

**Enabling women to address their priority
health concerns**

The role of community-based systems
of social protection

Working Paper

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of social protection

Working Paper

Francesca Moneti

**International Labour Office
Geneva**

Strategies and Tools against social Exclusion and Poverty (STEP)

The Strategies and Tools against social Exclusion and Poverty global programme (STEP) of the International Labour Organization (ILO) is active in two interdependent thematic areas: the extension of social protection to the excluded and integrated approaches to social inclusion.

STEP supports the design and dissemination of innovative systems intended to extend social protection to excluded populations, particularly in the informal economy. It focuses in particular on systems based on the participation and organization of the excluded. STEP also contributes to strengthening links between these systems and other social protection mechanisms. In this way, STEP supports the establishment of coherent national social protection systems, based on the values of efficiency, equity and solidarity.

STEP's action in the field of social protection is placed in the broader framework of combating poverty and social exclusion. It gives special emphasis to improving understanding of the phenomena of social exclusion and to consolidating integrated approaches at the methodological level which endeavour to reduce this problem. STEP pays special attention to the relationship between the local and national levels, while at the same contributing to international activities and agenda.

STEP combines different types of activities: studies and research; the development of methodological tools and reference documents, training, the execution of field projects, technical assistance for the definition and implementation of policies and the development of networking between the various actors.

The programme's activities are carried out within the Social Security Policy and Development Branch of the ILO, and particularly its Global Campaign on Social Security and Coverage for All.

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List of acronyms

ABPF	Association Béninoise de Promotion Familiale
ADB	Asian Development Bank
AGBEF	Association Guinéenne pour le Bien-Etre Familial
ASBEF	Association Sénégalaise du Bien-Etre Familial
AssEF	Association d'Entraide des Femmes (Bénin)
ASUCOB	Association Solidarité pour la Prise en Charge des Urgences Chirurgicales et Obstétricales de Bogandé (Burkina Faso)
FENAGIE	Fédération Nationale des Groupements d'Intérêt Economique (Senegal)
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ILO	International Labour Organisation
IPC	Initiative Privée et Communautaire contre le VIH/SIDA (Burkina Faso)
IPPF	International Planned Parenthood Federation
MECIB	Mutuelle d'Epargne et de Crédit de Icotaf Boubess (Senegal)
MURIGA	Mutuelle d'Entraide et de Solidarité pour la Santé de la Reproduction (Guinea)
NGO	Non-governmental organisation
PRISM	Pour Renforcer les Interventions en Santé de la reproduction et IST/SIDA (Guinea)
SEWA	Self-Employed Women's Association (India)
STIs	Sexually transmitted infections
STEP	Strategies and Tools against Social Exclusion and Poverty
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive summary

There has been growing attention on the part of communities, governments, civil society organisations and international development institutions to the role of community-based systems of social protection in the fulfilment of human rights, especially the rights of women and children. Of particular interest is their role in increasing access to health care services while also increasing the role of communities in their development and, in doing so, contributing to the achievement of various Millennium Development Goals, including poverty reduction.

An important question is whether they make a difference to women's lives in terms of enabling them to address their health concerns. To address this question, STEP drew upon direct observation, gathered and analysed data from 15 health micro-insurance schemes in three countries and complemented these with case studies and interviews from additional countries. This document presents a synthesis of the findings.

Following the introduction, chapters 2 and 3 document the context. They provide a general overview on community-based systems of social protection and of the understanding of reproductive health at local and international levels.

Chapters 4 through 6 describe the findings on how women's health concerns are raised and addressed during the different stages in the process for the establishment and operation of health micro-insurance. Special emphasis is placed on women's concerns related to reproductive health. The findings indicate that pre-feasibility studies provide an opportunity and a stimulus for communities to raise and discuss their health needs and to explore ways to address them. Feasibility studies go much further in deepening community understanding of priority health needs, availability of health services and capacity to access them. Once established, the schemes help communities to overcome financial barriers thereby increasing access to services. They also influence quality of care by facilitating discussion between health providers and users and promote prevention through the organisation of educational activities.

