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Submission Information

The Journal only accepts articles from undergraduate students. The Journal considers three types of articles:

1) Articles that discuss the development of a service-learning project and the impact of the project on the community served;
2) A case study of a service-learning project;
3) A reflection on service-learning and the development of personal leadership.

Each article will be reviewed by selected readers and the member of the editorial board. Manuscripts should be typed double-spaced, excluding block quotations which should be typed single-spaced, and references. To ensure anonymity, author's names and affiliation should appear on a separate cover page. Articles should not exceed 15 pages. Authors should follow APA format.

The Journal accepts Book Reviews on service-learning and social change. Book reviews should not exceed 2 pages and include Book Title, Author, and Publisher.

The Journal also accepts "Notes for the Service-Learning for Leadership Forum". The Forum is for a brief "Comment and Response" to create a national and international exchange on contemporary issues, concerns, or ideas about implementing service-learning to impact our communities. Forum notes should not exceed 3 pages.

Submissions should be sent in Word format. DO NOT HAVE HEADERS OR PAGE NUMBERING. Submit by e-mail to:

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Editor

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Fall 2015

The Editor's Notes

I admit I am a gym rat. It is not unusual for people I know at the gym where I work out to know what time it is when I walk in the door. Each day, before I begin my work out, I walk through the free-weight area strip the leg press machines, the Smith Squat Rack, benches, and incline presses of the weights that have been left on and re-rack those weights. I pick up the weights that have been left on floor and re-rack them, as well as the dumb bells that lay strewn across the area. It is not unusual to see leg press machines with more than ten 45 pound plates left on or incline press stations with 3 plates on each side. What is normal is that despite the signs on the mirrors requesting members to "please re-rack your weights", people hit the weight room, load up the machines or benches they are using, and when finished with their repetitions, walk off to the next exercise leaving the weights. Anybody who has been to a Gold's Gym, a L.A. Fitness, or a "Y" is all too familiar with this scene.

So each day I walk through the free weight area before I start my routine. I make small talk with those I know and go about the business of re-racking the weights. I take in the people working out and begin to realize how diverse they are. They are from all over the world. Languages from Eastern Europe to Pan-Asia resonate on cell phones. They represent all socio-economic classes. They are professional classes, working classes, faculty and graduate students, and retirees. They are from all income levels and life-styles. They share apartments, live in opulent houses, span sexual-orientations, and more. And they have in common coming to the gym on their schedule to keep themselves fit as they define it.

As I begin to re-rack the machines and benches that been had used, some look at me and, perhaps, feel a bit uncomfortable. There are some who begin to re-rack and I find continue to do so each time they come to the gym. But most just leave their weights, even as they watch me strip down other machines and benches next to the ones they are on. They are used to me "cleaning up". I don't mean to make anyone feel uncomfortable nor do I suggest to anyone that they should re-rack their weights. There are many times, in fact, that I enjoy straightening up. It's concrete and when the room is done it is so much easier to do a workout routine. Still, people come into the cleaned-up space, use the machines and leave their weights, and I continue to strip the machines between my sets until I am finished with my workout and leave for the day.

I do get comments as I strip the machines. "They ought to pay you for your work!" "I bet you're getting in an extra work out." "You're the only one I see doing this. People here are such slobs!" Just recently there was a young woman who wanted to use one of the leg machines. Both were free and both were laden with 45 pound plates. She just stood looking at them. I walked up and began stripping one of the machines and re-racking the weights. She asked me if I was going to use that machine. I told her no. I just had a thing about keeping the room a bit

straightened up. She looked at me; then grabbed the weights she wanted to use. I went to the next leg machine to strip that one. And before I finished, the young woman had finished her sets and left, leaving the machine loaded with the weights she used. A graduate student came up to me after and said that he always tries to remember to re-rack his weights and asked me why do I do this every time I come in?

It is an interesting question. My yoga instructor always reminds us, after shavasana, to take what we have "learned on the mat" with us into what we will do that day. I wondered what would happen is each of us cleaned our part of this "community" we called the gym for the next person coming whom we will never meet and never know. Could we learn to be more mindful from simply taking but a few moments to re-rack the weights we use. Certainly, the "community space" in which we do our routines would be better for all of us if each of us did something so simple. In doing this, would we learn be more caring of the space we use and leave for others? Could we take that lesson "from the mat" with us into our day-to-day lives and be mindful of that in all that we would do that day?

I do wonder what would we happen if each of us just cleaned our part in this little community of the gym. We would be exercising our empathetic consideration? And isn't this the grounding of servant leadership? In thinking about this, I realized that I was bringing what I hoped I was teaching through service-learning with me into my day-to-day. Isn't this what we hope our students will "take from the mat" when they do service-learning?

As for the question that the graduate student asked me, I answered simply that I was just trying to be a good neighbor. He nodded his head. He smiled a bit. And perhaps…well maybe.

So remember. After you finish your workout, please re-rack your weights!

--Ned Scott Laff--

Childhood Obesity Prevention

With rising expectations to meet standards in the classroom, many schools are cutting back on physical activity to allow for more time for academics. This lack of play throughout the school day could possibly lead to childhood obesity and other health risks (Shroeder, 2009). Many professional organizations are providing parks and recreational areas for communities. They promote conservation of natural resources, health, wellness, and the inclusion of people of all races and abilities. The National Recreation and Park Association (NRPA) believes parks and recreational areas for the community are the doorway to promoting health and connectivity for the community. Boundless Playgrounds also encourages people to become active and live healthy lifestyles while promoting the inclusion of people of all abilities. In partnering with other programs like the American Heart Association, many organizations are working to create environments that will lead children to a healthier future.

BREC (Baton Rouge Recreation) was created in 1946 by a State Legislative Act to maintain and operate park activities for all people in the Baton Rouge area. BREC offers many programs to encourage people of all ages to get outside and get active. Some of these programs include inclusive baseball, kayaking sessions, virtual park days for schools, martial arts, and fitness trainings.

We volunteered through the BREC program with an inclusive baseball league. The league meets every Saturday morning for a couple hours at BREC Forest Park and has three different games: age six and under t-ball, age seven to fourteen coaches' pitch and fifteen and up softball. We had the opportunity to play coaches pitch with the seven to fourteen year old age group. There were twelve children split between two teams, and the majority of the players had special needs (ten of the twelve). We assisted the children by making sure they were in the right place, helping them catch and hit the ball, and running with them from base to base. This was a great opportunity for the players to become active and have fun with their peers while doing so.

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To bring awareness of childhood obesity to our schools, we each taught two lessons on physical activity, a healthy diet, and the benefits of a healthy lifestyle. Our first lesson focused on the food pyramid where we used pictures to create the food pyramid as a class. We discussed the importance of each level of the food pyramid and how it applies to their daily lives and activities. At the end of the lesson, we introduced a food journal and challenged the students to record what they ate throughout the week and discuss healthy foods with their parents. Each page of the journal had a food pyramid and boxes to check each food group, with more boxes for healthier foods.

The second lesson we implemented focused on becoming active. We talked about how ofeten to exercise and ways to do so. We also read the story *I.Q. Gets Fit*, and brainstormed other ways to exercise than the ones mentioned in the story. We acted out some of these exercises and brought the lesson outside to experience more ways to move. Again, in trying to encourage the students to bring these healthy habits home, we gave each child an exercise journal to fill in with their parents. Both of these lessons encouraged involvement at home in hopes to change some of the unhealthy habits of our students.

Background

Childhood obesity is a growing epidemic in the United States. According to the Centers for Disease Control and Prevention [CDC] (2014), one in every three children is overweight or obese. Early onset of this disease increases a child's susceptibility to diabetes, heart disease, and cancers (Pulgaron, 2013). Studies have reported that the following three factors play a vital role in children becoming overweight or obese: genetics, behaviors, and the environment (Karnik and Kanekar, 2012). Teachers and parents can encourage healthy development by understanding how these factors play a role in childhood obesity.

