secretary, and treasurer), and a monitoring council[12]. In addition, many mutuelles have one or more gérant(e)s who are responsible for the day-to-day management. In principle, all people involved in running a mutuelle are non-salaried volontaires. Since the DECAM, the mutuelles are supported by a technical assistance unit at the departmental level, and are grouped into departmental unions, regional unions, and a national union, each with a number of specific tasks.

With this complex institutional architecture (see figure 2.1), the DECAM mimics the institutional architecture of the Senegalese state. As stated in the strategic plan for achieving UHC, the DECAM aims for a positive interaction between the mutuelles and local governments, who are said to "offer an institutional framework, experience in local development, the potential to mobilize local actors, and a structure which constitutes an important social asset for rapidly implementing the mutuelles". (Ministère de la santé et de l'action sociale, 2013: 19). Yet given the different problems with decentralization, important questions can be raised with regards to this purportedly positive interaction.

11 Interview with director of Agence CMU, January 22, 2018.

12 It is important to note that the West African Economic and Monetary Union (UEMOA) has adopted binding regulation (Reglement N°07/2009/CM/UEMOA) covering the regulatory aspects of mutuelles. This includes a blueprint for the organization and functioning of mutuelles, which was later transformed into national law (see http://www.droit-afrique.com/upload/doc/uemoa/UEMOA-Reglement-2009-07-mutualite-sociale.pdf)

Figure 2.1 The institutional architecture of the DECAM



Source Ministère de la santé et de l'action sociale, 2013: 22

2.2.3.2 Financing modalities

In addition to this complex institutional architecture, the DECAM put in place an equally complex financing system. Most importantly, it introduced a non-contributory element, with the government committing to subsidizing half of beneficiaries' premiums, which amount to a total of 7500 CFA (around USD 13) per head per year. In return for paying these premiums and the price of a moderator ticket (at the point of service delivery), beneficiaries gain access to a range of basic- and complimentary health services, provided respectively at local health care centers and hospitals. In addition, the Senegalese government has created specific mechanisms to subsidize the inclusion of target groups such as school pupils (who now pay 1000 CFA or USD 1.9 per head per year), and households entitled to a Bourse de Sécurité Familiale or BSF (fully subsidized), a social assistance scheme designed to eradicate the worst forms of poverty and exclusion.

As a consequence of these subsidization policies, the mutuelles now distinguish between two types of beneficiaries. On the one hand, there are classic beneficiaries who are expected to pay an annual premium of 3500 CFA (USD 6.5) per head per year (which is matched by government subsidies). On the other hand, there are heavily subsidized beneficiaries like pupils and BSF. For many mutuelles, these subsidized beneficiaries now constitute an important share of their membership base, and after the introduction of the subsidies some mutuelles have even stopped recruiting beneficiaries altogether. Yet during the field research, it became abundantly clear that there are major problems with the payment of government subsidies, and many mutuelles are now forced to rely exclusively on premiums paid by classic beneficiaries, a situation which poses obvious threats to their financial sustainability.

2.2.4 The Union départementale d'Assurance Maladie (UDAM)

In addition to the mutuelles, Senegal has a second system of CBHI, which was launched more or less simultaneously with the DECAM: the Union Départementale d'Assurance Maladie (UDAM). There are currently two UDAMs that are operating in two departments (Koungheul and Foundiougne), and were set up as pilot projects by the Belgian Development Cooperation. It is important to note that until mid-2017, the UDAMs were heavily subsidized by the Belgian government.

The UDAMs differ from the mutuelles in several respects. Firstly, rather than relying (solely) on voluntary staff, they are managed by a team of full-time, salaried professionals. Secondly, the UDAMs are organized at the level of the department rather than the commune, which implies that they have a larger target population, and a (potentially) bigger resource base, than the mutuelles de santé. Thirdly, the initiative to create the UDAMs was accompanied by efforts on the part of the Belgian Development Cooperation to improve local health services. Yet in the end, the UDAMs can be seen as a scaled-up version of the mutuelles de santé, which are similarly entitled to government subsidies, and face similar challenges in terms of reaching out to their target population.

2.3 Tanzania: the Community Health Funds

2.3.1 Tanzania at a glance: political and economic indicators

Like Senegal, Tanzania enjoys a fairly high degree of political stability. From independence (1961) until the mid-1990s, it operated under one-party rule. The first democratic election (in 1995) was won by the ruling party (Chama Cha Mapinduzi or CCM), and while the country has seen the emergence of a vibrant opposition, no other party has so far managed to take over the government (Anyimadu, 2016). Moreover, the current government is faced with mounting criticism for its increasingly oppressive stance vis-à-vis civil society and the political opposition (The Economist, March 17 2018).

Since independence, local governments have been established, abolished and re-established. The most recent phase of decentralization started in the 1990s with Local Government Reform Program. With this program, several competences including health, water and education were transferred to Local Government Authorities (District Councils). Yet in practice, the central government and the ruling party (CCM) continue to run the show, as illustrated by the fact that district officials are appointed by the President.

The country's economic history was long dominated by ujamaa, the socialist ideology embraced by the first elected president, Julius Nyerere. With the Arusha declaration of 1967, the Tanzanian government nationalized all means of production. In addition, people enjoyed access to free social services such as education and health care. Yet the ujamaa failed to deliver on its promises: public enterprises became increasingly inefficient; corruption and clientelism were rampant; and there was an over-reliance on government subsidies. By the late 1970s and early 1980s, the country faced a severe crisis (Ngowi, 2009). In the late 1980s, Tanzania embarked upon a liberalization process, allowing individuals to set up a business, and privatizing public enterprises. Today, Tanzania has a market economy, with price control interventions in selected goods and services. The agenda of the current government, which was elected in 2015 and is headed by President John Magufuli, is dominated by the fight against corruption, and by attempts to increase efficiency in the public sector. In addition, the government is trying to redirect public resources towards social protection, by reducing recurrent expenditure, and by increasing domestic revenue collection.

Over the past ten years, economic growth has averaged 7%, making Tanzania one of the fastest-growing African economies. Leading sectors (in terms of contribution to the GDP) are services (42%), agriculture (31%) and industry/construction (27%). Despite this impressive macro-economic performance, over 90% of Tanzanians are employed in the informal economy, 66.3% of them being agricultural workers (NBS, 2014; NBS, 2017; World Bank, 2017). Moreover, massive challenges

remain in the field of human development: the 2016 Human Development report ranks Tanzania 151st of 188 countries, and about 46.6% of the county's' population live below the poverty line.

2.3.2 Overview of the Tanzanian health care system

Since independence, the health care system has undergone important changes, in line with the changing socio-political and economic context. Under the Ujamaa, medical services were provided through a centralized system that provided free health care for everyone (Mpabije, 2017). Yet by the 1980s, the health care system was facing important challenges, with a lack of resources leading to shortages in medical equipment and medicine, lower wages for medical personnel, and lower staff morale (Mujinja and Kida, 2014). In the 1990s the government introduced major reforms, in an attempt to mobilize additional resources and improve access to health care (Boex et. al., 2015). These reforms focused primarily on financial reforms, such as the introduction of cost-sharing (through user fees) and pre-payments (Mpambije, 2017, Stoarmer et al., 2011). The introduction of user fees led to a significant drop in the utilization of health care (Laterveer et.al., 2004). In addition, under the broad banner of health insurance, the government also created three public insurance schemes, which target different population groups (see table 2.1). In addition, several private health insurance companies, micro-insurance schemes, and mutual health organisations have also started operating throughout the country.

Table 2.1 Overview of public health insurance schemes in Tanzania

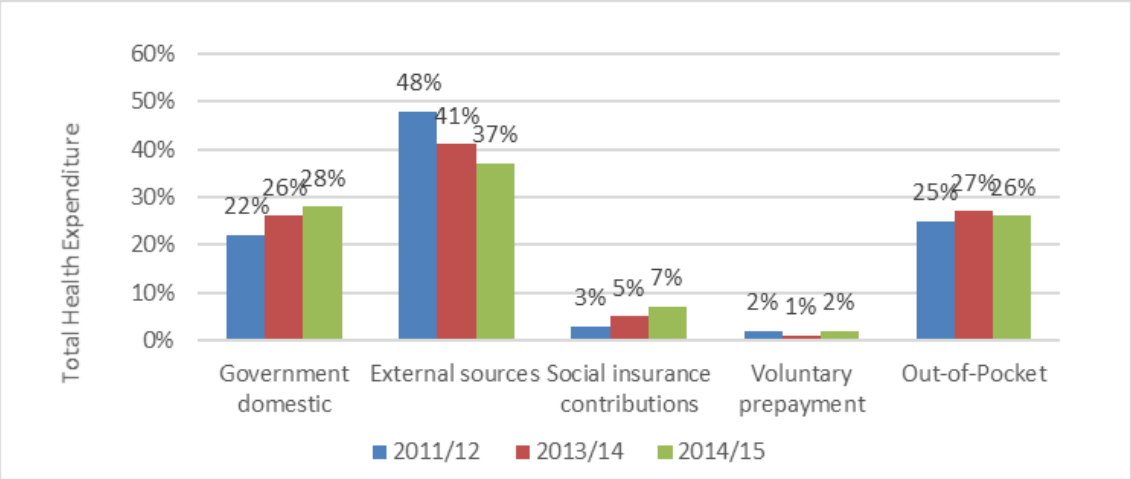
Insurance scheme	Year	Eligibility	Contributions	Benefit package
The National health insurance (NHIF)	Introduced in 1999; operational in 2001	Mandatory for public employees, covers up to 5 dependents. Also different options for private sector and informal workers	6% of gross salary per month; Both employee and employer contribute 3%.	Comprehensive- In-patient and out-patient care from public and accredited private facilities & pharmacies.
Social Health Insurance Benefit (SHIB)	Introduced in 1997; operational in 2005	Mandatory for Beneficiaries of the National Social Security Fund (NSSF), which is a national social security scheme for private and parastatal employees. Covers up to 5 dependents	NSSF members contribute 20% of their gross salary, split between employer and employee	Out-patient and in-patient care up to TZS 80,000 (40 USD) per case at selected facilities. Members have to sign up in order to receive benefits.
Community Health Fund (CHF)	Introduced 1995; operational in 1996	Voluntary, was designed specifically for informal workers. Household enrolment for a couple and 4 children under the age of 18	Range from TZS 5,000-30,000 (3-15 USD) per year per household	Primary health care at primary public facilities and private facilities in some districts. Limited referral care and hospitalization in some districts

Source Adapted from Kuwawenaruwa and Borghi (2012)

Despite these reforms, the CHF remains beset by important challenges:

- a first set of challenges relates to **revenue mobilization**. While the government spends approximately ten percent of its budget on health care, this has not been enough to cover even half of total health expenditure (URT, 2015b). Instead, health financing continues to rely heavily on donor funding and user fees. Overall, the role of social insurance contributions in health care financing remains very limited. Nonetheless, recent trends suggest a declining importance of external (donor) funding, and a growing importance of domestic revenues (see figure 2.2);
- a second set of challenges is related to the **fragmentation of the health care system**. There now exist a wide range of health care schemes that are financed from different funding streams (both domestic and external), that operate alongside- or even compete with each other. This fragmentation results in cost-inefficiency, and makes the overall coordination of the health care system extremely difficult (URT, 2015);
- a third set of challenges is related to **inequities in access to health care services**. While the introduction of health insurance in the late 1990s has increased access to health care - which had fallen to dramatic levels after the introduction of user fees - for formal workers, less than five percent of those in the informal economy currently have health insurance (Kuwawenaruwa and Borghi 2012; NBS and ICF International, 2016). Instead, informal workers often rely on costly user fees, or on micro-insurance schemes that offer only limited benefits.