The analysis brings to light that women and men alike consistently raise problems linked to pregnancy and delivery as priority concerns and ensure that these are covered by benefits packages. It also indicates that other reproductive health concerns, such as adolescent health, infertility, sexually transmitted infections and family planning, are raised and covered in different ways and various degrees by schemes. HIV/AIDS is also being increasingly taken into consideration. Some schemes have begun to go beyond undertaking educational activities and are explicitly covering treatment. The analysis also suggests that when reproductive health providers provide support to the establishment and operations of the schemes they play an important role in facilitating the discussion of reproductive health issues.

The conclusion is in Chapter 7. It points to the encouraging findings that the community-based systems of social protection studied strengthen the capacity of women to raise and address their health needs. More broadly, it suggests that the presence of the schemes, as well as the process of their establishment, increase interaction, mutual respect and collaboration between health providers and communities, thereby contributing to the better functioning of the health system. Finally, while recognising that more research is necessary, it suggests ways for the development

community to channel support to communities so as to complement the very significant energy and resources that they are already placing toward the attainment of the Millennium Development Goals aimed at improving health, empowering women and reducing poverty.

1. Introduction

1.1. Extension of social protection to increase access to health care

The importance of women's role in development is widely recognised and reflected in the Millennium Development Goal to "promote gender equality and empower women". This document reflects findings on how community-based systems of social protection strengthen the capacity of women to raise and address their health needs. Based on a human rights approach, the findings contained in the document intersect the rights to participation, social protection, health and reproductive health.¹

In developing countries, access to health care by poor families continues to constitute a challenge. Part of the problem is the very absence of health services of reasonable quality in poor communities. However, even when services exist, they are often underutilised because of financial barriers. When families living on less than US\$1 per person per day face a health problem, they may be unable to obtain the necessary funds to cover the costs of health care. They may therefore delay seeking health care or may not seek it at all. In order to obtain funds, they may sell assets or fall into debt to cover expenses.

NEEDS EXPRESSED IN MAURITANIA

Mauritania ranks 152 among 173 countries in UNDP's Human Development Index, a reflection of the difficult conditions confronted by the majority of the population. Heads of households identify insufficient means to obtain health care and illness and handicaps as two among the five major difficulties caused by poverty. They also identify access to health care and other social services among their highest needs, preceded only by access to clean water and to income-generating activities. In addition, the vast majority – 71% - indicate that the costs of health care are too high for them to afford. (Enquêtes permanentes sur les conditions de vie des ménages, 2000)

Systems of social protection in health can enable people to cover the cost of medical care. Yet, they are limited in coverage. In many of the less developed countries, less than 10 percent of the population can rely on statutory systems of social protection to help them cover health costs. However, in a number of countries, civil society organisations are organizing innovative systems of social protection in health that are community-based and increasingly linked to government efforts to extend access to health care.

Since 1998, the Strategies and Tools against Social Exclusion and Poverty (STEP) of the International Labour Organization (ILO) has been supporting communities in poor countries in their efforts to develop and extend these innovative mechanisms of social protection in health. In doing so, STEP has placed emphasis on providing support to women and to women's groups. By 1998, thanks to a study undertaken in West Africa with USAID's Partners for Health Reform project and a number of other development partners², STEP had initial indications that community-based systems of social protection in health could lead to improvements in:

- extending social protection to the disadvantaged sections of the population;
- access to health care;

- mobilisation and organisation of health resources;
- efficiency in the health sector;
- quality of care; and
- democratic governance.

Six years later, in 2004, there is more evidence that these systems strengthen the capacity of communities to address their health needs.

The most common form of community-based systems of social protection is health micro-insurance, sometimes referred to as mutual health organisations. Although usually with varying degrees of technical support from NGOs, government or other external actors, the schemes are typically established by the communities themselves. In view of this, they reflect community health priorities. Depending on the settings, schemes may cover common illnesses such as malaria and diarrhoea and respiratory infections and transport to health facilities. Some cover services that are expensive and infrequent, such as hospitalisation and surgical procedures, although the degree of coverage is limited by the members' contributory capacity. In settings where HIV/AIDS is recognised as a problem, health micro-insurance schemes have also begun to contribute to the fight against HIV/AIDS, both by covering AIDS-related curative services and by undertaking preventive activities.

Across different countries, women participate actively in community-based systems of social protection. In many cases, the systems are set up and operated by women's associations and emphasise the specific health concerns of women. As women are typically entrusted with the main responsibility for the care of the household, health micro-insurance is of particular importance to them, both to facilitate the care of the household and to meet their own health needs, including those linked to their reproductive role. Enabling them to meet these needs can contribute to a decrease in the high rates of maternal morbidity and mortality.