Behavioral factors related to childhood obesity include a child's diet, sleeping habits, and physical activity. Epstein, Gordy, Raynor, Beddome, Kilanowski, and Palcuh (2012) conducted a study that changed the eating patterns of parents and children who were obese. The results indicated that participants who increased healthy food intake lost more weight than those who decreased fatty food intake. Schools and parents should provide a variety of fruits and vegetables with every meal. Additionally, studies have found that children who experience restless sleep are more prone to eating empty calorie foods (Burt, Dube, Thibault, and Gruber, 2014). The CDC (2014) recommends that preschool children sleep for 11-12 hours a day and school-age children sleep about 10 hours a day. Teachers of preschool age children should set aside a portion of the day for naptime and provide parents with a record of how long their child slept to help determine a set routine for their child to go to bed. The last behavioral factor is frequency of physical activity. An increase in physical activity expends more calories and leads to a healthier lifestyle.

Environmental factors include safe homes, schools, and communities that support healthy living and exercise. Healthy environments provide nutritious food options and appropriate structures for active lifestyles. Rahman, Cushing, and Jackson (2011) write, “There is strong evidence to show that long-term solutions to the childhood obesity epidemic can be achieved by modifying the built environment to increase children's physical activity and access to healthful foods, and reduce their access to unhealthy foods.” Schools and families should provide accessibility to a wide variety of foods and physical activity in order to promote healthy living for students.

To promote healthy lifestyles at an early age, preschool students should participate in two hours of exercise a day including 60 minutes each of structured and unstructured play, typically broken up in 10-15 minute increments. While research has shown this is more beneficial for young children, there are not many policies to ensure schools provide their students with this time (Mazzeo, Arens, Germeroth, Hein, 2012, p.11).

Recommendations from the Field

Multiple organizations recommend practices in support of childhood obesity prevention and increase of playground play in children’s daily lives. Boundless Playgrounds, Healthy Kids Healthy Communities, and a local organizations such as Baton Rouge Recreation, advocate for the prevention of obesity by educating those on the factors listed above that lead to obesity.

Boundless Playgrounds is a non-profit organization that encourages children to improve their physical activity by installing inclusive playgrounds available to the public. Often, community parks are not appropriate or accessible to children with disabilities; however, Boundless Playgrounds hopes to change that by installing playgrounds where, “every child can reach the highest play deck, swings and bouncers have back support and sensory-rich activities let the imagination soar” (“Boundless playgrounds,” 2013). Their mission is to encourage people of all abilities to play and learn in a welcoming environment. Boundless Playgrounds’ mission states:

> To create a world where all children have the opportunity to gain the developmental and health benefits derived from unstructured play in an inclusive environment. To provide a learning and growing environment so children can develop a lifelong respect for and appreciation of individuals of all abilities (“Boundless playgrounds”).

The organization created their own criteria for designing inclusive playgrounds to meet the needs of the communities they build in. Currently there are two playgrounds in Louisiana built by Boundless Playgrounds—one in Mandeville and the second in Shreveport.

Similar to Boundless Playgrounds, Healthy Kids, Healthy Communities (HKHC) is a national organization that promotes healthy and active living by supporting communities and encouraging families and children to stay active. HKHC targets children susceptible to obesity. They provide funding and social supports in the community and help communities implement new playgrounds in order to encourage healthy lifestyles.

Baton Rouge Recreation's (BREC) main focus is to develop programming that helps families and children stay active outdoors. They offer classes, community events, and sports leagues in order to support active outdoor lifestyles. BREC provides camps in the summer and on school holidays, which aim to keep children active while they are away from school ("Baton Rouge Recreation," 2014). BREC works to reduce the percentage of childhood obesity by encouraging families to stay active and providing safe environments for physical activity.

Divergent Perspectives

Both parents and teachers were surveyed on the issue of childhood obesity (see Appendix A). A preschool teacher, who participated in the survey, stated, "I once had a child in my class who was so overweight I was scared if he'd wake up at naptime. He weighed 140 pounds at four years old" (A. Crawford, 2014). While 50% of teachers rated the urgency of childhood obesity as "extremely urgent," only 83% of teachers rated their general knowledge of obesity, understanding of the risks associated with it, and knowledge of preventative measures as proficient. These teachers do not feel that they are knowledgeable enough to educate parents and families on the subject. Therefore, we must educate teachers and encourage them to model healthy lifestyles to their students.

The media describes obesity as the greatest health risk for children today. Media sources such as *PTOToday* and *Examiner* suggest that in order for this trend to end, children must become more active. *Examiner* described that obesity can have long term effects, even if the children manage to lose weight later in life (Finch, 2014). *Auburn Reporter* indicated that these issues can begin at birth and believe that schools and parents should be the ones who set healthy habits for the children (Gustafson, 2014). *PTOToday* presented research that displays that physical activity in schools is decreasing and children are not compensated for this time at home (Brown, Sutterby, Thorton, 2014).

Though articles describe obesity as an increasing issue among children, *PTOToday* stated that pediatricians believe schools are attempting to increase "physical education, recess and development of community parks and playgrounds, especially in low-income areas (Brown et al., 2014)." Programs such as Healthy Buddies and pro athletes like Jacksonville Cornerback Alan

Ball are also supporting childhood obesity prevention. Ball is involved in the program NFL Play 60, which supports 60 minutes of play a day for children. In addition, *DailyPress* described an initiative in 4 states that hopes to reach 7,500 children in order to improve healthy habitats in early childhood centers. Research states that childhood obesity is increasing, but politicians, schools, doctors and athletes throughout the United States are working together to combat the issue and increase healthy living for children.

Below are reflections of our experiences.

Reflection 1

Prior to our advocacy project, I thought we knew a lot about childhood obesity and prevention; however, through reading research and discussing the problem with our stakeholders I learned more than we thought we would. Current research taught me the magnitude of this problem and how important it is to promote healthy lifestyles at a young age. I was surprised by the results of our stakeholder survey because I had predicted that the majority of teachers would think this is an urgent issue that is relevant to their lives. I was shocked when only half the teachers stated that. Reviewing the survey results guided me in planning and implementing an effective action plan that promoted healthy living.

One obstacle that I overcame was finding time to teach our healthy eating and exercise lessons. Although teachers understand the importance of this issue, they are currently under an immense amount of pressure to raise their test scores, and during this time of year, they are focused on "readying" their children for the next grade. As a group, we recognized these stresses and created short, simple lessons that can be taught in fifteen minutes at the end of a day.

Through volunteering, I learned how to keep children active regardless of disabilities. I also realized how crucial volunteers are. Without the support from the volunteers at BREC, the inclusion softball league would not be possible. I hope to find similar opportunities in the future that promote exercising on the weekends.

I noticed disconnects when reviewing our surveys. For example, one parent rated their knowledge of preventative measures of childhood obesity as a ten or "extremely knowledgeable;" however the same parent scored a four for "On a scale of 1-10 [one being not important and ten being extremely important], rate the importance of children spending 60 minutes a day exercising through unstructured play on appropriate playground equipment." To eliminate this disconnect, I want to educate parents on how important an active lifestyle truly is. Additionally, I had talked with many of the teachers who said this is an issue that needs to be advocated for but I continued to witness these teachers use candy as a reward in their classroom.

If I were to do this project again, I would change the questions of our stakeholder survey to multiple-choice rather than a numbered scale. I would also survey more families and teachers than those in my classroom. Overall, I found that our project has been successful thus far, and I plan on continuing advocating for this issue in the future.

Reflection 2

I knew some information and research about childhood obesity going into the project, but I learned a lot throughout the process. One interesting thing I learned was "pediatricians believe schools are attempting to increase physical education, recess and development of community parks and playgrounds, especially in low-income areas (Brown et al., 2014)." Throughout my student teaching placements, I was under the impression play and activity outdoors was being taken away in order for schools to focus on academics. I also found it interesting that, "a study done at the University of Colorado Cancer Center showed that childhood obesity can have long term effects on children, even if they manage to lose weight later in life (Finch, 2014)." This was interesting and a little disheartening to me, because often times obesity starts from birth and its sad to think that a child may have health problems from birth on, from something they could prevent. Along with the research, I found out about multiple organizations such as *Shape Up America!* and *Louisiana Organizations Fight Against Childhood Obesity* that work to prevent childhood obesity and help children and families become more active.