Figure 2.2 **Health financing sources as % of total health expenditure**



Source National Health Accounts (2016)

In its Health Financing Strategy 2016-2025, the government proposed several changes to address these challenges. Prime amongst these proposed changes is the introduction of a Single National Health Insurance (SNHI) that would be financed by domestic resources, collected in the form of mandatory contributions by all Tanzanian citizens. While the idea of a unified SNHI is now high on the political agenda, it is fraught with controversy, and it remains to be seen whether it will ever be translated into reality. In the meantime, the government of Tanzania is devoting a lot of attention to the improvement of the Community Health Fund or CHF, as the primary vehicle for extending social (health) protection to the informal economy.

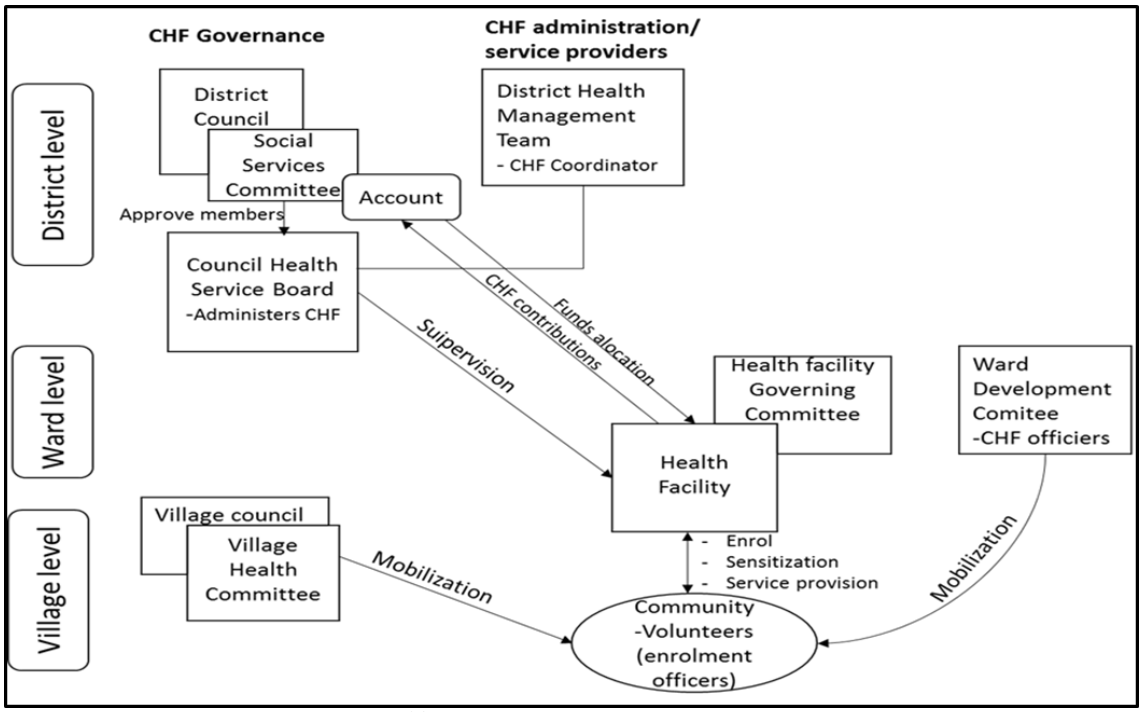
2.3.3 The Community Health Fund (CHF)

In 1995 the Tanzanian government, together with international partners, designed the CHF. Its primary objective was to eliminate user fees and improve access to health care through the mobilization of local revenues (URT, 2001). Implementation began in 1996 with pilots in a small number of districts, before the government enacted the CHF Act in 2001. Today, CHFs are operating in all districts of the country.

CHF is a contributory and voluntary scheme. Every household can participate by purchasing a health card at a flat rate, which varies across districts from 5,000 TSH (2.2 USD) to 30,000 TSH (13.2 USD) per household per year (maximum of 6 beneficiaries per household). Covered households are entitled to a basic package of curative and preventive health care services at primary facilities. In line with the situation in Senegal, the CHF has a non-contributory aspect, with the government matching premiums with government subsidies. The government has also put in place targeted subsidies for vulnerable population groups such as pregnant women, children below five, poor people, and theelderly. Yet like in Senegal, there are major problems with the payment of these subsidies.

Local governments play an important role in the organizational structure of the CHF (see figure 2.3), and the districts enjoy substantial autonomy in terms of designing and running a CHF. More precisely, the wards and villages have the responsibility to monitor CHF-operations, to mobilize and administrate funds, to set exemption criteria, and to promote CHF at the community level. At the district level, the CHF is regulated by Council by-laws through the Council Health Service Board and Council Health Management Team, which are coordinated by District Medical Officer (DMO). At the national level, the government provides policy guidelines and subsidies through the Ministry of Health. Key nodes within this complex organizational structure are CHF-officers and enrolment officers, who work together to sensitize the population about CHF. These enrolment officers are community volunteers that are selected by village councils, and are responsible for collecting household data and -premiums.

Figure 2.3 The organizational structure of the CHF



Source Adapted from Swiss Tropical and Public Health Institute (2010)

The CHF continues to face important challenges with regards to scheme uptake. By June 2016, the nationwide enrolment rate was just 9.2% (NHIF 2016). In an attempt to address this problem the government, together with external partners, launched a number of pilot projects to experiment with alternative forms of CHF. At the time of the field research, at least four such pilots were operating in five regions, under the broad banner of 'CHF iliyoboreshwa' or improved CHF. The key features of these improved CHF-schemes, and how they differ from the original ones, are summarized in table 2.2. During the budgetary session of the financial year 2017/18, the government announced that improved CHF would be extended to other regions. Yet it was not clear which of the 4 models the government was talking about. Interviews with the Director of Policy and Planning at the Ministry of finance, and with the National CHF-coordinator, seemed to indicate that the government was planning to develop a new model, based on the best practices of ongoing programs.

Table 2.2 Differences between standard (old) CHF and redesigned (improved) CHF

	Standard (old) CHF	Redesigned (Improved) CHF
Organizational structure	No separation between purchaser and provider of health care services. District councils play both the role of"provider" and "purchaser" of health services.	Reorganised structure that specifies the roles of purchaser (CHF) and health care provider (health facilities)[13]
Data management	Weak data management system. Data stored manually, usually in the form of counterbooks. One identity card given to head of household.	Reform of data management system: insurance management system with central server with online and offline modes. Each member receives individual membership card.
Recruitment	Passive enrolment strategy based on recruitment at health facilities.	Close-to-client strategy with village-level enrolment officers. Active community mobilization with marketing strategies.

Source Adapted from Kalolo et al., 2015

To understand the effectiveness and sustainability of these improved CHF-schemes, two pilots were selected as case studies. The first program (CHF iliyoboreshwa) is implemented in Central Tanzania (Dodoma) by the Health Promotion and System Strengthening Project (HPSS), with support from the Swiss Agency for Development and Cooperation (SDC). The second program (improved CHF or iCHF) is being implemented in Northern Tanzania (Kilimanjaro) by PharmAccess Tanzania, a Dutch NGO. The cases differ on three aspects: the inclusion of private health providers; premium prices and benefits package; and reimbursement mechanisms (see table 2.3). In Dodoma the improved CHF allows members to access primary care at any public facility within the region, while in Kilimanjaro members can only choose between two contracted facilities (a public and a private one) within the district.

13 In the original structure District councils were responsible for the implementation of CHFs as well as supervising the operation of health facilities, whereas Council Health Service Board represented both the interests of CHF members and health care providers. In the improved structure, CHF managers/coordinators represent the interest of the providers.

Table 2.3 Differences between the two CHF-pilots included in this study

	Improved CHF (CHF iliyoboreshwa) – Dodoma	Improved CHF (iCHF) – Kilimanjaro
Premium price	TSH 10,000 TSH (USD 5) per household (max. 6 members) per year	TSH 30,000 (USD 15) per household (a couple and a maximum of 4 children below the age of 18) per year
Benefits package	Primary health care at public facilities within the region. Once registered, members can access health care at any primary facility (dispensaries and health centers) in any district or region in which CHF iliyoboreshwa operates.	Primary health care with referral and hospitalization (up to 3 days) at two selected public and/or private facilities within the district. Members select one primary facility and one referral facility of their choice (public or private), that are contracted by the iCHF scheme.
Reimbursement mechanism	Claims: the District Council reimburse health care facilities following the submission of claim forms.	Capitation: Advance payment for prospective number of patients is made to the health care facilities by the National Health Insurance Fund (NHIF) regional office.
Ownership/Management	Owned and managed by the local government (district councils).	Owned by district councils; co-managed by NHIF (managing finances), PharmAccess (for technical support) and district councils (conduct awareness campaigns and appoint enrollment officers through village governments).

Source Key Informant Interviews with iCHF Program Director and HPSS Project Team Leader

3 | Revenue collection and recruitment: challenges and strategies

Box 5: Key takeaways from chapter 3

- CBHI-schemes are facing important challenges in the field of revenue collection and recruitment. These challenges are at least partly related to the diverse character of the rural and informal economy.
- Given this contextual complexity, it is important for CBHI-schemes to attain a certain degree of flexibility. Yet flexibility comes at a price, and is not easy to realize due to the limited scale and resources of most CBHI-schemes.
- CBHI does not operate in an institutional vacuum. Instead, the way in which CBHI-schemes interact with other local institutions can have a critical influence on their ability to reach out to the target population.
- Particularly in environments characterized by political decentralization, an engagement with local state officials presents CBHI-schemes with both opportunities and challenges.

In the last two decades, a number of studies have evaluated the experience of CBHI in Senegal[14] and Tanzania[15]. While most of these studies agree that CBHI can have positive effects on the utilization of care, important challenges remain with regards to the financial sustainability of CBHI-schemes, and their capacity to enroll and retain beneficiaries. While government efforts in Senegal and Tanzania to subsidize the inclusion of target groups have boosted membership rates, uptake amongst the target population remains low. In Senegal, with the notable exception of the UDAM of Foundiougne (which has a penetration rate of 29%[16]), only one of the mutuelles included in the research had succeeded in enrolling more than 10% of its target population. In Tanzania, as of June 2016, the nationwide enrolment rate in the CHF was just 9.2% (NHIF, 2016). Combined with the non-payment of government subsidies and problems associated with weak (local) government capacity, these low enrolment rates are posing existential threats to the long-term sustainability of CBHI-schemes. In the long run, the only way for CBHI-schemes to guarantee their sustainability is to recruit and retain new beneficiaries, and to collect their premiums on a regular basis.