1.2. Interagency initiative

STEP has developed its efforts in the extension of social protection in health in association with key partners at the international level specialised in increasing access to health. Within the UN system, it has developed collaboration with UNICEF in a few countries, working together at national and sub-national levels. It has also worked with WHO and the World Bank, especially on issues related to health policy and the financing of health services.

In 2001, STEP entered into an innovative partnership with UNFPA, which also involved UNICEF and WHO. Subsequently known as "Stronger Voices for Reproductive Health", this interagency initiative aimed to explore mechanisms that enable users of health services to influence the quality of reproductive health care. It received major financial support from the United Nations Foundation. The Stronger Voices project began with a working hypothesis that:

"Significant improvements in quality can be achieved by increasing women's awareness of their reproductive rights and strengthening their capacity to organize their existing resources and use these to more actively negotiate with providers with respect to decisions on the provision of services".

Its approach is based on the premise that the quality of care is influenced by both demand and supply factors. Accordingly, Stronger Voices set out to explore ways to enable households to access health services and influence their quality, thereby complementing efforts to upgrade and increase the availability of health facilities.

Between 2001 and 2003, STEP worked within the Stronger Voices context to test this hypothesis in Mauritania. With the support of the national programme of reproductive health of the Ministry of Health and Social Affairs, STEP worked closely with UNFPA and UNICEF in different regions of the country to provide support to communities in exploring the option of health micro-insurance which was new to the country. It also worked with WHO to ensure complementarity with another innovative effort to increase access to emergency obstetric care.

The collaboration with UNFPA stimulated STEP to undertake an in-depth analysis of the relationship between health micro-insurance, reproductive health and quality of care. The major findings of the analysis are contained in this document.

1.3. Rationale and structure of the document

The last few years have witnessed significant growth in the number of health micro-insurance schemes, especially in francophone Africa and Asia. This growth, as well as the continued search for mechanisms that improve the functioning of health systems, has drawn significant interest from the development community on community-based systems of social protection.

Literature reviews, such as the one carried out in the context of the study undertaken by the Commission on Macroeconomics and Health in 2001, found that community-based financing mechanisms are effective in reaching low-income populations that would otherwise be excluded from financial protection against the cost of illness. The Commission's study included a micro-level household data analysis. Its results provided further support to previous findings by STEP and other development partners that health micro-insurance improves access by poor populations to basic health services and protects them in varying degrees against the impoverishing effects of illness.³

Aware of the growing interest in the subject, this document aims to increase understanding of health micro-insurance by systematically going through the process of their establishment and operation and, for each phase, describing how women's health concerns are raised and addressed. In doing so, it builds on and expands the initial findings by other partners on the contribution of health micro-insurance to improvements in maternal health care.⁴ The findings are applicable to efforts aimed at improvements in health and poverty reduction, both of which are essential for the achievement of the Millennium Development Goals.

This document focuses on the process and does not attempt to measure the impact of health micro-insurance on health and, more specifically, on maternal mortality and morbidity. However, the increased awareness and discussion of women's health and the increased capacity of communities to address it observed among the health micro-insurance schemes studied suggests that there should be an impact on health. This is a key area for future research and needs to be undertaken in collaboration with partners whose mandates focus on the functioning of health systems.

This document combines the subject areas of extension of social protection, women's participation and the functioning of health systems. The latter is understood according to the WHO definition as comprising of all organizations, institutions and resources that are devoted to producing health actions whose primary purpose is to promote, restore and maintain health.⁵ Therefore this includes households as well as a variety of governmental and non-governmental actors involved in the provision of health care. Within the health field, the document looks in particular at issues relating to reproductive health and quality of care. Readers may have expertise in one or more of these fields.

Chapter 2 provides a general overview on community-based systems of social protection and on the process of establishing and operating them. The overview aims to provide a synthesis of information and is intended to offer readers with limited knowledge of community-based systems of social protection the necessary context⁶ for the finding presented in chapters 4 through 6 into context.

Chapter 3 reminds readers of the international consensus on reproductive health and reproductive rights. It compares the definitions reached in international conferences with the perspectives of women encountered by STEP and partners working on community-based systems of social protection.