During the project, there were a couple of obstacles we met. Our first obstacle was figuring out exactly what we wanted to advocate for and what we would be the most passionate about. We began wanting to advocate for playground play, but through research we became more interested in and passionate about childhood obesity. Therefore, we switched our main issue to childhood obesity, but focused on active play in order to incorporate our initial playground interest. Another obstacle we came across was our volunteer opportunity falling through. We initially wanted to volunteer to help build a playground with the civil engineer department at LSU, but there was no playground building opportunity for this semester. Thus, we got in touch with BREC and volunteered with their inclusive baseball league, which was very rewarding.

There was quite a difference in the information the media provided and the information advocacy groups provided on childhood obesity. The media offered a variety of statistics on childhood obesity, along with well-known people who are involved in change, such as Michelle Obama and famous athletes. The media also provided recommendations for how much healthy foods should be eaten daily and how much physical activity children should receive, but not much information on how to accomplish this. The advocacy groups provided the same type of information with much more information on how these things can be accomplished. These groups also provided children and families with ways to eat healthier and get more active. Some of the organizations

provided gardening days, recipes, and work out programs, to help families change their lifestyle to a healthier one. The main difference between the media and the advocacy organizations was that the media provides information and striking statistics, while the advocacy groups provide this information along with resources on how to change the statistics.

Through my volunteer experience at BREC I learned a variety of things. The main thing I learned was how far a little encouragement can go for a child. The children were so easily discouraged as soon as something went wrong in their game, but as soon as someone said "way to go" or "you can do it" they suddenly become completely capable of completing the task at hand. I thoroughly enjoyed volunteering with this team and plan to return in the future.

Reflection 3

In beginning our advocacy project to prevent childhood obesity, I was astounded to find out nearly 43 million children in the world who are overweight (Rishardson, Paulis, Middelkoop, Koes, 2013). After seeing how childhood obesity affects the students in my placements, it was very interesting to find more information about how these families feel. Research shows children should have almost two hours total between structured and unstructured physical activity throughout the day, although we know that does not always happen in schools. Teachers are often over stressed from trying to meet grade level standards and feel time in the classroom is more beneficial in trying to meet those standards. In all actuality, providing students with time to get active and use some of that pent up energy is not only beneficial to their health, but has shown to have academic benefits as well (Schroeder, 2009). Fortunately, the media and literature have very similar stances on childhood obesity and ways to prevent this problem such as encouraging healthy eating habits and becoming more active. Although many of our stakeholders did not think this issue applied directly to their lives, they too have a basic knowledge of what childhood obesity is, that it is a problem, and ways to help prevention. Because most people are on the same page with understanding that it is an issue, I feel we did not face many obstacles throughout advocating for prevention of childhood obesity.

We partnered with BREC to volunteer with their inclusive baseball league. The league meets every Saturday and plays t-ball, coach's pitch, and softball with people of all abilities ages six and up. This was an amazing experience to get active with children who were so excited to be out playing with their friends. We worked with coach's pitch ages seven to fourteen which had twelve children playing, all but two with disabilities. The league is set up to be very encouraging and seems like they have created their own family, even with the players that were playing other versions of baseball. As soon as someone showed up, everyone was saying hello and already knew their name because of the wonderful community they had created. Although there were probably only two or three children who struggle with weight, it was a great to see the other children encouraging and getting active with them.

Most stakeholders recognize childhood obesity as at least somewhat of a relevant problem, many did not see how it really connected to their lives, all the risks associated with childhood obesity, or preventative measures. This disconnect lead us to informing children and their families of ways to get healthy and active. Students in my classroom had great ideas for healthy eating and exercises they could do at school or at home. I also sent home food and exercises with students to fill out with their parents, and although I didn't receive a few back, the ones I did receive were pretty similar in some of their eating habits except one student. I expected this one student's journal to be very different due to the prior knowledge I had of his eating habits. He only eats chicken nuggets and French fries for dinner. For lunch, he typically brings Cheetos puffs, goldfish, Hershey kisses, about ¼ of an apple, a special treat such as a laffy taffy, a capri sun, and boxed Hershey's chocolate milk. Although my teacher has talked with his parents about the lack of nutritional value in his lunch, his parents have not changed what they provide for unknown reasons. I hope in teaching the student about healthy eating habits, it at least has some effect on his diet.

I am very pleased with the way our advocacy project turned out. We were able to get involved in organizations such as BREC that I would like to continue with in the future, and I felt we were able to reach many of our students and their families. Even if it caused one of our students, their families, and their teachers focus more on healthy habits; I feel we have been successful in our advocating for prevention of childhood obesity.

Appendix A

Teacher Parent

1. **How much do you know about childhood obesity?**

   1 2 3 4 5 6 7 8 9 10
   Nothing A lot

2. **How much do you know about the risks associated with childhood obesity?**

   1 2 3 4 5 6 7 8 9 10
   Nothing A lot

3. **How much do you know about the preventative measures for childhood obesity?**

   1 2 3 4 5 6 7 8 9 10
   Nothing A lot

4. **Do you think this is an urgent issue that should be advocated for?**

   1 2 3 4 5 6 7 8 9 10
   No Yes

5. **How relevant is this issue to your life?**

   1 2 3 4 5 6 7 8 9 10
   Irrelevant Extremely relevant

6. **How influential are playgrounds for preventing childhood obesity and promoting healthy development for gross motor skills?**

   1 2 3 4 5 6 7 8 9 10
   Nothing A lot

7. **Rate the importance of children spending 60 minutes a day exercising through unstructured play on appropriate playground equipment (including jungle gyms, swings, bikes, jump ropes, monkey bars, etc.).**

   1 2 3 4 5 6 7 8 9 10
   Not important Extremely important

Appendix B

Exercise is FUN! - Track your Move-It Minutes:

Color the box every time you exercise	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
15 Move-It minutes							
15 Move-It minutes							
15 Move-It minutes							
15 Move-It minutes							
Extra Move-It minutes							

My favorite Move-It activities are: _____

More Nutrition Fun www.ChefSolus.com

Sweets					
Dairy					
Protein					
Fruit					
Vegetable					
Grain					

(2005)

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Village Health Insurance

"Je vous remercier, nous sommes vraiment des pauvres et voilà que surtout ce programme d'assurance là… si tu as vu, au village ça a nous sauvé"-Komla Alaza.

Introduction

Located in Kuwdé, a rural mountain village in Northern Togo, the Case de Santé (CDS) offers a micro-health insurance system to the community. The Case de Santé is a state-run health clinic that primarily treats malaria and other minor sickness and injuries while also operating as a birthing center. Serving 156 families, the CDS is one of the only clinics of its kind that provides health insurance to patients- a system that successfully saves both the CDS and insured families money. However, many members of the community leave the advantageous system and others do not join at all. We first analyzed the current standing of the system, calculating exactly how much money insured families were saving and how much money uninsured families were losing. The primary goal of our research was then to discern the perception of health insurance within the village, and understand why some families left or simply were not joining an advantageous system. Our research was thus cultural and socio-economical and at other times purely mathematical.

Background

The Case de Santé falls under the control of the highly standardized healthcare infrastructure in Togo. Healthcare infrastructure in West Africa is currently under scrutiny due to the ongoing Ebola crisis. As of now, Ebola has not been reported in Togo, but has been responsible for thousands of deaths in Guinea, Liberia, Sierra Leone and Nigeria. How does Togo's healthcare infrastructure compare to affected West African countries? As of 2013, the World Health Organization (WHO) calculated total health expenditure (THE) in Togo as 8.6 percent of its GDP. A lower THE suggests that a lack of resources are devoted to healthcare, while in contrast a higher THE implies widespread healthcare infrastructure and superior use of technology. Comparably, in the following affected countries the common health-financing indicator is higher in comparison to Togo's: 15.5 in Liberia and 15.1 in Sierra Leone (compared to 17.9 in the United States) (World Health Organization, 2013). The prevalence of poverty in many affected countries

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is also intensifying the Ebola outbreak. Within the affected countries, Guinea and Sierra Leone are in the top 25 of IMF's list of poorest countries while Liberia is 4th. While unaffected Togo comes in 12th, its affected neighbor Nigeria is the least statistically impoverished coming in at 45th (International Monetary Fund, 2014) Togo's total health expenditure is not only lower than its affected West African counterparts, but it is also more statistically impoverished than the majority of Ebola affected nations.