In this section, we will therefore zoom in on the challenges facing CBHI-schemes in Senegal and Tanzania in the domains of recruitment and revenue collection. As we will see, these challenges overlap partly - but not completely - with those identified in box 1, where we discussed the challenges of extending social protection to the informal economy. Subsequently, we move on with a discussion of the strategies that CBHI-schemes can deploy to confront some of these challenges.

3.1 Challenges in the field of recruitment

3.1.1 Low and irregular income

In an environment characterized by pervasive poverty and seasonal variation in household income (due to, amongst others, the agricultural cycle), many people are unable or unwilling to pay premiums for CBHI. This was abundantly clear in Tanzania, where respectively 7 and 40 percent of surveyed households in Dodoma and Kilimanjaro regions were unable to afford just one or two meals per day.

14 See amongst others Jütting, 2004; Ouimet et al., 2007; Mladovsky, 2014; Seck et al., 2017

15 See amongst others Borghi et al., 2013; Duta, 2015; and Stoermer et al., 2011).

16 The penetration rate is the percentage of the target population that is enrolled in the mutuelle. This information was provided by the accountant of the UDAM of Foundiougne, during an interview on January 29, 2018.

Survey data in Tanzania also indicated a clear income disparity between urban and rural areas, with average incomes in rural areas being two times lower than in urban areas. On the other hand, Senegalese respondents repeatedly indicated that rich people tend to prefer private health care - which is perceived as providing better quality - over public health care services.

3.1.2 Diversity in the local economy

It was recognized by different respondents that particularly in (peri-)urban areas, the diversity of the local economy (which may include farmers, (petty) traders, artisans, professionals, …) was posing challenges for recruitment, because different target groups have different needs and priorities, and may therefore require a differentiated approach. One example are the '*bodaboda'* (motorcycle drivers) in Tanzania, who are convinced that the benefits package offered by the CHF is inadequate given the high-risk nature of their profession. As one motorcycle driver put it: *"It is useless to us, their benefits can only help us to see a doctor, no more. What if I get an accident and my leg got broken? I will have to pay. So why should I join such a scheme?"*[17]. At the same time, this citation indicates serious problems with the supply side (see below). Another example are pastoral people in Senegal, such as the Peul or the island dwellers of Foundiougne, who are seen as more difficult to recruit because they are both highly mobile and relatively poor.This may partly be related to prejudice, with pastoral people being widely seen as lazy and ineffective.

3.1.3 (Political) Geography

It was repeatedly indicated that people in remote (rural) areas are more difficult to recruit. In Senegal, whereas the target population of a mutuelle is typically the entire municipality, in reality most beneficiaries will often come from a smaller number of villages closer to the health care center. In addition to a higher poverty incidence, survey data in Tanzania indicate that the distance to health care infrastructure is one of the key reasons for non-enrolment or non-renewal of membership. As one respondent indicated: *"if you go to real remote areas, you will find that people don't care about health insurance at all, they would tell you that we are not sick, or will ask whether we would provide transport for them, but it is true, in some rural areas transport is of more concern than other health care costs"*[18]. In Senegal, several respondents also referred to cultural norms, and a lack of knowledge about health care services amongst the rural population. One Senegalese respondent provided a different albeit very interesting explanation for the under-representation of the rural population. More precisely, he argued that the exclusion of people from remote rural areas may be a product of historically rooted inequalities between different villages. In some communes, the center (often the bigger and more centrally located villages in a commune) has historically monopolized power and resources at the expense of the periphery (more remote villages)[19]. This is often reflected in the membership of the mutuelle: whereas the target population is often the entire municipality, in practice a mutuelle's membership is often confined to a number of villages. In this way, the establishment of a CBHI-scheme may intersect with local power struggles, and thereby impact on its ability to reach out to the target population.

3.1.4 People that do not meet enrollment criteria

In both Senegal and Tanzania, the household remains the primary unit of enrolment. In several cases, this created problems for people who are not part of an ordinary household. For example, single young men and women in Tanzania were found unwilling to contribute, because they have to pay the same rate as an entire household. "*I am single and I don't have children, my mother wanted to add me in her*

17 Informal discussion with motorcycle drivers, Dodoma.

18 Interview with community development officer in Dodoma, Tanzania, January 2018.

19 Interview with André Wade of Graim, January 23, 2018.

household because they are only three, but they refused while the requirement is six household members. They wanted me to have my own insurance and pay the same amount as a household. I can't do that, it does not make sense to me.'[20]

3.1.5 Gender issues

Especially in Senegal, men are considered more difficult to convince than women. This problem is at least partly related to a highly paternalistic culture, which treats caring as a female task. As one respondent put it: "Health care is a feminine thing. If you're ill, who do you need? Your mother, right?"[21] If households enroll, it is usually the initiative of women. The fact that many mutuelles in Senegal (particulary in Thiès and in Kaolack) were initiatied by women's organisations (Fonteneau et al., 2004) can partly explain why they are more inclined to enroll compared to their male counterparts. This observation is confirmed by other studies (Chankova et al., 2008[22]) that confirm the higher propensity (when compared to other West-African countries) of female-headed Senegalese households to enrol in mutuelles.

3.1.6 (Perceived) supply-side problems

While affordability is an important issue determining people's decision to enrol for the first time, survey data in Tanzania indicate that the challenge of drop-out is chiefly related to supply-side issues, such as a (perceived) lack of high-quality health care services, and a failure of CHF-schemes to meet the expectations of beneficiaries. Respondents from both of the improved CHF-schemes that were included in the study reported that the benefits package still did not meet their health care needs. Instead, many respondents referred to more convenient alternatives such as traditional medicines, private diagnostic centres (laboratories), and pharmacies. Other problems were related to the unavailability of basic medicine., and the existence of competing insurance schemes that may be perceived as more attractive than CBHI. For example, the National Health insurance NHIF has designed another scheme specifically for informal workers, which has been marketed alongside the CHF for the past two years. A similar situation can be observed in Senegal, where Seck et al. (2017) observed that negative perceptions of health care, as well as the distance to health care centers, were major factors affecting the decision to enroll and/or remain in the mutuelles.

3.2 Challenges in the field of revenue collection

In both Senegal and Tanzania, people involved in the management of CBHI-schemes indicated that revenue collection was posing important problems in a context marked by pervasive poverty. In both countries, members of CBHI-schemes are required to pay annual premiums, and most respondents agreed that this is is a significant challenge for cash-strapped households - even if contributions are relatively low. However, most respondents also agreed that a system based on annual payments is better than systems with a more frequent collection rate. In Senegal, the mutuelles that existed prior to the DECAM usually relied on a system of monthly contributions, which ranged from 150 to 250 CFA per month. This system of monthly contributions posed practical challenges for the mutuelles as well as their members, especially in rural areas where the distance to the collection center (often the seat of the mutuelle in the center of the commune) is much bigger. Under the new system that was introduced with the DECAM, beneficiaries are expected to contribute 3500 CFA per head per year. While this new revenue collection system may well restrict the flexibility of the mutuelles in terms of revenue collection, it also diminishes the administrative burden.

20 Young men during FGD in Kilimanjaro region.

21 Interview with president of mutuelle in Dara Mbosse, January 29, 2018

22 For more information see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2430720/

3.3 Strategies to confront these challenges

3.3.1 Traditional recruitment strategies adapted to local realities

All of the CHFs and mutuelles included in the research claimed to rely (to varying extents) on some form of proactive recruitment, which may include door-to-door campaigns, public meetings and discussions, and promotional convoys. In addition, both the UDAMs in Senegal and the CHFs in Tanzania also rely on more 'professional' recruitment practices, including the distribution of brochures and leaflets, or communication through (social) media outlets (see figure 3.1).

Figure 3.1 Picture used to promote the UDAM-system

Source https://www.enabel.be/nl/story/la-couverture-en-sante-un-droit-universel-0

Several respondents indicated that it is important to adjust these recruitment strategies to local realities. For example, in farming communities, recruitment is best scheduled in the afternoon, when people have returned from the field. Artisans, on the other hand, are best visited in their workplace. Finally, several respondents indicated that weekly markets offer important opportunities for recruitment. For this reason, the regional union of mutuelles in Kaolack (Senegal) was encouraging its members to set up market stalls (*guichets*) that serve as vehicles for recruitment, and possibly for revenue collection.

3.3.2 Professionalization

One of the key characteristics of CBHI-schemes is that they depend on voluntary and non-salaried staff. This poses clear limitations for what is possible in terms of recruitment and revenue collection strategies, because more sophisticated and more flexible strategies that are in tune with local realities

generally tend to be more time- and resource-consuming. It was a similar analysis that prompted the Belgian Technical Cooperation (now EnaBel) to build the UDAMs around professional structures[23]. In addition to being run by a team of professional, full-time employees at the departmental level, they also employ salaried collectors (*collecteurs*) that are 'locally rooted'[24], and are each responsible for 3 or 4 municipalities. Their primary tasks consist in recruiting new beneficiaries, cultivating their loyalty, and collecting their contributions. They have substantial autonomy to fulfill these tasks, and develop monthly schedules that are in tune with local needs and realities[25]. In addition, the collectors work together with a broad network of local contacts, which include the antennes locales, the délegués de village, local government authorities, and various local associations. Finally, their transportation costs are fully reimbursed, and they have motorcycles at their disposal, which means that they can adopt a more proactive approach to recruitment and revenue collection, which is closer to the people. At the same time it is important that the UDAM's more professional approach benefited from the handsome financial support of the Belgian Development Cooperation, which ended in mid-2017.

In line with the UDAMs, the CHFs in Tanzania also have a reasonably professional structure. Firstly, they are overseen by a manager who is responsible for coordinating the operations, increasing coverage, and ensuring the quality of health care services. Yet the extent to which CHF-managers are actually in control of the scheme varies considerably across areas: while in Dodoma, managers were intimately involved in coordinating CHF-operations and marketing the scheme, CHF-managers in Kilimanjaro were far less involved, and most CHF-activities were coordinated by Pharm Access (the supporting NGO) and the NHIF. Significantly, enrolment rates are higher in areas where CHF managers are more intimately involved in managing the CHF. In addition to their managers, the different CHF-schemes included in the research also relied on trained enrolment officers: members from the local community, who are selected by the village council, who are responsible for collecting data about (potential) members, recruiting them into the CHF, and collecting their contributions. As locals, they can identify the best opportunities for enrolment, and work together with local partners (e.g. local government officials, local associations). While these enrolment officers are supposed to be volunteers, in practice they receive a 10% commission for each contribution they collect.