Chapters 4 through 6 present the findings. Each of these chapters describes how women's health concerns are raised and addressed with respect to a different stage in the process of establishment and operation of health micro-insurance. The document relies heavily on illustrative examples, contained in text boxes, to render the concepts concrete. The examples cannot be generalised to all community-based systems of social protection in health as these vary significantly in their characteristics (size, location, membership) as well as in their process of establishment and in their operation.

Chapter 7 draws conclusions from the findings outlined in the previous three chapters. These are meant to be useful for practitioners and promoters of community-based systems of social protection to enable them to better address the priority health needs of women. More broadly, the conclusions are aimed at stimulating reflection among government institutions, national and international NGOs and international development partners working on women's health on how they could support the extension of social protection in health to make headway in the achievement of the Millennium Development Goals and in the fulfilment of the rights of women and children.

1.4. Sources of information

The findings outlined in the document stem from a variety of sources. A major source is the field experience, observation and analysis by STEP colleagues working directly with communities, NGOs and governments on the extension of social protection in health. This experience was drawn from a number of countries in West Africa, especially Benin, Burkina Faso, Guinea, Mali, Mauritania and Senegal, as well as from countries in other regions, including Bangladesh, Ethiopia, India, Nepal, the Philippines and Tanzania.

The information gathered through direct experience was complemented and validated by data collected in the course of a major assessment aimed at drawing lessons and informing future programme development. This exercise involved an in-depth study of 15 health micro-insurance schemes in three West African countries: Burkina Faso, Guinea and Senegal.⁷ It was undertaken in the second half of 2003 by the Hoger Instituut voor de

Arbeid of the Catholic University of Leuven, Belgium. This exercise entailed the gathering of detailed information on the characteristics of the schemes, their functioning, and the perspectives of individuals and institutions involved in them. The data were gathered through structured interviews and discussions with scheme managers, with their members and with representatives of their federations. They were also obtained from health service providers working with micro-insurance schemes, government officials as well as from NGOs and international institutions providing support to schemes. Other sources of data included registers and other management and monitoring tools used by schemes to record their operations, how they covered the benefits provided and their financial situation. Initial findings were presented and discussed at a workshop with scheme managers as well as other national government and non-government partners held in Dakar, Senegal in November 2003. At the time of this writing, in January 2004, the results of this activity had not been finalised and consequently had not been published.

The information gathered in the context of this activity was complemented by additional interviews and discussions on reproductive health and quality of care with a number of health micro-insurance schemes in Benin, Mauritania and Senegal.⁸

Additional information was drawn from a set of case studies undertaken by STEP over the course of 2001 and 2002 in collaboration with the Conditions of Work Branch of the ILO that examined maternity benefits available through community-based health financing schemes in five countries in Asia and Latin America: Argentina, Chile, Colombia, India, Nepal and the Philippines. However, the first-hand information stemming from Asia and Latin America was much more limited than that from West Africa. Further research would be desirable in these continents as well as in East and Southern Africa.

The multitude of sources used made possible the identification of trends and common characteristics across schemes and among different countries and regions that had not been previously documented. However, the use of a variety of sources meant that the information was not always fully comparable. Thus, it was not possible to draw conclusive evidence on many of the trends identified.

1.5. Major findings

The heterogeneity of the data analysed and the limited number of health micro-insurance schemes reviewed, do not permit drawing conclusions applicable to all community-based systems of social protection. Nonetheless, the findings point to the positive effects of health micro-insurance.

The analysis indicates that the process of establishing and operating health micro-insurance schemes strengthens the capacity of women to face their priority health concerns in three major ways, namely:

- increasing discussion and collaboration on health concerns among women and with health service providers
- covering fees for priority health services thereby making them more accessible
- undertaking preventive health activities.

The schemes studied also indicate that health micro-insurance leads to increases in the number of deliveries assisted by trained personnel. Overall, the findings suggest that by increasing the interaction and the collaboration between communities and health service

providers, health micro-insurance contributes to improvements in quality of health services and, more broadly, to a better functioning of the health system. This indicates that these systems could enable communities to make progress in all Millennium Development Goals that are directly related to health; they can contribute to improvements in maternal health as well as to the reduction of child mortality and to combating HIV/AIDS, malaria and other diseases. Moreover, by making the health services more accessible, they can directly contribute to the eradication of poverty.