Within Togo, healthcare infrastructure is under control of the government, as many health structures like the CDS are highly standardized. The health care system in Togo is divided into a pyramidal system consisting of three levels: 1) the summit of the pyramid which encompasses the central level of Teaching Hospitals, 2) the intermediate or regional level, and 3) the peripheral, prefectural or sanitary district level. The nation is divided into six health care regions, which are subsequently divided into 35 total districts (International Organization for Migration, 2014)

The CDS is located within the region of Kara, which is statistically more disadvantaged than the rest of the country. This disparity can be attributed to numerous reasons, such as Kara's mountainous terrain and inadequate road system that inhibit access to resources as well as underdeveloped sanitation systems that leave inhabitants vulnerable to water born diseases. Infant mortality, an essential health indicator, is 86 per thousand live births in Kara, compared to 78 for the nation's average (World Bank, 2001).

The CDS is located in Boa/Kuwdé serving the surrounding villages of Kuwdé, Boa, and Farendé. The CDS has two medical assistants, Basile and Oedil, who received training over 15 years ago via short two week internships. In the neighboring plain village, Farendé, is the Centre-Médicale Sociale, which is a larger medical center primarily run by a young medical assistant. The CDS provides medicine and care to local patients and also non-locals passing through the region, absorbing some of the minor responsibility from nearby Centre-Médicale Sociale while referring patients to the larger medical center if needed.

As 53% of Togolese live on less than two US dollars a day, the price of medication and health care can be expensive for members of the village (World Bank, 2011). Most of the families in the village live on the margin, living off the land that they cultivate. Started in 2008, the micro health insurance system allows families to join the system at any time. To join, each family, regardless of size, pays a flat fee of 1800 CFAs ($3.46 US dollars) for the year. In return, they receive ¼ the price of medication and do not have to pay a 50 CFA consultation fee each visit.

Methodology

Over the course of two months in the summer of 2014, we analyzed the health insurance system using patient data within the CDS. We spent mornings and often afternoons at the CDS working with Basile and Oedil at the clinic.

Informal Conversations

We spent a lot of time simply using Basile and Oedil's experience and advice to our advantage, posing informal questions about the CDS, local perceptions, and cultural cues that we would not have understood otherwise. Within the village, we also had many conversations with Togolese friends and our host families about village health care in general. We also shadowed Francois, the medical assistant at the Centre-Médicale-Sociale in Farendé and spoke to him and other CMS employees about health infrastructure.

Data Analysis using CDS Records

Our first task was to analyze the current standing of the system. We examined which families had left or stayed in the insurance system, and also accounted for families that have recently joined. Analyzing insurance notebooks at the CDS, we calculated how much money each insured family had saved/lost in the past year.

Using a larger notebook that accounts for all patient visits at the CDS, we documented every visit in the past year, including family name, price, and patient history. From this data, we were able to discern which uninsured families could benefit from the system and calculate how much they could have saved if they had been insured. We also evaluated pregnancy data at the CDS, taking into account the high price of giving birth within our patient history calculations.

To contextualize the system within the CDS, we used all data to calculate the total yearly cost of the health insurance system. We then calculated the clinic's total annual revenue taking into account both insured and uninsured patient history.

Structured Interviews

After analyzing the data, we choose over two-dozen families to interview. There was a range subject groups, including insured families, uninsured families, and those who had left the system. These interviews were crucial to understand village perceptions of the system and hear firsthand why some villagers chose to leave an advantageous system or chose to not join at all.

Village Meeting

We held a village wide meeting at the end of our time in Kuwdé to explain the system, clear up misconceptions, and to hear feedback from local patients. This also allowed insured patients to testify their experiences for other villagers.

Initial Findings

We examined the records of insured families since 2013. We found at the start of 2013 there were 18 families in the system. However, in 2014 only nine of those families stayed in the system, and nine did not return. Additionally, two new families joined in July 2013 and four new families joined in 2014. Therefore with the nine that stayed in the system and the six new families, the current system yielded 15 families. A number is given to each insured family for record keeping purposes. Some families have the same last name, so a number serves to properly identify the family, and is an indicator of when the family joined the system relative to others.

We then analyzed all patient visits in 2013 for insured families. Our goal was to gain a comprehensive overview of how much each family was saving, or losing, within the system. For the families that were insured, the following calculations were made:

- How many times during the given time period the family had been to the Case de Santé – "Nombre de visites"
- How much each family had to pay for medications (25% of the price for those who are uninsured) – "Argent paié (pour medicaments)"
- How much each family saved for the medication – "Argent economisé (de l'argent pour les medicaments)"
- How much each family saved from consulations – "Argent economisé (de l'argent pour les consultations)
- How much each family saved overall (including the insurance fee for that period) – "Argent economisé (avec frais d'assurance-1800)"

Table 1: Familles Assurés Jan 2013-Jan 2014

Family	Numero de compte d'assurance	Nombre de visites	Argent paié (pour médicaments)	Argent economisé (de l'argent pour les médicaments)	Argent economisé (consulatations)	Argent economisé totale avec frais de l'assurance (1800)
Bawilla	1	9	1872.5	5617.5	450	4267.5
Kakona	2	12	2456.25	7368.75	600	6168.75
Basseliki	4	6	1337.5	4012.5	300	2512.5
Yoabalo	5	2	350	1050	100	-650
Balayrou	7	6	1408.75	4226.25	200	2726.25
Wella	8	8	907.5	2722.5	400	1322.5
Koriko	9	6	1198.74	3596.25	300	2096.25
Biao	12	9	1472.5	4417.5	450	3067.5
Plasah	14	2	593.75	1781.25	100	81.25
Sarah	15	3	420	1260	150	30
Santi	17	4	715	2145	200	545
Kai	18	10	1830	5490	550	4190
Falla	19	6	885	2655	300	1155
Alaza	20	6	1465	4395	300	2895
Eyeba	22	3	417.5	1252.5	150	-397.5
Ayaki	26	2	562.5	1687.5	100	-12.5
Kai	28	2	213.75	641.25	100	-1058.75
Kpissiré	30	9	701.25	2103.75	200	503.75

Insured Families

We found that of the nine families that stayed in the system, every single one had saved money during this time. Of the families that did not return to the system, five saved and four ended up losing money (see Argent economisé totale avec frais de l'assurance in Table 1). This calculation represents each family's total insurance savings (or losses) for this past year. However, the insurance system has been in place for many years, so it is also necessary to put this year's numbers in context with previous years. Therefore, we grouped the insured families into three categories (Table 2). We did not have the numerical data for older years (2009-2010), but we did know in general whether a family was or not in the system. A dash "-" means the family was in the system that year, where an "x" means they were not in the system.

Rénouvelés- Renewed Families

These are the families those who stayed in the system. There were nine total, and they all saved money this past year. Taking into context previous years as well, all of these families have saved extraordinary amounts when we totaled annual savings every year they have been in the system. On average, each of these "veteran" families has saved a total of 7300.15 over the past three years.

Pas rejoignent, mais economisent-those who left the system although they saved money

These families represent the greatest mystery of the project- families that saved money in the system, but did not continue. As seen in Table 2, many families have saved money every year, totaling to very large amounts. Thus, these families have continuously been saving money, but decided not to rejoin. These five families we knew would be crucial to our interviews, and would shed light on perceptions of the system and why they did not return.

Pas rejoignent, et perdent- those who left the sytem yet also lost money

Of these four families, one did not visit the CDS at all in 2013. These familles represent why its important to look at insured patient history over time rather than just a single year. Although all in this group had lost money this year, in previous years they may have benefitted greatly. In fact, three of the four families actually have saved money in total by being in the system. This was an important point; although one year may not save a family money, the family should continue with the system anyway for long term benefits.