While the Senegalese mutuelles are more constrained due to their smaller scale and the limited resources at their disposal, some are nonetheless taking small steps towards a more professionalized approach. For example, the mutuelle of Ngaye Mekhé is paying small compensations to its relais de village, and the mutuelle of Dara Mbosse was in the process of training its two gérantes as collectors, a task for which they would receive a (small) salary paid with the support of local government subsidies.

3.3.3 Deconcentration

The third strategy, deconcentration, was particularly apparent in Senegal, where both the mutuelles and the UDAMs have relinquished (partial) responsibility over revenue collection and/or recruitment in a designated geographical area (typically a neighborhood or a village) to a specific (group of) person(s) (see figure 3.2). By initiating such a process of decentralization, it is hoped that the CBHI-scheme advantage of deconcentration lies in the fact that it enhances the CBHI-scheme's reach, by bringing it closer to its target populationThese deconcentrated units vary in terms of institutional sophistication. In some cases it is simply a member of a mutuelle's administrative or executive council who is appointed as 'délégué de zone' or 'relais de quartier'. In other cases, more elaborate structures are put in place, which may even mimic the institutional structure of the mutuelle. A notable example are the 'bureaux de zone' established by the mutuelle of Diass. To varying extents, these deconcentrated units work together with local associations and local notables, such as village or

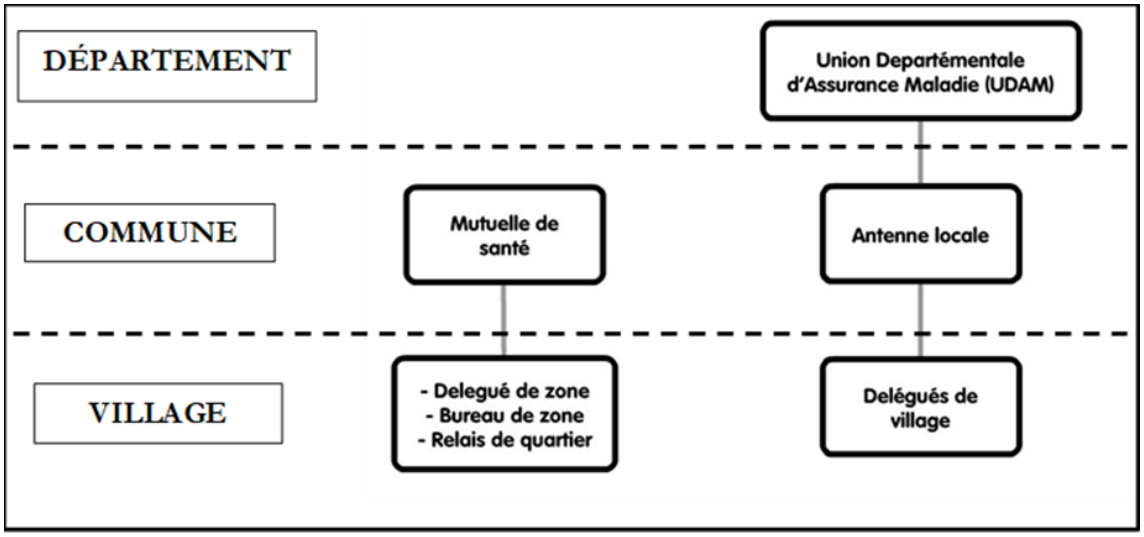
23 Interview with Enabel-staff in Brussels, December 19, 2017.

24 Interview with UDAM-accountant, January 29, 2018.

25 FGD with UDAM-collecteurs, January 29, 2018.

neighborhood leaders, or religious leaders (see below). By far the most sophisticated of these deconcentrated structures are the so-called 'antennes locales', which were created by the UDAM of Foundiougne. Organized at the level of each commune (remember that the UDAMs operate at the departmental level), these antennes are perhaps best described as a mutuelle 'light'. In fact, when the UDAM of Foundiougne was established, it absorbed several pre-existing mutuelles, transforming them into antennes locales. Yet when compared to the mutuelles, the autonomy of the antennes locales is very limited, and their tasks are limited to sensibilization and providing support to the UDAM- collectors. Significantly, the antennes locales in turn have elected délégues at the village level, who work closely together with village authorities.

Figure 3.2 Deconcentration in the mutuelles and the UDAMs



Source Own data

3.3.4 Flexible enrolment procedures

In both Senegal and Tanzania, CBHI-schemes are expected to adhere to fairly rigid enrolment procedures, which were introduced respectively with the DECAM and with the CHF-act. In both countries, the household remains the primary unit of enrollment. After enrolment, members have to observe a waiting period before they can enjoy their benefits. In cases where these procedures are effectively followed, they can become an important barrier to enrolment, particularly for people who do not belong to a traditional household (e.g. singles, widows, and migrant labour). In several of the CBHI-schemes included in the research, this problem was circumvented through the use of more flexible enrolment procedures.

One example is the mutuelle of Diass, which was attempting to recruit workers of large agribusiness firms. To accommodate these workers, most of whom are migrants without families, it offered the possibility of individual enrollment. Another example are CHF-schemes in the region of Kilimanjaro, which were enrolling small groups of widows or poor people as 'alternative households'. The CHF-scheme in Dodoma was even more flexible, and basically considered any group of six people eligible for enrolment. In Senegal, several of the mutuelles as well as the UDAMs in Senegal were even actively encouraging the enrolment of groups such as women's or worker's associations. There was widespread agreement that in addition to inflating membership numbers, group enrollment significantly reduced the administrative burden for CBHI-schemes. For the same reasons, the UDAMs are even experimenting with the enrolment of entire villages. One such village lies in the municipality of Toubacouta, where the village chief had donated one of his fields to his co-villagers.

This field is now being worked as a collective field (champs collectif), and the revenues from the harvest are used to pay for villagers' contributions.

In an attempt to convince more people to join, some district councils in Dodoma (Tanzania) have decided to eliminate the waiting period. Likewise, in Senegal, some of the mutuelles as well as the UDAMs are making 'special offers', such as reduced enrollment costs or the elimination of waiting periods, in an attempt to encourage groups of people to enroll. While there was widespread agreement that this is an effective strategy, it increases risks for adverse selection, i.e., the tendency for high-risk individuals to strategically enroll in health insurance.

3.3.5 Flexible payment modalities

As indicated earlier, rather than just waiting for people to come to a central revenue collection center, some CBHI-schemes now rely on more proactive revenue collection strategies that are closer to the people. In particular, it was discussed how both the UDAM, the CHF, as well as some of the mutuelles, now rely on collectors or (in the case of the CHF) enrolment officers. Several of the schemes included in the research were also allowing people to pay in smaller installments, until their premium is completed. In addition, several of the Senegalese mutuelles are accepting payments by mobile phone (orange money) which, for a growing number of people, is replacing a bank account as a repository of money.

In other instances, it is not the CBHI-scheme that organizes flexibility, but members themselves. A particularly interesting case was a women's association in Toubacouta (Senegal), which had set up a tontine de santé. This savings scheme, which is composed of 16 women, was designed with the specific purpose of helping households to save money to enroll in the UDAM. Specifically, each member is expected to contribute 1000 CFA (USD 1.9) per week, and at the end of the week a lottery is organized. The winner can enroll herself and 5 family members. It is important to note that this scheme is actively facilitated by the UDAM's collecteurs, who work closely together with the women's association, and will regularly visit the village in order to enroll the new beneficiaries.

3.3.6 Couplage: coupling healthcare and other services

A few of the Senegales mutuelles that were included in the research have started providing their members with services that are not (or not directly) related to health care - a practice referred to by one respondent as couplage[26] (coupling). One example is the mutuelle of Dara Mbosse: to confront the growing problem of drop-out, the mutuelle had started lending small amounts of money to loyal members, who can invest the money and repay it at a later point in time. Another example is the national confederation of Senegalese workers (CNTS) in Dakar, which was coupling its attempts to set up mutuelles de santé for informal workers with commercial trainings. This strategy was borne out of the realization that the target population is primarily composed of small vendors and traders, who are mainly interested in expanding their commercial activities.

3.3.7 Working with and through local institutions

CBHI-schemes do not operate in an institutional vacuum. Instead, there exist a variety of local institutions that fulfill functions in various domains of life. Important examples include local government authorities (which will be discussed separately in the following section), credit- and savings associations, religious associations, cooperatives and professional organizations, or womens' associations. To varying extents, CBHI-schemes attempt to capitalize on the presence of these

26 Interview with staff of the regional union of Kaolack,

institutions. As the examples below illustrate, this institutional embeddedness can greatly increase a CBHI-scheme's effectiveness in terms of revenue collection and recruitment.

- in Senegal, many mutuelles are working together with so-called *groupes de promotion feminine* (GPF): women's associations that promote the socio-economic emancipation of women. In several cases, the histories of these GPF and the mutuelles are intimately entangled[27]. It was indicated by different respondents that the GPF can act as a catalyst for the recruitment of new households. In addition, several GPF provide their members with savings- and credit services, which may help them pay their membership premiums;
- in Tanzania, enrolment officers are working together with religious institutions (churches and mosques) to educate people about the importance of health insurance, and to stimulate wealthier people and formal economy workers to contribute for the payment of premiums of less privileged members. Some religious leaders in Kilimanjaro even mobilized their networks in the diaspora to pay for people's health insurance in their home village. Similarly, the mutuelle of Dara Mbosse in Senegal was coordinating with the local imam, in an attempt to sensitize men about the subject of health care. Officials of the mutuelle are convinced that religious norms are compatible with the spirit of mutualism, and they know that men are more likely to heed the call of religious leaders;
- one of the improved CHF-schemes included in the study actually built on an existing farmer's association: the Kilimanjaro Native Cooperative Union (KNCU). More precisely, before the introduction of the CHF, many farmers were covered by a health insurance plan offered by KNCU. Together with PharmAccess (a supporting NGO), the government transformed this health insurance plan into improved CHF. While this move facilitated the expansion of the CHF, and helped to reduce fragmentation of health insurance in the region, it generated confusion amongst KNCU-members, some of whom were perfectly comfortable with the old scheme;
- the UDAM of Foundiougne was working together with so-called *associations de ressortisants*, associations of labour migrants, both in Dakar and abroad. Their remittances were in some cases used to pay for contributions of their families;
- in the case of the mutuelle of Ngaye Mekhé, a local sports association had repeatedly organized fundraisers and collections to help pay for the enrollment of poor beneficiaries.

3.3.8 Working with local government authorities

Both in Senegal and in Tanzania, decentralization has greatly increased the importance of local (electoral) politics. Yet in both cases, important problems remain with regards to local government capacity, corruption, and clientelism. In such an environment, the interaction between a CBHI-scheme and local government structures poses both opportunities and challenges.

3.3.8.1 Opportunities

The mutuelles in Senegal invariably recognized the importance of garnering the support of local politicians (the mayor, members of the municipal council, village chiefs, and neighbourhood chiefs), because their support can act as a catalyst for recruitment. For example, it was observed in Tanzania that enrolment was significantly higher in localities where local politicians (district officials and village leaders) are favorable to the CHF. In Bahi, one of the best performing districts in Dodoma, the involvement of local officials in awareness-raising campaigns was mentioned as the most important reason for high enrolment rates. Vice versa, in areas where local officials are not promoting CHF, scheme uptake was lower.