All health micro-insurance schemes reviewed cover pregnancy and delivery services. Many also provide coverage for transport costs in cases of complications with delivery. Those that include secondary level care within their benefits packages also cover emergency obstetric care. Moreover, health needs related to pregnancy and deliveries appear to be spontaneously and consistently raised by women and men alike in the process of establishing and operating micro-insurance schemes. Concerns include the inability to afford emergency obstetric care in cases of complications with a delivery. The term “reproductive health” is often understood by communities to comprise primarily the concerns relating to pregnancy and delivery. When these are raised, the ensuing discussion can lead to other reproductive health issues such as family planning, infertility, and sexually transmitted infections.

Contrary to the commonly held notion that health micro-insurance only covers curative health services, the analysis found that the majority of schemes studied cover preventive services, and that schemes are keen to organise health promotion activities such as educational sessions. However, their capacity to carry them out often depends on the willingness of health service providers and NGOs, to provide technical and financial resources that are not available within the community. When these partnerships are forged, the support structures benefit directly by having more and better informed users.

2. Community-based systems of social protection

Where households and communities have no social protection coverage through statutory systems, they look for different ways to cover risks such as accidents, illness and death. Among these are community funds and other traditional forms of social protection.

Over the course of the past decade, some communities have established more structured systems of social protection to cover their risks. Among these are systems covering health risks, namely health micro-insurance. Micro-insurance schemes, also referred to as mutual health organisations, are not always set up by community groups. They may also be established by NGOs or health service providers.

MICRO-INSURANCE

“Micro-insurance is not merely another form of insurance or healthcare financing. It is a form of social organization, based on the concepts of solidarity and risk-pooling, which involves the active participation of the groups’ members.”
(World Labour Report 2000)

2.1. Characteristics

As their name suggests, health micro-insurance schemes are typically established as a result of locally driven processes. Because of their local nature, the schemes vary significantly in size, design and operational capacity. Their differences can be considered a strength, to the extent that they reflect the separate realities of the different organized groups that establish schemes. However, the high degree of variation makes it difficult to draw broad conclusions that are applicable to all health micro-insurance schemes. This feature should be kept in mind when considering their potential contribution in strengthening the capacity of women to address their priority health concerns.

This document refers only to micro-insurance schemes that are community-based and have the following characteristics:

- based on solidarity among members (everyone pays the contributions on a periodic basis but only those who incur a risk included in the benefits package can draw into the scheme to cover its costs);
- voluntary membership;
- not-for-profit ;
- operate on the basis of decisions taken by the members themselves or by their management structures;
- take action to promote mutual help among members in light of the social risks they face.

The term micro-insurance suggests that it is a small scale insurance system. Indeed, many micro-insurance schemes have no more than a few thousand beneficiaries. The very small ones have a membership of no more than 100, yet there are also schemes that cover over 100,000 beneficiaries. For all schemes, “micro” refers to the small size of the financial transactions, especially to the very small contributory capacity of members. This capacity is proportionately related to the revenue of the poor and to their imperative obligations

toward immediate basic needs for themselves and their families. In the West African and South Asian contexts, annual membership contributions are in the order of one to two US dollars for each individual.

The main features of health micro-insurance are illustrated by using the example of a village-based scheme established by a local association of women in Tivaouane, a town of about 42,000 inhabitants situated about 90 kilometres from Dakar, Senegal.⁹ The scheme is family-based and has approximately 300 members, thereby covering over 1000 women, men and children.

THE INSURANCE FUNCTION

"We cover the cost of curative consultations and hospitalization as well as ante and post-natal consultations. We also reimburse the cost of prescribed medicines, but only if they are generic" explains Bokhaya Dieng Diop, president of the Tivaouane scheme.

In Tivaouane, as elsewhere in Senegal, the weak earning capacity of non-salaried workers and their lack of any form of social protection render access to essential health care virtually inaccessible to most of the population. "Before the arrival of the health micro-insurance scheme, people from here practised self-medication or they paid for the consultation but then had insufficient funds to purchase the prescribed medicines" asserts Moussa Diop, who is a teacher in Dakar.

The insurance function – The primary function of the schemes is to provide an insurance benefit to its members. Like with all insurance schemes, this entails the pooling of risk and the pooling of resources through the payment of regular contributions by members.