Table 2: Comprehensive Insurance Histories 2009-2014

		Rénouvlés					
		Argent economisé totale avec frais de l'assurance (1800)					
Famille	**Numero de compte d'assurance**	**2009-2010**	**2010-2011**	**Aug 2011-12**	**Sept-Dec 2012**	**Jan 2013-14**	**Totale**
Bawilla	1	-	-	3390	940	4267.6	8597.6
Kakona	2	-	-	6970	5132.5	6168.75	18271.25
Basseliki	4	-	-	1175	500	2512.5	4187.5
Balayrou	7	-	-	300	0	2726.25	3026.25
Boura	8	-	-	5440	5162.5	1322.5	11925
Kouriko	9	-	-	1907.5	1025	2096.25	5028.75
Biao	12	-	-	5075	500	3067.5	8642.5
Santi	17	x	-	-225	1375	545	1695
Falla	19	x	-	872.5	2300	1155	4327.5
						Avg:	7300.15

Pas rejoignent, et perdent							
		Argent economisé totale avec frais de l'assurance (1800)					
Famille	**Numero de compte d'assurance**	**2009-2010**	**2010-2011**	**Aug 2011-12**	**Sept-Dec 2012**	**Jan 2013-14**	**Totale**
Yoabalo	5	-	x	3450	0	-650	2800
Kassoka	6	-	-	-837.5	0	-1800	-2637.5
Ayaki	26	x	x	1532.5	0	-12.5	1520
Eyeba	22	x	-	-655	1910	-397.5	857.5

Pas rejoignent, mais economisent							
		Argent economisé totale avec frais de l'assurance (1800)					
Famille	**Numero de compte d'assurance**	**2009-2010**	**2010-2011**	**Aug 2011-12**	**Sept-Dec 2012**	**Jan 2013-14**	**Totale**
Plasah	14	x	-	-900	2062.5	81.25	1243.75
Sarih	15	x	-	2745	600	30	3375
Kai	18	x	-	6581.25	1770	4190	12541.25
Alaza	20	x	-	x	x	2895	2895
Kai	28	x	x	x	x	2878.75	2878.75

Uninsured Families

Many uninsured families are not aware of how much they could benefit from the system. We calculated how much each uninsured family would have spent over the course of the year if they had been insured. This provides a finite, personalized calculation for families, demonstrating how much they could save by joining the system. We went through the patient history for every single family in the system, narrowing it down to targeted families that could benefit the most. For each family, we calculated the following:

- How much each family had to pay for medications and consultation – "Argent paié (pour medicaments et consultations)"
- How much each family would have paid for medication if they had been insured – "Argent paié pour medicaments et consultation (avec l'assurance)"
- How much each family would have saved for medication and consultation if they had been insured – "Argent economisé pour medicaments et consultation (avec l'assurance)"
- How much each family would have saved overall (including the insurance fee for that period) – "Argent economisé totale avec frais de l'assurance"

Table 3: Selected Uninsured Families Analysis July 2013-July 2014

	Argent paié (pour médicaments et consultation)	Argent paié pour médicaments et consultation (avec l'assurance)	Argent economisé pour médicaments et consultation (avec l'assurance)	Argent economisé totale avec frais de l'assurance (1800)
Gniouta	4300	1037,50	3262,50	1462,50
Bahim	2580	620	1960	160
Awissi	4230	1020	3210	1410
Dolou	3400	837,50	2612,50	812,50
Alare (Maman)	5800	1375	4475	2675
Sintayele	7550	1787,50	5762,50	3962,50
Adem	5600	1312,50	4287,50	24875
Tando	7380	1732,50	5647,50	2847,50
Yoritchao	7390	1735	5655	3855

Calculating uninsured data provided a few challenges. The first of which was cultural. Households in Togolese villages often contain a mother and father who are not raising their own children. It's a simple division of resources-as families may take in nieces, nephews, grandchildren, etc. because they can support them. Therefore, many children do not have the same last name as the parents in their household. This posed a problem when we are trying to figure out which last name belongs to which household families. In the notebook only a simple first and last name was written, so we consulted Basile for each entry, making sure to patch people with the correct household family.

Secondly, the notebook did not give the price of each visit, but rather a list of prescribed medicines and the patient's age. As shown below, we had to create a price list of the medicines to determine how much each visit cost. The CDS falls under extremely standardized care, so each patient is given a set number of pills/medications based on his/her age and symptoms.

Table 4: Standardized Medicine Price List

		Dose Cost			
Medicine	**Unit Price 1 pill**	**AGE 1-4**	**AGE 5-14**	**AGE 15-44**	**AGE 45+**
Paracetamol	10 CFA	100 CFAs	100 CFA	200 CFA	200 CFA
Ibuprofen	10 CFA	100 CFA	100 CFA	200 CFA	200 CFA
Fer	10 CFA	100 CFA	100 CFA	200 CFA	200 CFA
Faf	10 CFA	100 CFA	101 CFA	201 CFA	201 CFA
Amoxicillin	50 CFA	150 CFA	250 CFA	500 CFA	1000 CFA
Metronidazole (Flagyl/Metro)	15 CFA	75 CFAs	150 CFA	300 CFA	300 CFA
Vitamin C	15 CFA	75 CFA	150 CFA	300 CFA	300 CFA
Biscopan	20 CFA	N/A	200 CFA	400 CFA	400 CFA
Indocide	10 CFA	N/A	100 CFA	100 CFA	200 CFA

Multivitamin	10 CFA	N/A	100 CFA	200 CFA	200 CFA
Quinine	55 CFA	330 CFA	330 CFA	550 CFA	1100 CFA
Bactrim	20 CFA	100 CFA	200 CFA	400 CFA	400 CFA
Vermox	25 CFA	25-50 CFA	150 CFA	150 CFA	150 CFA

Pregnancies

The CDS serves as a birthing clinic for many women in Kuwdé and the surrounding areas. A birthing table, is in one of the rooms in the clinic, and a kitchen hut out back allows family members to cook for the mother while she is recovering. Unfortunately, the cost of pregnancy is extremely high, costing around 5150 CFA including the 300 CFA birthing consultation fee (Table 5).

In 2013, a new policy was put in place; instead of receiving ¼ cost of birthday meds, insured families should receive half the cost. Because the fee of pregnancy is so high the entire system could bottom out if the normal insurance system applied to births. Since the cost of giving birth is so expensive, families nearly automatically save money by being on insurance. Thus, it is in every pregnant woman's best interest to be insured. Our goals within the pregnancy system were to first ensure pregnancy insurance polices were being correctly followed. We then calculated family patient history taking into account pregnancies, hoping to incentify more pregnant woman to join the system, making it clear that it will save money.

Table 5: Standardized Cost of Pregnancy

Medication/Materials	Cost
Paracetamol	200 CFA
Quinine	1100 CFA
Amoxicillin	1000 CFA
FAF	200 CFA
Biscopan	400 CFA
Alcohol	350 CFA
Bandages	600 CFA
Giant	400 CFA
Dettol	100 CFA
Declaration	100 CFA
Compression gauze	200 CFA
Soap	200 CFA
Total	**4850**
Total with 300 CFA consultation fee	**5150**

Initially, we found that the CDS was making insured families pay the normal ¼ cost of birth medicine rather than the policy previously put in place to instead pay half. Thus, we made all calculations following this format. We were surprised the ½ off pregnancy condition was not instated, and we spoke to Basile and Oedile about starting to use this format of pregnancy insurance.

It was evident the uninsured families that lost the most money were ones with births the past year at the CDS. Likewise, the insured families that saved the most were ones that had births and received the benefits. As shown in Table 6, in 2013, 18 families gave birth at the CDS, but only four of them were insured. The price of birth is standardized, except some mothers receive Buscopan (400 CFA- an abdominal pain reliever) and others do not. Uninsured families thus pay 5150 or 4750 CFA for a birth at the CDS, while insured families in 2013 paid only 1212,50 CFA to give birth. Ideally, the price of birth medicine should be only half off, making insured families pay around 2425 CFA in the future.