Several of the Senegalese mutuelles were also able to secure tangible financial and/or technical support from local governments. Examples include the opportunity to use local government infrastructure (e.g. a car, a speaker, or a meeting room), the construction of a seat for the mutuelle,

27 Examples include the mutuelles of Wër Wërle in Thiès and the Mutuelle of Dara Mbosse in Kaolack.

or subsidies to pay small salaries to the mutuelle's officials. Numerous accounts were given of local politicians that were enrolling people in the mutuelle as an act of 'goodwill'. A similar trend was observed in Kilimanjaro (Tanzania), where a women's association affiliated with the governing party was subsidizing the enrollment of other women's associations in the district.

The collaboration with local politicians was probably most far-reaching in the case of the UDAMs, which have a local political representative at every level of their organizational structure. Moreover, they do not shy away from attempts to marry political interests to those of the UDAM, amongst others by allowing local politicians (particularly mayors) to showcase the UDAM during their campaign[28].

3.3.8.2 Pitfalls

While engaging with local politicians can thus provide CBHI-schemes with important advantages, including in the field of recruitment and revenue mobilization, it is important to recognize the risks involved. Despite repeated claims on the part of CBHI-officials that the schemes are apolitical, there are indications that in practice, it is difficult to prevent at least some degree of politicization.

For one, the mutuelles provide local politicians with important opportunities for patronage, as demonstrated by cases whereby local politicians pay for the inclusion of certain (groups of) people. While in itself, patron-client relations need not be problematic, and may inflate membership figures, patronage easily descends into clientelism and nepotism. One illustration is the aforementioned women's association in Tanzania, which is openly affiliated with the ruling party. Another example from Senegal are the Bourses de Sécurité Familiale (BSF, households entitled to social assistance), who now constitute an important share of many mutuelles' beneficiaries. The selection of BSF is the responsibility of local elected officials, and particularly during the earlier stages of the program, there are important indications that officials in some localities selected friends and allies, rather than those who are truly in need of assistance[29]. In the case of the UDAM of Foundiougne, it was admitted that local politicians - who already have a strong representation in the UDAM's organizational structure - and other local notables (e.g. religious leaders) have a strong influence over the election of village délégues and officials of the antennes locales. The biggest problem with clientelism is not necessarily that it can be inefficient, but that it is selective, and may therefore contribute to a further marginalization of those who are most in need of assistance, but lack the necessary political connections[30].

Ultimately, an uncritical engagement with local politicians risks undermining the sustainability of CBHI-schemes. Insofar as CBHI-schemes are currently getting support from local politicians, it is often haphazard, and depends upon the goodwill of these politicians. This raises questions about what happens if a local politician suddenly decides to withdraw his or her support, or is voted out of office. In the case of Tanzania, threats to sustainability took on an even more specific form. Acting on bold promises made to local communities, politicians in Dodoma have been pressuring CHF-schemes into eliminating the waiting period. According to a health facility managers in Dodoma, this creates problems of adverse selection, and ultimately financial problems for the CHF-scheme: *"These politicians don't know how insurance works. Yesterday a councillor was here forcing us to give service to CHF members who registered the same day. For us, doing that is no different from providing free health care, because we can't claim that money, nobody will reimburse you for non-compliance. At the district council, they only pay for members who are recognised by the system"*.[31]

28 This became very clear during a short discussion with the mayor of Toubacouta on January 30, 2018.

29 This issue was raised by different respondents, but see also https://www.leral.net/Bourses-de-securite-familiale-a-Thies-Des-responsables-aperistes-denoncent-l-attribution-clienteliste_a150880.html

30 These observations were confirmed during a discussion with people from CNTS, a large trade union that is currently trying to set up mutuelles de santé for informal workers in Dakar.

31 Interview with a health facility manager in Dodoma.

4 | Conclusions and policy recommendations

This case study paper has zoomed in on CBHI, as a prime example of contributory social protection mechanisms for the informal economy. It has been demonstrated that CBHI-schemes are facing important challenges when it comes to reaching out to their target population; challenges that are at least partly related to the complex and diverse nature of the informal economy. At the same time, it has been demonstrated throughout this paper that CBHI-schemes are embedded in a broader political and institutional context, and it is quintessential that efforts to analyse and improve the effectiveness of CBHI need to take this context into account.

In this final chapter, we provide a number of empirically informed recommendations for external actors (which may include governments, donors, or NGOs) that wish to support an evolution towards more sustainable CBHI-schemes - or other non-contributory social protection schemes, for that matter. These recommendations target different levels, namely (1) the CBHI-scheme (the micro-level); (2) the local political and institutional context (the meso-level); and (3) supra-local political and institutional structures (the macro-level).

4.1 Competing approaches to supporting CBHI

Before proceeding with these recommendations, however, it is important to elaborate on the different approaches that have previously informed external support for CBHI. Broadly speaking, two such approaches can be identified (their key characteristics are summarized in table 4.1).

1. **The community-based approach**: this approach is characterized by a firm belief in the participatory and community-based character of CBHI. Rather than treating it exclusively as a mechanism to improve access to health care, CBHI is also seen an instrument for the empowerment of local (rural) communities and health care users. Interventions informed by this approach focus primarily on helping local communities to set up more inclusive CBHI-schemes. Key proponents include the Belgian health funds (mutualiteiten) and NGOs such as Solidarité Socialiste and Wereldsolidariteit.
2. **The efficiency-oriented approach**: this approach is concerned less with popular empowerment, and sees CBHI as just one amongst a range of possible mechanisms for financing and organizing health care. It is characterized by a central preoccupation with efficiency (in terms of sustainability, coverage, and revenue mobilization), and is skeptical of the potential of small-scale CBHI-schemes. A key proponent of this second approach is the World Health Organization, which recently stated that *"relying only on voluntary, small-scale schemes and small pools with little or no subsidization of poor and vulnerable groups, can play only a very limited role in helping countries move towards UHC."* (Mathauer et al., 2017). For proponents of this second approach, part of the solution inevitably lies in a process of up-scaling and professionalization. While lip service is paid to the importance of popular participation, in practice the democratizing aspects of CBHI do not receive priority attention.

The distinction between both approaches became abundantly clear during the field research in Senegal. While the DECAM - which is supported by American (USAID) and Japanese (JICA) donors - put in place a supra-local structure, and added a non-contributory element in the form of government subsidies, it remains committed to supporting truly small-scale, community-based

mutuelles. The director of the Agence CMU himself insisted that the mutuelles have an important political function, because they allow local communities to organize themselves and 'counterbalance' the powers of the state[32]. The UDAMs –which were supported by Belgian Development cooperation– clearly bear the imprint of an efficiency-oriented approach, with their focus on scale, professionalism, and a more systematic approach to improving health care services. Indeed, according to staff of the Belgian Development Cooperation, the UDAMs were even developed in response to the shortcomings of the mutuelles, which are seen as inefficient due to their small scale and lack of professionalism[33]. The distinction between both approaches has not only created divisions within civil society, but has also contributed to a further fragmentation of the Senegalese health care system.

The CHF in Tanzania can also be seen as a clear expression of a more efficiency-oriented approach. Government interventions have focused primarily on upscaling the CHF, which is not merely seen as an instrument to improve access to health care, but also (and arguably more importantly) as a mechanism to improve domestic revenue mobilization for health care. Within Tanzania, there is now increased debate about making contributions to the CHF mandatory, as a way to improve revenue mobilization[34].

Table 4.1 Competing approaches to supporting CBHI

	Community-oriented approach	Efficiency-oriented approach
Understanding of CBHI	Community-based, participatory, and autonomous organizations	One possible mechanism to organize/finance health care
Focus of external support	Institutional design: assist local communities to set up inclusive CBHI-schemes and provide targeted technical and financial support	System-wide approach: focus on integration of CBHI into broader health care system; up-scaling; efficiency and professionalism; and possibly the introduction of a non-contributory element (e.g. government subsidies).
Key strengths	Local ownership and inclusive management (but autonomy?)	Efficiency and realism
Key weaknesses	Questions of financial sustainability	Lack of attention for local ownership and inclusiveness
Key proponents	Belgian health funds and selected NGOs, DECAM	WHO, UDAM, CHF

Source Own data

Clearly, both approaches have merits and shortcomings. On the one hand, a clear case can be made for locally embedded, community-based, and autonomous CBHI-schemes. Yet in practice, genuine autonomy is difficult to realize in a context characterized by a growing importance of electoral politics. Moreover, it has long been recognized that CBHI-schemes face inherent limitations due to their small scale and limited resource base.

On the other hand, mechanisms like the UDAM and (to a lesser extent) the CHF demonstrate the potential of a more efficiency-oriented approach. Yet these schemes seem to have relinquished the quest for popular empowerment, and have instead put in place a highly formalistic form of political representation which is based on an uncritical engagement with local politicians. Given the merits and shortcomings of both approaches, there is a need to find a middle ground and move towards a more pragmatic approach, which builds on their combined strengths. Such an evolution would effectively be more in tune with realities on the ground, where such a process towards hybridization is already under way both in Tanzania (the improved CHF), and to a lesser extent also in Senegal.

32 Interview with director of Agence CMU, January 22, 2018.
33 Interview with Enabel-staff in Brussels, December 19, 2017.
34 Interview with CHF Director, August 17, 2017

4.2 Micro-level: targeted financial, technical, and institutional support

As our discussion in chapter 3 has hopefully demonstrated, CBHI-schemes in Senegal and Tanzania are developing responses to the challenges they face in the field of revenue collection and recruitment. Important examples include the deconcentration of institutional structures and the recruitment of professional (and salaried) staff like collectors and managers. Yet these responses need not be the result of a deliberate strategy, but may emerge gradually, as a combined result of ad hoc responses to everyday problems. A prime example here includes the development of more flexible collection and enrollment procedures. However, there is only so much that CBHI-schemes can accomplish given their small scale and limited financial and human resources.

Given these constraints of CBHI, external actors can play an important role in realizing a transition towards more adaptive CBHI-schemes, by providing them with targeted financial, technical, and/or institutional support. Amongst others, they could provide support in a number of domains: To facilitate this process, we have developed a short participatory planning- and assessment tool, which can be found in appendix 1.

- digitalization: enhance the use of digital solutions such as online registration, mobile money;
- organize trainings in the field of revenue collection and recruitment;
- stimulate a critical reflection and the sharing of best practices about recruitment strategies, the most appropriate institutional structure (e.g. more centralized or decentralized), and the appropriate benefits package, and how these are best adjusted to a given target population;
- support the formation of supra-local federations that can in turn provide technical support.