The insurance function increases members' financial access to health services. The Bolo Suxali Tivaouane scheme enables its members and their families to manage their medical expenses collectively. When faced by illness or other health conditions that are covered by the benefits package, they can rely on the

insurance to cover all or part of the costs. This can make a major difference to families who may otherwise delay seeking health care in order to collect the funds, or forego care altogether. Alternatively, they may sell assets or fall into debt in order to pay for the services out-of-pocket.

The greater financial access to health services is particularly beneficial to women. Because of their lower status in society, women generally suffer greater degrees of exclusion from systems of social protection in health than men and have lower access to well-remunerated employment. They also have specific reproductive health needs. The fact that these are not met contributes to the unacceptably high rates of maternal mortality and morbidity in many countries. Women are also more affected by the absence of social protection because of their traditional role of caregiver within the household.

The benefits packages of health micro-insurance schemes vary significantly, but need to be proportionately related to the contributory capacity of the members. The revenue of most community-based schemes comes primarily or exclusively from the contributions of their members. Since the contributory capacity is low, the benefits packages cannot be comprehensive. Communities who set up schemes are therefore faced with wanting to cover many health risks – which would make the scheme too expensive, exclude the most in need and keep membership low – and wanting to keep contributions to an affordable level – which means covering only some of the health risks.

In practice, schemes usually cover a mix of primary care preventive and curative services, some secondary care and, in some cases, costs of transport to health facilities. Many

include co-payments to discourage unwarranted over-utilisation of health services. The ones that include secondary level services often set limits on the number of yearly claims for these or on the amount of reimbursement for each.

A stronger voice - Micro-insurance also strengthens the voice of communities vis-à-vis the providers and managers of health services. The stronger cohesion around health issues and the pooling of some of the resources being used to cover the costs of health care enable them to negotiate more effectively with health service providers.

Health service providers tend to value and support the schemes because they help to establish a solvent and structured demand for services – one that increases utilization and where health staff have the assurance that they will be paid. This gives the micro-insurance practitioners a negotiating capacity that would not be possible for individual users. Schemes negotiate for better fees and paying mechanisms (where applicable) and for measures to assure and improve quality.

They have an internal incentive to use this capacity to work with health service providers to improve quality of health services, for this can in turn increase the membership of the scheme. Their negotiation capacity increases further to the extent that schemes organize into networks and unions that can influence national health and social protection policies and legal frameworks.

STRONGER VOICE

The women of the Bolo Suxali Tivaouane scheme did not hesitate to rally the local leader to their cause. Over time, they have become important counterparts vis-à-vis the local health practitioners. They negotiated reduced fees with the two health centres of Tivaouane, and reductions in the price of hospitalization. Better informed, they now demand the prescription of generic, less costly drugs.

Collective action in health – A third feature of health micro-insurance is that it empowers communities to take collective action in health. This may take the form of information campaigns and other educational activities. In some cases, it takes the form of working with health service providers to assure availability of essential drugs at the health centre – a measure that is beneficial to members and non-members alike.

COLLECTIVE ACTION IN HEALTH

The other major activity of the Bolo Suxali Tivaouane micro-insurance scheme is the organization of awareness-raising campaigns against malaria, HIV/AIDS and other sexually transmitted infections and against malnutrition that often affects the children.

2.2. Stakeholders

A multitude of actors play a role in the establishment and operation of health micro-insurance schemes:

Communities – they are the core actors who set up and manage the individual schemes. As noted above, women often play a significant role. The term “community” is used in the broadest sense. It can be geographically defined, such as village, urban neighbourhoods or regional grouping. It also includes groups organized around common interests such as informal trade or agricultural associations, cooperatives and women’s associations. These may be local or have national reach, sometimes with local chapters or affiliates. The size of the organized groups may range from a village association of a few hundred members to

a federation of informal trade associations or of cooperatives whose membership is in the hundreds of thousands.

Health service providers working in facilities used by members – these include staff in the health facilities used by the members of the scheme. The health providers may be public, private not-for-profit or private for profit. Health personnel typically participate in setting up schemes by providing information about health facilities and fees and by taking part in discussions about different possible options for benefits packages. Once the schemes are operational, they have the key role of providing the health services. In the typical West African context, schemes sign agreements with health service providers that spell out the benefits to be provided and the payment modalities. Health staff provide services upon presentation of a document verifying the affiliation of the client to the scheme and are reimbursed by the scheme. This set-up translates in regular interaction between health service providers and the scheme. There are also other set-ups, more common in Asia, where scheme members use any provider they wish and are reimbursed directly by the scheme upon presentation of evidence of treatment received and payment made. This latter set-up entails less regular interaction between schemes and health service providers.