Comprehensive Calculations

It was necessary to analyze comprehensive earnings and losses of the CDS and insurance system. We calculated the amount the health insurance system gained/lost in a calendar year. The system is based off the price of buying and selling medicine. For example the CDS buys medicine at x price, such as a pill for 100 CFAs. Medicine is sold at the CDS for a 2x (200%) markup. This is a governmental protocol for all Case de Santés. Thus, the pill is sold to the normal uninsured patient for 200 CFA allowing the CDS to make a profit and sustain itself. Insured families receive 25% the price of medicine as uninsured families do, or .5x the price of medicine. The 200 CFA pill that an uninsured patient receives costs an insured patient only 50 CFA.

Using the following calculations, we found the insurance system made 11,717 CFAs in the past calendar year. In addition, we calculated the total amount gained and lost by the system in its entirety (the health insurance system and the uninsured people combined). In the past year, the entire system made 75,490 CFAs. Therefore, the system is a win-win; it saves patients money and also provides income to the CDS.

To find the amount the Health insurance system gained/lost for a given time:

$$1800x - (The\ total\ cost\ of\ Medicine\ purchased + 1212.5P)$$

Where x is the number of insurance payments during the given time interval, P is the

number of pregnancies for that given year and 1212.5 is the rough amount of money lost when there is a pregnancy (since the rough price of the medications for a pregnancy is 2425 CFAs (market price) the system loses 50% or 1212.50 CFAs). The money lost through consultation fees, 50 CFAs for a regular appointment and 300 CFAs for a pregnancy, has been neglected by Charlie's request.

For the Period of January 2013-2014 (a calendar year):

$x = 21, P = 6, total\ cost\ of\ medicine\ purchased = 18807.5$

$1800 * 21 - (1212.5 * 6 + 18807.5) = 11717$ CFAs

The total cost of medicine purchased was found by adding up the "Argent paié" column in Table 1. The 21 payments were found in the same table and calculated by counting every family name with a tick.

For the Period of January 2013- July 2014:

$$x = 21 + 12 = 33, P = 6$$
$$total\ cost\ of\ medicine\ purchased = 18807.5 + 5430 = 24237.5$$
$1800 * 33 - (1212.5 * 6 + 24237.5) = 27887.50$CFAs

5430 CFAs were found by adding the column "Argent paié pour meds" in Table 1. The additional 12 payments in x is also found in this table.

To find the total amount gained/lost by the system in its entirety (the health insurance system and the uninsured people combined):

$$(0.5C + 50n + 300P + 1800x) - (total\ cost\ of\ medication\ sold\ to\ the\ insured)$$

Where C= the total cost paid by the uninsured in the given time, and n= the total visits by uninsured in the given time. P is the total uninsured pregnancies in the given time, and x is the number of insurance payments in the given time.

During the Period of July 2013-2014 (this time was chosen because we had enough data for the calculation):

$$P = 7, n = 104, x = 15, C = 113455,$$
$$total\ cost\ of\ medication\ sold\ to\ the\ insured = 10107.5 + 5430 = 15537.50$$

$(0.5 * 113455 + 50 * 104 + 300 * 7 + 1800 * 15) - 15537.50 = 75490$ CFAs

C was calculated by summing the column "Total Cost" in Table 2 and adding it to the total cost calculated and 2425 CFAs by the number of pregnancies. The variable *n* was tallied up from the total number of uninsured visits within a year. P was calculated by counting the uninsured pregnancies that fell between July 2013- June 2014 Additionally, x can be found within the amount of families insured Jan 2014-July 2014."Total cost of medication sold to the insured" was made by adding up the prices found in Basile's insurance book.

Patient History Clarity

We created personalized sheets with patients' economic history at the CDS. These we given to the patient during each interview, allowing them to see a finite number of how much they were (or were not) saving.

While some families have been in the system for years, many have no concept of its advantages. We believed it was vital for families who were insured to see the exact amount of money that have saved by being in the system. First off, it is an incentive for them to stick with the system. If a family is aware of how much they are saving, they are more likely to rejoin each year. Patients left the interviews with a physical copy of their insurance history including the figure of how much they have saved in the system. Thus, it is less likely for them to forget than if we had just simply told them the number. Furthermore, insured families could speak from personal experience and cite the benefits they received within the system. It is important for members of the community to hear other's personal success within the system, rather than be told of its advantages from outsiders like us.

Uninsured members of the community were also given sheets with their patient history, detailing how much they would be saving if they had been insured in the past year. We found that many villagers were not aware of exactly how much the system can save a family. These sheets made the difference between insured and uninsured costs apparent. The idea to make these sheets came from many conversations with Basile and Oedil, and members of the CDS committee. To increase transparency, we also spoke with Basile and Oedil about pointing out cost savings potential to uninsured patients while the patients are paying. For example, if an uninsured patient must pay 200 CFA for medications, Basile or Oedil could point out the price would be only 50 CFA if the patient were insured. Likewise, it also is important for insured patients to know how much they are saving each visit. Instituting physical history sheets with finite figures and starting this increased transparency allow families to have a more finite grasp on what the savings entail.

Interviews

We conducted a total of 23 interviews separated into the three groups. All interviews were recorded using an iPhone and audio records of each interview have been archived. A figurehead of the family, usually the eldest female or male represented each family during the interview. One unprecedented cultural challenge we faced was figuring out how many members are in each family. We would ask the family figurehead how many people were in his or her immediate family unit, and often Basile and Oedil had to help the interviewee count off the members in his or her family household. In Togolese culture, homesteads don't necessarily, and rarely, constitute a mother and father and their immediate children. Instead, families are a product of the division of resources and children between cousins, aunts, uncles and neighbors. Children residing within a homestay often are distantly related to the adults they live with. Furthermore, women marrying into homesteads complicate things further, as it was unclear whether the woman belonged to her husband's or parent's family unit.

Interestingly, during interviews, we asked residents how the CDS in Kuwdé compared to others in nearby villagers. They all claimed it was significantly more successful, providing cheaper cost of medicine to patients and was free of corruption. This is attributed to the insurance system, which offers a lower cost of medicine to insured patients, but also saves the CDS itself money. We heard testimonies of other CDS that closed down due to corruption, as the workers often overcharged prices of medicine to benefit themselves, or in an attempt to bring more money into the clinic. Thus, the health insurance system in Kuwdé, the only of its kind, creates a sustainable clinic that ensures quality health care is available to village residents.

In addition to recording each interview, we also took pictures of each interviewee for documentation. Pictured here is (right) Tckenéway a member of Basseliki family, and (left) Kakona, an insured leader in the CDS committee.

Rénouvelés-Renewed Families

These were the families that have continued in the system. Our goal of these interviews was to communicate to them how much they have saved during their time under insurance. Previously, many of the insured families were not interviewed, focusing only on those who had left the system or were not currently insured. For many families it was the first time they had seen the exact amount they had saved in the system. In addition, we asked about their perceptions and the village's perception of the system and why not more people were interested.

Pas rejoignent, mais economisent-those who left the system although they saved money

These families were perhaps of the most interest to us. We wanted to interview them to understand why they had left the system even though they had benefitted from it. We first communicated how much they had saved in the past year, which was usually a large sum that surprised many interviewees. The conversation usually then flowed into their general perceptions of the system and finally, why they did not rejoin. There were various reasons why each family had not rejoined. Two families did not know that patients could rejoin at any time, and thought they had missed their opportunity at the beginning of the year. For example, Alaza had been in Nigeria during January, and Sarih claimed that he did not have the money in January either. They were surprised to learn you could join at any month and promised they would rejoin soon. Another man, Plasah rejoined the system later that day after the interview. Furthermore, it was interesting to see the clash between traditional and bio-medicine in Kai's interview. He said that he had been in Benin for the past nine months treating hemorrhoids with traditional methods, which were very expensive. Therefore, he didn't currently have the money to rejoin the system but recognized its benefits and claimed that he would join once he paid for the traditional medicines.

These interviews seemed successful; we learned it was important to communicate to the village that you could rejoin the system at any time. None of the patients had left the system intentionally, which was a good indication about the perception of health insurance in the village.

Uninsured

We also interviewed many uninsured families that could greatly benefit from the system. Our goal was to make sure that they understood how insurance works, and how they could save money. We showed them their personal history at the CDS and how much they had been spending relative to how much they could have been saving.