Yet even where these objectives are attained, the question of scale still looms on the horizon. As indicated in section 4.1, this is a sensitive question, which lies at the root of the distinction between both approaches to supporting CBHI. If external actors would be willing to lend support to a process of up-scaling, the UDAMs harbour interesting lessons. By providing the UDAMs with financial and technical support, Belgian Development Cooperation has pushed them beyond the threshold required to create and sustain a larger resource base and a more professional structure. Yet in mid-2017, Belgian support for the UDAMs ended, and it remains to be seen whether the UDAMs are viable without external support. One of the key lessons of the UDAMs seems to be that in order to be sustainable, it is quintessential that a process of up-scaling is financed at least in part by revenues raised by the mutuelles themselves - which does not imply that such a process cannot be supported by external actors. Here, overarching structures such as the regional and national unions should play an important role. For example, the regional union of Kaolack was trying to convince its members to contribute to a solidarity fund that would be managed at the regional level, and would reduce risks for individual mutuelles.

In Tanzania, external actors hav also played an important role in improving the CHF. In addition to capacity building and trainings for the management, financial assistance was provided for a process of digitalization, although the operational costs ultimately came from membership contributions and government subsidies. This financial injection had a significant impact on the sustainability of CHF-schemes, particularlyin Dodoma where enrolment rates were better compared to other places, despite the fact that HPSS had stopped supporting the scheme over the past two years. However, questions remain over how donors can best provide technical assistance. While some donors provide support without interfering in the scheme's operations, others do interfere, which raises questions about sustainability once this support ends. For example, in Kilimanjaro, where PharmAccess is in charge of the CHF-scheme, local leaders and even CHF-managers showed less interest and understanding of program activities.

4.3 Meso-level: politically smart interventions that foster institutional synergies

One thing that became very clear in the case studies is that although they are operating in an environment characterized by pervasive informality, CBHI-schemes do not exist in an institutional vacuum. On the one hand, people invariably depend on social networks and a variety of institutions to fulfill their needs in various domains of life, including (but not limited to) health care. These institutions operate with varying degrees of formal recognition, and may include local state institutions, savings- and credit associations, religious associations, agricultural cooperatives, or women's associations. Our empirical evidence contains important indications that the interaction between CBHI-schemes and these local institutions can improve their ability to reach out to the target population. This proposition is supported by the outcomes of a recent field experiment in Kenya, which concluded that working through existing social networks greatly increases the take-up of health insurance (Chemin, 2018). A logical consequence of these findings is that rather than focusing one-sidedly on providing micro-level support to CBHI-schemes, external actors should also work towards a better integration of CBHI- schemes in local social, political, and institutional structures. Such an institutionally sensitive approach should try to avoid duplication and competition, and foster synergies between CBHI-schemes (or other social protection mechanisms) and existing local institutions.

Particular attention should be devoted to the interaction between CBHI-schemes and local political institutions. A growing body of evidence indicates that politics has a determining influence on the impact and effectiveness of development interventions[35]. To some extent, our case studies of Senegal and Tanzania seem to corroborate these findings. While CBHI-schemes may claim to be politically autonomous, in practice this is impossible to guarantee. While a mutual entanglement between local political structures and CBHI-schemes need not be problematic, it may pose a clear threat to the sustainability of CBHI-schemes, due to (amongst others) the ebbs and flows of electoral politics, and the perverting influence of political clientelism. To prevent this from happening, it is critical that external support for CBHI-schemes is politically smart.

- A first step towards politically smart support is to think politically, i.e., to recognize that politics matters. In line with many other countries, Senegal and Tanzania are undergoing a process of decentralization, which has greatly increased the importance of local (electoral) politics. Furthermore, in the case of Tanzania, we are faced with a government party that has long controlled the state apparatus, and seems increasingly willing to use authoritarian strategies to quell political dissent. In such an environment, it is naïve to assume that politics will not interfere with the functioning of CBHI-schemes. External actors need to ensure that there is at least a minimal understanding of the political context, and the power relations underpinning CBHI-schemes.
- A second step is to move beyond political thinking, by actually working politically. In particular, we wish to emphasize the importance of a more critical engagement with local powerbrokers. While CBHI-schemes in Tanzania and Senegal succeed in solliciting support from local politicians, this support often remains ad hoc, and dependent upon the goodwill of these politicians. This creates clear opportunities for clientelism and favoritism which, combined with the uncertainties posed by the electoral cycle, may threaten the inclusiveness and sustainability of CBHI-schemes. In short, there is a need to develop strategies to deal with this uncertainty, by working towards more sustainable and more institutionally anchored forms of local government support. This brings us to a third and final set of recommendations, which target the broader structural context.

35 The following discussion is based in part on a policy brief written by the Thinking and Working Politically Community of Practice. See TWP (sd).

4.4 Macro-level: towards a comprehensive approach

This case study paper has focused primarily on revenue collection and recruitment strategies, and how these can be adapted to the complex realities of the informal economy. However, it became abundantly clear that even where such strategies are in place, there are limitations to the outreach capacity of CBHI. The UDAM of Foundiougne is a case in point. Despite claiming to operate in the entirety of the department, and despite relying on professional and targeted recruitment and collection strategies, the UDAM was only able to recruit approximately 30 percent of its target population. To fully understand the limitations of CBHI-schemes, then, it is important to also take into account the structural context, and how it may foster or undermine the effectiveness of CBHI.

A first set of structural challenges is broadly related to problems within the health care system. Despite attempts on the part of governments and donors to improve the (public) health care system, both Tanzania and Senegal continue to suffer from a lack of critical health care infrastructure (particularly in remote rural areas), a shortage of skilled medical personnel, and in some cases even a lack of basic medicine. Another important challenge is fragmentation, with diffferent systems of health care provision and social health protection operating alongside- or even competing with one another. Rather than supporting a transition towards a more coherent approach, donors share part of the blame for this fragmentation (Freedland, 2013). This became painfully clear in Senegal where, on the one hand, the government and donors such as USAID and JICA are supporting the DECAM; whereas the Belgian Development Cooperation put in place an alternative system that revolves around a completely different understanding of CBHI. In Tanzania, this fragmentation even exists within the CHF itself, as different donors have come up with their own specific CHF-model, and are lobbying the government to implement it in the whole of the country.

This problem of fragmentation is related to a second set of structural challenges: the apparent lack of genuine political support. To be sure, in both Senegal and Tanzania, the government has committed to supporting CBHI as part of a broader strategy to increase social health protection in the rural and informal economy. Yet in both countries, this support is failing to materialize. At the national level, both governments are currently failing to deliver on their promise to pay subsidies, which could not only provide a lifeline to ailing CBHI-schemes, but could also increase their attractiveness for new members. At the local level, despite the official role allocated to local governments under the DECAM and the CHF, government support remains inherently unstable, and sensitive to patronage politics.

Given these structural challenges, what is needed is a more comprehensive approach to supporting CBHI - and social protection more broadly - which not only provides targeted support to CBHI-schemes, but also works towards towards their integration into local institutional structures, and attempts to address some of the challenges inherent to the structural environment. If CBHI-schemes are indeed mechanisms for popular empowerment (cf. the community-oriented approach), external actors could try to strengthen their advocacy role. In this way, CBHI-schemes could work the political system, by pressurizing governments into supporting CBHI, and making improvements in the health care system. Indeed, without significant improvements in health care supply, attempts to reinforce CBHI-schemes may eventually prove futile. External actors such as donors and NGOs, should at the very least work towards reducing fragmentation, by coordinating amongst themselves, and by trying to avoid interventions that work against the grain of government policies.

- APPENDICES -

appendix 1 Participatory planning and assessment tool

This participatory planning- and assessment tool aims to stimulate a critical reflection amongst CBHI-schemes and the external actors that support them (including Belgian civil society organizations and government actors) about recruitment and revenue collection strategies, and how these can be strengthened.

Assessment item	Assessment criteria	Best practices (based on case studies and existing research)
Micro level: recruitment and revenue collection		
Recruitment strategies	Are there proactive recruitment strategies? Are these adapted to local needs and realities? Are there strategies to prevent drop-out?	- Door-to-door campaigns, public meetings and discussions (e.g. in public markets), promotional convoys - (More professional) Distribution of brochures and leaflets, or communication through (social) media outlets - In farming communities, recruitment is best scheduled in the afternoon, when people return from the fields. Artisans, on the other hand, are best visited in their workplace. - Weekly markets offer important opportunities for recruitment. E.g. the regional union of mutuelles in Kaolack (Senegal) encourages its members to set up market stalls (*guichets*) that serve as vehicles for recruitment, and possibly for revenue collection. - Providing additional services aside from health insurance, (couplage). Examples include money lending and the provision of trainings to members (e.g. commercial training by the National confederation of Senegalese workers for vendors and traders who are particularly interested in expanding their commercial activities). - Pro-active follow-up of members to ensure their continued engagement and prevent drop-out
Payment modalities	Are there proactive revenue collection strategies? Are these adapted to local needs and realities?	- Presence of (more or less) professional revenue collectors. - Flexible payment schemes that allow members to pay in installments - Mobile payments, e.g. some Senegalese mutuelles are accepting payments by mobile phone, which is increasingly assuming the role of a banking account.
Institutional design	Is there a good fit between the institutional design of the CBHI-scheme and local economic geography?	- Some mutuelles have erected deconcentrated structures (e.g. antennes locales, relais de quartier) that have specific tasks in the field of recruitment and revenue collection. This enables a more proactive and more attuned response to local realities.
Professionalization	Is there a professional management structure	- CHFs in Tanzania and UDAMs in Senegal are overseen by managers who are responsible for coordinating the operations, increasing coverage, and ensuring the quality of health care services - Technical support facility for CBHI schemes (e.g. organized at departmental level in Senegal)
	Are specific people tasked with recruitment and revenue collection? Is there a system to motivate them?	- Collectors and recruiters working together with a network of local contacts, e.g. in Senegal: antennes

Assessment item	Assessment criteria	Best practices (based on case studies and existing research)
	How do they engage with the local population?	locales, délegués de village, local government authorities, various local associations - Members from local communities being trained as recruiters and collectors (Tanzania & Senegal) - Reimbursement of costs incurred during working hours (transportation and catering costs) - Provision of some sort of compensation in the form of a salary or a percentage of the collected premiums (e.g. 10% in Tanzania CHF) - Provision of motorcycles to recruiters by the UDAM allowed them to adopt a more proactive approach to recruitment and revenue collection - Encouraging local saving schemes such as the tontine de santé set up by the women's association in Toubacouta (Senegal).
Supply side	Are attempts made to improve the provision of health care at the local level?	- Monitor (perception of) quality of health care services that are offered to members - Efforts to work with local health care providers towards improving supply
Meso level: local institutional structures		
Relationship with local institutions and organisations	Are there attempts to foster synergies between CBHI-schemes and local associations and social networks?	- Associations acting as a catalyst for the recruitment of new members (e.g. women or farmer associations, sports associations, associations of labour migrants, …) - CHF enrolment officers working with churches and mosques to sensitize people (incl. wealthier people) about the importance of health insurance.
	Are there efforts to develop (durable) relationships with local government and local politicians?	- Support from municipal councils, village chiefs, neighbourhood chiefs can act as a catalyst for recruitment - Local government/politicians can provide tangible financial or technical support, e.g. the use of cars for promotional convoys, the use of public buildings, … - However, it is important to develop strategies to minimize risks of clientelism, adverse selection, and political instrumentalization of CBHI.
Macro level: national institutional structures		
Is support for CBHI **part of a broader, comprehensive approach to societal change?**	Are attempts made to engage with political or development actors to address structural problems in health care and social protection?	- Lobby and advocacy strategies? E.g. multi-actor networks (world solidarity?) - Attempts to identify and work with development entrepreneurs, i.e., people within the system who are pro-reform - What role for CBHI-federations?