We found that many families did not understand the system, and therefore we explained it thoroughly during the interview. Others understood the system, but stated that they had not joined due to negligence. Many claimed they did not currently have the money to join

because of various reasons such as funeral costs, or that they would have the means after the harvest in the fall.

Village Meeting and Conclusion

Before we left, we held a village wide meeting to communicate information on the insurance system, and also allow villagers to ask questions and give their input. Michaela gave a speech outlining and summarizing the many points of the system. After the interviews, we made sure to explain that patients can join the system at any point in time. Furthermore, we stressed how pregnant mothers could only benefit by joining the system. We also learned from interviews that some families thought it was 1800 dollars per person rather than per family, and thus we explained how this was a misperception. Although we did not use names, we gave real examples of how much an insured family saved in comparison to an uninsured family. Again, this use of finite numbers provided the reality of the benefits of the system. Another focal point was how insurance provides a cheaper cost of medicine. In turn, insured patients can frequent the CDS more without fear of spending too much. Thus insured patients can receive a greater quantity of health care, while saving money. Health is a priority for the people of Kuwdé. As a community dependent on physical labor, they believe a healthy body is essential to cultivate and provide food and income. Finally, Michaela spoke to the insured people in the room, urging them to tell their neighbors and friends the benefits of the system. Overall, the meeting was successful and insured members in the room even testified their personal benefits.

Our work at the CDS was challenging, and taught us much about social and cultural dynamics in the village. Within a week of the village meeting and our departure, 10 families had joined the insurance system, increased the number of families from 15 to 25. By the spring, we learned there were over 46 families in the system. This success was unprecedented, as most families don't have the means to pay until later in autumn after the harvests. In the previous year, only two families joined following the town meeting. Thus, these new additions serves as a great indicator for the system's continued success. Our comprehensive calculations showed that system also saves the CDS money every year. We plan to keep in touch with Basile to monitor the system's progress, especially following harvest months in November when more families will have the means to join the system.

Pictured: Odile showing malaria tests results to Michaela in the health hut. The majority of visits are for the treatment of malaria.

Future considerations

There are many possible next steps for future work at the CDS. First off, one of the major challenges will be calculating annual insured figures . More and more families are joining at different months of the year, therefore presenting a problem when it comes to analyzing all insured families in one year. Future calculations will somehow have to take this into account.

Furthermore, Basile and Oedil's roles within the CDS can be developed in the future. Most importantly, they have not have had training in over 15 years. It is vital for them to learn the newest medicinal procedures and information, perhaps at some sort of training in Kara. Secondly, although they keep the notebooks on the insurance system, they have never learned how to calculate the analysis like we did. If we were to teach them, they could run the figures themselves and provide insured families with their annual savings. We also started an archival project, documenting the notebooks in the CDS. All notebooks and records are thus scanned and saved, and can be viewed at any time here to complete further research. These archived notebooks can be used to create a training program in advance for Basile and Oedil.

In general, work at the CDS should continue to stress the clear distinction between insured and uninsured numerical savings. It should be put into common practice for

Basile and Oedil to tell insured families exactly how much they are saving each visit, and uninsured families how much they could be saving.

Although we did not have the time, an interesting research concept could be the impact of malaria on the village. We were interested in researching the impact of government supplied mosquito nets in malaria trends during various times of the year (rainy vs. dry season for example). This topic could be explored in the future.

Finally, if the system becomes extremely successful, there might be a point where it "bottoms out" and the CDS ends up losing money. This point should be calculated and precautions and changes should be made to avoid it. The impact of our work this summer will continued to be monitored and recorded as families come in and out of the system.

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Interplay Between Agency, Perception, Structure, and Faith

Introduction

For the last three months of Spring, 2015 semester, I have been volunteering at the Durham Rescue Mission (DRM) thrift store. The thrift shop earns profits that go towards the Durham Rescue Mission, a shelter that provides a faith-based Victory Program for homeless and addicted people in the Greater Triangle area to garner financial independence and learn life skills. Many of the thrift shop employees are graduates of this program. There are three such thrift stores located in Chapel Hill, Raleigh, and Durham; I conducted research at the Durham location. Volunteering has allowed for full immersion into the day-to-day activities at the thrift shop in order to take field notes that accurately represent the store's culture. Over the last five visits, I noticed certain emerging themes. In particular, I became interested in how different factors contributed to employees' agency. In this paper, I examine the effect religious and organizational undertones have on employee ethics and agency. Faith shapes many employees' identities, playing a strong role in developing ethics. Yet, these Christian ethics come into tension with the Store's capitalist ethics and the want to convey universality. Employees then exercise agency, a source of power, in negotiating ethics.

Relationship between Opposing Employee Ethics and the Impact on Agency

Daily ethics serve as the foundation for people's social behaviors, perceptions, and reactions to oneself and to others. In Paul Brodwin's *Everyday Ethics*, he characterizes ethics as, "standards of behavior concerning the close-in landscape of practice" (2013: 5). In my ethnographic research at the Durham Rescue Mission Thrift Store, I found the employees' choices to act in particular ways depended on their ethical perspectives. I examine the roles that Durham Rescue Mission's status as a faith-based organization and personal faith plays in employee's everyday ethics. I argue that, similar to staff at other faith-based organizations, religion plays a strong role in shaping employee's interactions with each other and with customers. However, conflict emerges in balancing personal and organization-based Christian ethics with the Durham Rescue Mission's status as a "store". Store ethics include acting to promote business and profit and recognition of the diversity of customers—Christians and non-Christians alike. Christian ethics, then, exist in tension with two ethical orientations: capitalist "store" ethics and universality. In negotiating between ethics, employees exercise agency to determine whether a situation can be resolved according to one ethic over the other; as such, personal ethics can be a way of exercising power.

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Although diverse in many respects, the thrift store employees form a common bond as Christians and express a want to abide by larger Christian values of charity and goodwill, values upon which the DRM was founded. From "a gap-toothed, middle-aged white woman" to "an African American male with a round-face and grand smile" (Field Notes, 3/22/14 & 3/27/14), the employees stem from various backgrounds, races, and genders. Despite these differences, each embodies aspects of faith and Christian values, be it in rhetoric or conduct. Though I do not wish to generalize all employees as adhering strongly to religion, the majority of interactions I encountered included some reference to Christianity. For example, as explored earlier John said, "6 or 7 of us go to the same church, we're like a big church family that comes to work here, no hostility at all" (Personal Communication, 4/3/14). Another time, he responded to a customer's inquiry about his music taste, "I actually love Southern gospel music…it reminds me I need to follow God's plan for my life, no matter what troubles I'm in." His words reflect one of the two major factors involved in forming everyday faith-related ethics: that of personal and community faith. Employees often bring their outside perspectives on faith into the workplace, allowing it to influence their actions.

The employees' faith-based ethics are also shaped by the Christian influence of the thrift store's parent organization, The Durham Rescue Mission. Patricia Wittberg, an anthropologist researching how parent organizations shape the religiousness of member organizations, states, "faith-based parents help member organization's staff retain and strengthen their religious identity" (Wittberg 2013: 549). Miss Fay, indicated in an interview that she underwent the Victory Program run by DRM; the site defines it as, "addiction counseling, employment training and other essential services…all classes geared toward the message of hope through Christ and His Virtues" ("Victory Program," Durham Rescue Mission website). Not only does personal faith impact the employee's ethics, but relationships rooted in Christian-based institutional services do too. These two factors are not mutually exclusive; they work together to impart a Christian ethical mindset onto staff.

However, the Christian ethics ingrained in employees comes into contact with the ethics of running a business. Wittberg's article highlights how faith-based organizations often juggle "competing" (Wittberg 2013: 546) religious identities with other political or economic interests. While the thrift store incorporates religious aspects into its operations, it also desires to maintain its status as a store. John, a cashier I interviewed, relates the fine line between ethics, "Yeah, there are a lot of poor customers who shop here…once you develop a good relationship with one of them, and they start asking for discounts, you have to say, 'Oh, I'll give it to you this one time,' but then you're technically breaking the rules. It's a fine line" (Personal Communication, 04/3/14). In order to survive as a business and continue operation, employees must seek sale optimization to increase profit, which may entail refusing to sympathize and comply with the customer's financial troubles. Employees, then, struggle to reconcile Christian ethics that laud the "Good Samaritan" who is charitable, with business ethics that prioritize yielding funds sufficient to continue the store's operations.

Another store ethic that establishes tension with Christian ethics is the desire to appeal to a diverse customer basis. If an employee lets his Christian values, conduct, or rhetoric overpower his actions, he risks imposing a feeling of alienation or estrangement on customers who are not Christian (or religious at all), potentially resulting in loss of customers. The growing religious diversity in America coupled with rise in secularism, agnostics, and atheism (Harris 2011: 1) pushes businesses to secularize, in order to attract the most customers. Susan Chambré's article on the meaning of "faith" in faith-based organizations reports that organizations honored religious roots, but the meaning of faith secularized, likely due to "synthesizing elements from mainstream religion, including a belief in God, and secular culture" (Chambré 2001: 454). Thus, religion is not absent at the Thrift Store, but employees try to limit its ostensible presence in order to discourage religious imposition on or alienation of the customer population.

Encounters at the field site reflected this attempt to display universality while maintaining Christian influence. In an interview between the assistant floor manager, Miss Fay, and my classmates, she told us, "We play Christian music sometimes, but we try to be secular, you know, we won't play overly religious gospel music" (Personal Communication, 03/29/14). The employees describe a Christian universality, focusing on Christian virtues, rather than a specific sect of Christianity. For example, signs hung up in the store showcased virtues, rather than specific tenets of Christianity. One explained that volunteering was an " expression of faith and love", another proclaimed, "When I am weak, then I am strong" with a person kneeling in the background (Field Notes, 3/27/14 & 4/3/14). Staff at another faith-based organization, Mercy House's Franciscan nuns, define faith more narrowly in China Scherz's "Let us make God our banker." To the nuns, faith involves strong belief in "the workings of divine providence" (Scherz 2013: 625) to accomplish goals, leading to difficulties such as limited agency and inability to plan long-term. Opposing this, the Thrift Store staff's *choice* to relate its faith in universal terms, concurrent with Chambré's findings, enables its employee's flexibility in conveying a Christian moral ethic without feeling it hinders a customer's freedom to express him or herself.

Despite employee's cognizance and acceptance of the diversity of shoppers, at times their supposed universalistic faith did not prevent certain customers from experiencing an overwhelming Christian presence. I had a casual interview with an Indian woman, who experienced this sentiment while browsing for a dress, "They [the employees] always seem to put church dresses on the racks, there's never anything Indian, only for Christians who go to church" (Personal Communication, 3/22/14). Examples like this, albeit rare, speak to the disparity between how employees perceive their religious ethics as compared to perceptions of non-Christian customers. Their disquiet suggests an ineffective communication and reconciliation of secular and Christian ethics.

While some scholars, such as Patricia Wittberg, have witnessed ethical quandaries I show that they assert themselves as agents choosing to abide by Christian moral ethics or business ethics. Wittberg

portends in her article, “competing identities [of religion, politics, and economics] can result in paralysis and instability [of an organization]” (2013: 546). I challenge her claim that paralysis and instability inevitably result from competing ethics, finding Thrift Store staff exercised agency in responding to the tension between different ethics. In one interaction they may choose act like a shopkeeper, in another, a charitable Christian. For example, when a pregnant woman, toddler by her side, could not pay for items because she forgot coupons, she begs mercy of the cashier, who accepts her pleads (Field Notes, 2/28/14). The cashier faced a decision and chose, for a multiplicity of reasons, to abide by his Christian ethics. Had the situation been different, perhaps if the woman was not pregnant or did not have a child nearby or was of the opposite gender, the cashier might have chosen instead to follow store ethics.

Employees, then, exert agency over their ethics in deciding how to act, enabling them a source of power. Didier Fassin’s “Humanitarian Reason” reflects this kind of power, writing, “A critique of compassion is necessary because it presupposes a relation of inequality” (Fassin 2011: 3). Employees choosing to act as Christians suppose an equal employee-customer relationship, but inequality arises in that it is this choice determining the fate of customers. Thus, equality does not necessarily translate into the most ethical decision; it depends on which ethic the employee believes is more relevant and appropriate under given circumstances. One can now observe that Brodwin’s everyday ethics concept is not merely a set of guidelines employees follow, rather encompasses complex, even opposing, ethics over which employees wield power

Conclusions

This study observed the Durham Rescue Mission to explore the intersection of agency with perception, structure, and faith. I observed employees’ Christian ethics come into conflict with capitalist and universalistic ethics. Mediating between these ethics enable the employee’s agency because they must decide which ethic is most appropriate in a situation. I believe the implications of these relationships are relevant across the world when applied to other faith-based and structured organizations within a similar local context.

Although this study did illuminate interesting trends, it is important to acknowledge the limitations of it. For instance, I was only able to formally interview two employees, so their personal views greatly impacted our view of the Durham Rescue Mission. Similarly, I never was able to get in contact with a donor, volunteer, or the DRM at large, so my views may have been heavily skewed based on the thrift shop. Due to time constraints, I was only able to visit DRM thrift shop five times over the course of three months for approximately twenty hours, so I recognize that I may not have gotten the full picture of how the thrift shop operates.

These limitations are not stated as a means of expunging the study’s conclusions. Overall, this

study adds to the current understanding of agency, perception, structure, and faith. Not only can it be used to understand the complex web of interactions that influence identity at DRM, but it can also be generalized to understand the interplay between agency, perception, structure, and faith in the larger world.

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Book Review

BEYOND THE CAMPUS: Building a Sustainable University-Community Partnership, by Debra Harkins, Charlotte, NC: Information Age Publishing Inc., 2013, 181 pp., $45.99. 978-1-62396-241-8

Beyond the Campus begins by humbly revealing the original intentions of the research team: to aid in an intervention to decrease violence between young children within an early learning center, and build a partnership between a university and the community in which co-created solutions would be made and implemented. Their claim: university-community collaborations can be beneficial to both partners and provide shared learning experiences. They found that youth violence in the early learning center was the result of a larger system issue in which power imbalances and competing interests were causing confusion and tension.

Part I of the book outlines the action-based theoretical approach that was used as the foundation of their project, followed by emphatically stating the need for universities to revisit their mission statements, in which civic engagement and responsibility are highlighted as crucial components of a college education. Part II details two drastically different types of teaching: traditional versus liberation approaches, and their relationship to the civic engagement movement that is being implemented at many universities. The authors argue that the traditional approach to learning perpetuates social inequalities, and that a liberation teaching approach in which students and teachers reciprocally enrich each other's experiences is much more appropriate in service learning classrooms. Finally, in Part III, the university research team addresses the fundamental lessons learned, successes, and shortcomings experienced during their partnership with the early learning center.

This book details the development and results of a university-community partnership in an extremely organized and concise way. The pedagogical nature of the study detailed in its subject matter is eloquently reflected in the design of the writing. Further, the authors brilliantly include the perspectives of students participating in service learning, faculty, staff, and teachers at the early learning center, providing a well-rounded understanding of the university-community partnership.

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The authors address the lack of civic engagement that is implemented at universities and the power struggles that exist between 'privileged' universities and the underserved communities. The authors do not, however, fully address the hierarchal power imbalances that exist across different universities. Although some universities may lack the ability to engage students in civic engagement due to a great emphasis on individual success, other universities simply cannot request the amount of time and dedication university-community partnerships require of their students. According to a recent government census, 71 percent of the nations college students were working in 2011, and roughly 50 percent of those students work over 20 hours per week for a large portion (27-59 weeks) of the year (U.S Census Bureau, 2012). The everyday demands of the average non-traditional or working college student may make community service learning initiatives difficult to implement at many universities.

As a current college student, I found this book particularly compelling because implementing service learning within universities would result in a more enriched learning experience with stronger possibilities for continued education. The comprehensive and detailed methods described in this book proved to be extremely effective when working in the early learning center with faculty and staff. Just as the authors suggest, a multitude of different professionals, staff, and researchers can benefit from applying the techniques drawn out in this book to their own partnerships. Overall, the authors make an extremely strong argument for the implementation of service learning programs in higher education.

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