appendix 2 List of interviews

a2.1 Senegal

Date	Name, organization (location)
19/12/2017	Paul Bossyns & Stefaan Van Bastelaere, BTC/Enabel (Brussels)
22/1/2018	Dr. Daff, Directeur Agence CMU (Dakar)
22/1/2018	Dr. Abdou Salam Fall, LARTES-IFAN (Dakar)
23/1/2018	André Wade, GRAIM (Thiès)
24/1/2018	President of mutuelle de Mekhé (Mekhé)
24/1/2018	Treasurer of mutuelle de Lalane Diassap (Lalane Diassap)
25/1/2018	President and treasurer of mutuelle de Diasse (Diasse)
26/1/2018	President and treasurer of mutuelle de Wër Wërle (Thiès)
29/1/2018	President of mutuelle de Dara Mbosse (Dara Mbosse)
29/1/2018	Union Régionale de Kaolack (Kaolack)
30/1/2018	Treasurer of UDAM Foundiougne (Foundiougne)
30/1/2018	President of UDAM Foundiougne (Foundiougne)
30/1/2018	FGD with collectors of UDAM Foundiougne (Foundiougne)
30/1/2018	Chef de village and marabout (Toubacouta)
31/1/2018	President of antenne locale UDAM Foundiougne (Toubacouta)
31/1/2018	Mayor of Toubacouta (Toubacouta)
2/2/2018	Annie Diouf, CNTS (Dakar)
15/2/2018	Ilère Ngongang, Wereldsolidariteit (Brussel)

a2.2 Tanzania

Date	Name, organization (location)
30/5/2017	Dr. Christine Fenenga (Senior Global Health Advisor) PharmAccess Group, Amsterdam
6/7/2017	Dr. Heri Marwa (Program Director) PharmAcess, Tanzania
7/7/2017	David Kaali (Director of Social Protection) Ministry of Labor Employment, Dar es Salaam
7/7/2017	Alfred P. Misana (Assistant Director- Policy and Planning), Ministry of Health and Social Welfare, Dar es salaam
11/7/217	Victor Njau (Ag. Regional Manager) NHIF, Kilimanjaro
11/7/2017	Rosemilia Msigwa (Compliance office) NHIF, Kilimanjaro
11/7/2017	Sofia Maulid Darabu (Officer in charge- Lambo Dispensary), Hai, Kilimanjaro
12/7/2017	Dr. Adam Mtui (facility manager- Sanya Juu RC Dispansary), Siha, Kilimanjaro
12/7/2017	Amani Kissanga (Ashengai Health centre), Siha, Kilimanjaro
12/7/2017	Happy Sanga (Levishi Dispensary), Siha, Kilimanjaro
13/7/2017	Judith Malle (Uuwo Dispensary) Moshi Rural, Kilimanjaro
13/7/2017	Sia (Uuwo Dispensary) Moshi Rural, Kilimanjaro
16/8/2017	Janeth Kibambo (CHF Coordinator), Ministry of Health and Social Welfare, Dar es salaam
16/8/2017	Gonza (Director of Economy and Research), TUCTA, Dar es Salaam
17/8/2017	Silvery Mgonza (Ag. CHF Director), NHIF, Dar es salaam
18/82/2017	Senior Social Protection Specialist, WB Tanzania, Dar es Salaam
18/8/2017	Serapia Maghembe (Coordinator-MKURABITA), Dar es Salaam
21/8/2017	Hema Daniel (Compliance officer), NHIF, Dodoma
22/8/2017	Prof.Manoris Meshack (Team leader), HPSS Project, Dodoma
30/8/2017	Ansgar Mushi (Director of Research, Acturial and Policy), SSRA, Dar es Salaam
5/1/2018	Raymond (Ag. CHF Manager), Bahi, Dodoma
5/1/2018	Abdala Misenyi (CHF Manager), Chamwino, Dodoma
5/1/2018	Athman Masasi (District Executive Director), Chamwino, Dodoma
6/1/2018	Godfrey Myamale, Chamwino, Dodoma
8/1/2018	Rachel Chuwa (Ag. District Executive Director), Bahi, Dodoma
8/1/2018	Dr. Kolowa (Facility Manager), Hahi Health Centre, Bahi, Dododma
8/1/2018	Simon Mtwanga (CHF Coordinator), Bahi, Dododma
8/1/2018	FDG1, CHF Beneficiaries (non-members), Bahi Dodoma
9/1/2018	Salome Ngoda (Officer in charge), Mpamatwa Dispensary, Bahi, Dodoma
9/1/2018	Joyce Luoga (health worker), Mpamatwa Dispensary, Bahi, Dodoma
9/1/2018	Bosco Emmanuel (Chairman-Village government), Mpamatwa, Bahi, Dododma
9/1/2018	Ward Executive officer, Mpamatwa, Bahi, Dododma
9/1/2018	Enrollment officer, Mpamatwa, Bahi, Dododma
10/1/2018	Venave Gerald (Chairman-Village government), Bahi Makulu, Bahi, Dododma
10/1/2018	FDG2, CHF Beneficiaries (members), Bahi Dodoma
10/1/2018	Salome Komba (Village Executive officer-Uhelela) Bahi, Dododma
10/1/2018	Isaya Lamek (Enrollment Officer), Uhelea, Hahi, Dododma
10/1/2018	Catherine Ipemba (fomer VEO), Uhelea, Hahi, Dododma

Date	Name, organization (location)
10/1/2018	Angel Samson (health worker), Bahi health center, Bahi, Dododma
11/11/3018	Abdallah Saidi (village Executive Office), Chamwino Ikulu, Chamwino, Dododma
11/11/3018	Ngaiga (CHF Coordinator), Chamwina, Dododma
11/11/3018	Dr. Zipora Mfugale (Facility Manager) Chamwino Hospital, Chamwino, dododma
12/11/3018	Joseph Seganje (Chairman-Village government) chamwino Ikulu, Chamwino, Dodoma
12/11/3018	FGD3 (CHF beneficiaries – Members), Chamwino, Dodoma
12/11/3018	FGD4 (CHF beneficiaries – no-members), Chamwino, Dodoma
12/1/2018	Benson (CHF officer) Machalia, Chamwino, Dododma
13/1/2018	Dr. Fredrick Kangalo (Facility manager), Chalinze dispensary, Chamwino, Dododma
13/1/2018	Sospeter songo (Village Executive Office) Chalinze, Chamwino, Dododma
13/1/2018	FGD5 (CHF beneficiaries – Members), Machalia, Dodoma
13/1/2018	FGD6 (CHF beneficiaries – non-members), Machalia, Dodoma
15/1/2018	?CHF Marketing Officer, PharmAcess, Kilimanjaro
15/1/2018	?CHF Coorduinator, Siha, Kilimanjaro
16/1/2018	Agness Mtende (Village Executive Officer-Sanya Juu), Siha, Kilimanjaro
16/1/2018	Chairman-Village Government, Sanya Juu), Siha, Kilimanjaro
16/1/2018	FGD7 (CHF beneficiaries – Members), Sanya juu-Siha, Kilimanjaro
16/1/2018	FGD8 (CHF beneficiaries – no-members), Sanya juu-Siha, Kilimanjaro
16/1/2018	Mathias Stephano (Enrollment Officer), Siha, Kilimanjaro
17/1/2018	Andrea Alfred Gunda (Ward Executive Officer), Karansi, Siha, Kilimanjaro
17/1/2018	Jackson Moye (Village Executive Officer), Karansi, Siha, Kilimanjaro
17/1/2018	FDG9 (CHF beneficiaries – no-members), Karansi, Siha, Kilimanjaro
17/1/2018	FDG10 (CHF beneficiaries – no-members), Karansi, Siha, Kilimanjaro
18/1/2018	Dr. Alex Kazula (District Medical Officer), Moshi, Kilimanjaro
18/1/2018	Onesmo Mnyawi (Village Executive officer- Ongoma), Uru-Moshi, Kilimanjaro
18/1/2018	Helen Kisaya (Village Executive officer- Njari), Uru-Moshi, Kilimanjaro
19/1/2018	Edmund Moshi (Ward Executive Officer-Mwika Kaskazini) Moshi, Kilimanjaro
19/1/2018	Venista sam (Village Executive officer- Uuwo), Moshi, Kilimanjaro
19/1/2018	FDG11 (CHF beneficiaries – members), Mwika-Moshi, Kilimanjaro
19/1/2018	Brigita (Village Executive officer- Lole), Moshi, Kilimanjaro
19/1/2018	Facility Manager, Msae Health Centre, Moshi Kilimanjaro
20/1/2018	Mary Shao(Enrollment officer- Uuwo), Moshi, Kilimanjaro
10/1/2018	Officer in charge- Uuwo Dispensary, Moshi, Kilimanjaro
20/1/2018	FDG 12 (CHF beneficiaries – non-members), Moshi, Kilimanjaro

References

Acharya, A., Vellakkal, S., Taylor, F., Masset, E., Satija, A., Burke, M., & Ebrahim, S. (2013). The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries: A Systematic Review. *The World Bank Research Observer*, *28*(2), 236–266.

Alfers, L., Lund, F., & Moussié, R. (2017). Approaches to social protection for informal workers: Aligning productivist and human rights-based approaches. *International Social Security Review 70*(4), 67-85.

Annear, P. L., Ahmed, S., Ros, C. E., & Ir, P. (2013). Strengthening institutional and organizational capacity for social health protection of the informal sector in lesser-developed countries: A study of policy barriers and opportunities in Cambodia. *Social Science and Medicine*, 96, 223–231.

Anyimadu, A. (2016). The political economy of Tanzania: Decline and recovery. *African Affairs*, 115(459), 373–375.

Barrientos, A., & Hulme, D. (2009). Social protection for the poor and poorest in developing countries: reflections on a quiet revolution: commentary. *Oxford Development Studies*, *37*(4), 439-456.

Barrientos, A., & Santibanez, C. (2009). Social Policy for Poverty Reduction in Lower-income Countries in Latin America: Lessons and Challenges. *Social Policy & Administration*, *43*(4), 409-424.

Beck, L.J. (2008). *Brokering Democracy in Africa.* Berlin: Springer.

Benjamin, N., Mbaye, A. A., & Diop, I. T. (2012). *The informal sector in Francophone Africa: firm size, productivity, and institutions*. Washington: World Bank.

Boex, J., Fuller, L., & Malik, A. (2015). Decentralized Local Health Services in Tanzania: Are Health Resources Reaching Primary Health Facilities, or Are They Getting Stuck at the District Level. Urban Institute Elevate Debate, Washington DC.

Boidin, B. (2014). L'extension de la couverture maladie par les mutuelles communautaires en Afrique : mythes et réalités. *Bulletin de La Societe de Pathologie Exotique*, *108*(1), 63–69.

Bonner, C., & Spooner, D. (2011). Organizing in the informal economy: A challenge for trade unions. *Internationale Politik und Gesellschaft*, *2*(2011), 87-105.

Borghi, J., Maluka, S., Kuwawenaruwa, A., Makawia, S., Tantau, J., Mtei, G., & Macha, J. (2013). Promoting universal financial protection: a case study of new management of community health insurance in Tanzania. *Health Research Policy and Systems 11*(1), 21.

Carrin, G. (2003). *Community based Health Insurance Schemes in Developing Countries : facts, problems and perspectives.* World Health Organization Discussion Paper 1 - 2003. Geneva: World Health Organization.

Chemin, M. (2018). Informal Groups and Health Insurance Take-up Evidence from a Field Experiment. *World Development 101*(1), 54-72.

Chen, M. (2008). Informality and social protection: Theories and realities. *IDS bulletin*, *39*(2), 18-27.

De Allegri, M., Sauerborn, R., Kouyaté, B., & Flessa, S. (2009). Community health insurance in sub-Saharan Africa: What operational difficulties hamper its successful development? *Tropical Medicine and International Health*, *14*(5), 586–596.

Defourny, J., & Failon, J. (2011). Les déterminants de l'adhésion aux mutuelles de santé en Afrique subsaharienne : un inventaire des travaux empiriques. *Mondes En Développement*, *153*(1), 7–26.

Duta, A. (2015). Prospects for Sustainable Health Financing in Tanzania: Baseline Report. Health Policy Project, Futures Group, Washington, DC. Retrieved from https://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubId=788

Ekman, B. (2004). Community-based health insurance in low-income countries: a systematic review of the evidence. *Health policy and planning*, *19*(5), 249-270.

Franzoni, J. M., & Sánchez-Ancochea, D. (2016). *The quest for universal social policy in the South: Actors, ideas and architectures*. Cambridge: Cambridge University Press.

Freedland, N. (2013). Social protection and the four horsemen of the donor apocalypse. In Bender, K.; Kaltenborn, M., & Pfleiderer, C. (Eds.), *Social Protection in Developing Countries: Reforming Systems*, (pp. 226-235). Oxon: Routledge.

Gifford, P. (2016). Religion and politics in contemporary Senegal. *African Affairs*, *115*(461), 688-709.

van Ginneken, W. (1999). Social security for the informal sector: A new challenge for the developing countries. *International Social Security Review*, *52*(1), 49-69.

van Ginneken, W. (2003). Extending social security: Policies for developing countries. *International Labour Review 142*(3), 277-294.

Gottret, P. E., & Schieber, G. (2006). *Health financing revisited: a practitioner's guide*. World Bank Publications.
Guanais, F. C., & Macinko, J. (2009). The health effects of decentralizing primary care in Brazil. *Health Affairs*, *28*(4), 1127-1135.
Harriss-White, B. (2010). Work and Wellbeing in Informal Economies: The Regulative Roles of Institutions of Identity and the State. *World Development*, *38*(2), 170–183.
Hickey S. (2008). Conceptualising the Politics of Social Protection in Africa. In: Barrientos A., Hulme D. (Eds.), *Social Protection for the Poor and Poorest* (pp. 247-263). London: Palgrave Macmillan.
Houeninvo, T., Gassama, K., & Sabo, I. (2017). *African Economic Outlook: Sénégal 2017*. Retrieved from http://www.africaneconomicoutlook.org/en/country-notes/senegal on 22/11/2017.
Ifakara Health Institute (2012). Lessons from Community Health Fund reforms, A review of the past three years. Ifakara Health Institute. Spotlight Issue 15.
ILO – Internatinoal Labour Organization (2017). *World Social Protection Report 2017-2019: Universal social protection to achieve Sustainable Development Goals.* Geneva: ILO.
ILO – International Labour Organization (2018). *Women and Men in the Informal Economy: A Statistical Picture.* Available online at http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_626831.pdf.
Jakab, M., & Krishnan, C. (2004). Review of the strengths and weaknesses of community financing. *Health financing for poor people: resource mobilization and risk sharing.* In Preker, A.S., & Carrin, G., *Health Financing for Poor People: Resource Mobilization and Risk Sharing* (pp. 53-117). Washington: The World Bank.
Jowett, M. (2003). Do informal risk sharing networks crowd out public voluntary health insurance? Evidence from Vietnam. *Applied economics*, *35*(10), 1153-1161.
Jütting, J. P. (2004). Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. *World development*, *32*(2), 273-288.
Juul, K. (2006). Decentralization, local taxation and citizenship in Senegal. *Development and Change*, *37*(4), 821-846.
Kalolo, A., Gautier, L., Radermacher, R., Stoermer, M., Jahn, A., Meshack, M., & De Allegri, M. (2018). Implementation of the redesigned Community Health Fund in the Dodoma region of Tanzania: A qualitative study of views from rural communities. *The International journal of health planning and management, 33*(1), 121-135.
Kuwawenaruwa, A., & Borghi, J. (2012). Health insurance cover is increasing among the Tanzanian population but wealthier groups are more likely to benefit. *Ifakara Health Institute Spotlight 11*, 1-4.
Lagarde, M., & Palmer, N. (2008). The impact of user fees on health service utilization in low-and middle-income countries: how strong is the evidence?. *Bulletin of the World Health Organization*, *86*(11), 839-848.
Laterveer, L., Munga, M., & Schwerzel, P. (2004). Equity implications of health sector user fees in Tanzania. Do we retain the user fee or do we set the user f(r)ee? Analysis Of Literature And Stakeholder Views. Leusden: ETC Crystal.
Mathauer, I., Mathivet, B., & Kutzin, J. (2017). *Community-Based Health Insurance: How can it contribute to Progress towards UHC?* WHO Health Financing Policy Brief 3. Geneva: World Health Organization.
Mbengue, S.A., Mbaye, S., & Camara, M. (2014). *Political Winds Blow a New Life into Senegal's Mutuelles de Santé.* Washington: USAID.
McCord, M. J., Buczkowski, G., & Saksena, P. (2006). Premium collection: Minimizing transaction costs and maximizing customer service. In Churchill, C., & Matul, M. (Eds.), *Protecting the Poor, A Microinsurance Compendium* (pp. 197-215). Geneva: International Labour Organization.
Meagher, K. (1995). Crisis, Informalization and the Urban Informal Sector in Sub-Saharan Africa. *Development and change*, *26*(2), 259-284.
Ministère de la santé et de l'action sociale (2013). *Plan stratégique de développement de la Couverture Maladie Universelle au Sénégal.* Dakar: Ministère de la santé et de l'action sociale.
Mladovsky, P. (2014). Why do people drop out of community-based health insurance? Findings from an exploratory household survey in Senegal. *Social Science & Medicine*, *107*, 78-88.
Mpambije, C. J. (2017). Decentralisation of Health Systems and the Fate of Community Health Fund in Tanzania: Critical Review of High and Low Performing Districts. *Science Journal of Public Health, 5*(2): 136-144.
Mujinja, P., & Kida, T. (2014). Implications of Health Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services. ESRF Background Paper. Economic and Social Research Foundation, Dar es Salaam.
NBS - National Bureau of Statistics (NBS) (2014). Tanzania Integrated Labour Force Survey 2014, Dar es Salaam, Tanzania.
NBS - National Bureau of Statistics (NBS) (2017). National Accounts of Tanzania Mainland, 2007-2016. Dar es Salaam, Tanzania.
NBS - National Bureau of Statistics (NBS) and ICF International (2016). 2015-16 Demographic and Health Survey and Malaria Indicator Survey - Key Findings. Dar es Salaam, Tanzania.
Ngowi, H. P. (2009). Economic development and change in Tanzania since independence: The political leadership factor. *African Journal of Political Science and International Relations*, *3*(5), 259-267.

Ouimet, M. J., Fournier, P., Diop, I., & Haddad, S. (2007). Solidarity or financial sustainability: an analysis of the values of community-based health insurance subscribers and promoters in Senegal. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 341-346.
Sané, Y. (2016). La décentralisation au Sénégal, ou comment réformer pour mieux maintenir le *statu quo*. *Cybergeo: European Journal of Geography*. Available online at http://cybergeo.revues.org/27845.
Schremmer, J., Coheur, A., Jacquier, C., & Schmitt-Diabaté, V. (2009). Extending health care coverage: Potential linkages between statutory social security and community-based social protection. *International Social Security Review*, *62*(1), 25–43.
Seck, I., Dia, A., Sagna, O. & Leye, M. (2017). Déterminants de l'adhésion et de la fidélisation aux mutuelles de santé dans la région de Ziguinchor (Sénégal). *Santé Publique*, *29*(1), 105-114.
Stoermer, M. V, Radermacher, R and Vanderyden, M. (2011). *Transforming Community Health Funds in Tanzania into Viable Social Health Insurance Scheme: The Challenges Ahead*. Schweizerisches Tropen and Public Health (Swiss TPH).
The Economist (March 17, 2018). How to save Tanzania? Available online at https://www.economist.com/news/leaders/21738885-start-containing-president-john-magufuli-how-save-tanzania.
TWP (sd). *The case for thinking and working politically: the implications of 'Doing development differently'*. Available online at http://publications.dlprog.org/TWP.pdf
URT - United Republic of Tanzania (2001). The Community Health Fund Act, *United Republic of Tanzania Health Affairs 14*(2), 68-82.
URT - United Republic of Tanzania, Ministry of Health & Social Welfare (2015a). Health Sector Strategic Plan IV (HSSP IV), June 2015-July 2020 Reaching all Households with Quality Health Care. Dar es Salaam.
URT - United Republic of Tanzania, Ministry of Health & Social Welfare (2015b). Tanzania Health Financing Strategy 2015-2025, Path towards Universal Health Coverage (3rd Draft). Dar es Salaam.
Vaes, S., Fonteneau, B., & van Ongevalle, J. (2017). *Towards Redistributive Social Protection: Insights from Senegal and Morocco.* HIVA-KU Leuven policy brief. Available online at http://www.befind.be/Documents/PBs/PB5.
Verbrugge, B. (2014). Capital interests: A historical analysis of the transformation of small-scale gold mining in Compostela Valley province, Southern Philippines. *The Extractive Industries and Society*, *1*(1), 86-95.
WIEGO (2017). About the informal economy. Retrieved from http://www.wiego.org/informal-economy/about-informal-economy.
World Bank (2017). Country Overview, Tanzania. http://www.worldbank.org/en/country/tanzania/overview. Accessed on February 19, 2018.
Zelenev, S. (2015). Universal social protection: The World Bank Group and ILO join forces in launching the Universal Social Protection Initiative. *International Social Work*, *58*(6), 840-843.