In many countries, health providers have set up schemes. These “provider-based” schemes function with a somewhat different logic than the community-based ones and are beyond the scope of this document.

Associations of workers and of employers – In a number of countries, associations of workers and of employers in the informal economy have directly established and operated schemes or have provided support to their members to do so.

**WORKERS ASSOCIATIONS PROMOTE
MICRO-INSURANCE**

The *Fédération Nationale des Groupements d'Intérêt Economique des Pêcheurs* of Senegal (FENAGIE-PECHE) aims at improving the conditions of women and men working in the fishing and fish processing industries. Having already established a network of savings and credit, it is now working to extend health coverage to all of its members through a network of health micro-insurance schemes.

An example is the National Federation of Economic Interest Groups of Fishermen (FENAGIE – PECHE) of Senegal. It consists of 2100 groups of fishermen, fishmongers, women selling fish in markets and women who process fish, for example by smoking it. The economic interest groups are organized in local, departmental and regional informal trade associations in the seven maritime regions and in the Kolda region. Total membership is of

approximately 30,000, of which over 62% are women. Between 2000 and 2002, FENAGIE-PECHE provided support to five communities in the outskirts of Dakar to enable to set up micro-insurance schemes. It continues to provide management assistance to the schemes. It also carries out training activities for scheme managers as well as for members of various committees. In turn, the schemes provide direct experience and lessons that FENAGIE disseminates among other economic interest groups that are part of the Federation.

One of the most well-known examples of an informal trade union that has set up a health micro-insurance scheme is the Self-Employed Women's Association of India. As of 2003, SEWA has a membership of some 700,000 poor women. Its health micro-insurance scheme covers just over 100,000 individuals and is further expanding thanks to an effort to set up regional offices beyond its initial base in Ahmedabad, in Gujarat State.

Besides playing a direct role in the establishment and operation of schemes, organizations like SEWA also play an important role in influencing the national policy and legal context. Existing regulation in India requires that institutions providing insurance hold a capital equivalent to about US\$22 million – which would be impossible for micro-insurance. It also mentions that cooperative societies can enter the insurance market but does not provide guidelines for how this can be done. SEWA is working directly with the Ministry of Finance and the Insurance and Development Authority to work out viable solutions.

Some of the associations of workers providing support to the development of health micro-insurance also have a voice in international fora. For example, the General Federation of Nepalese Trade Unions (GEFONT) that is providing support to poor urban and rural communities in setting up schemes also participates in the International Labour Conference of the ILO. SEWA has participated in meetings of the Global Economic Forum.

Other civil society institutions – there are a variety of other civil society institutions that provide technical, organizational or financial support to health micro-insurance schemes. These include non-governmental organizations active in development activities. They exist at sub-national (district or regional) and national levels. Some of the better-known national NGOs that have set up health micro-insurance for their members are in South Asia. In Bangladesh, both Grameen and BRAC (formerly known as Bangladesh Rural Advancement Committee) have done so.

NATIONAL NGOs IN BANGLADESH

Grameen Kalyan was established by Grameen once it recognized that health problems were along the major causes for inability of members to repay their loans. The micro-insurance scheme, which is part of a broader health programme, uses the Grameen Bank infrastructure (the Grameen women groups) for the collection of the annual premiums and for promotion activities.

Often the NGOs are local and not internationally known. For example, the *Association Mauritanienne pour l'Auto Développement* is a local development NGO that provides support to rural communities in the Brakna region of Mauritania. Working in particular with women and youth, it provides support in the areas of food security, income generation, literacy and health. Over the past three years, AMAD has provided support to the villages of Woithié and Dioudé for the establishment of health micro-insurance schemes that cover the majority of their households. AMAD is now working with a regional women's credit and savings network to establish a scheme that would cover a much larger population in the Brakna region.

Government – a major role of government is to ensure the availability of health services of acceptable quality. Without these, there would be no incentive to establish systems of insurance. In addition, at local and district level, the support of both administrative government and government health managers and practitioners is important and can facilitate the functioning of the schemes.

At national level, government can play a central role in promoting social protection coverage. This can entail supporting innovative systems of social protection and their relationship with statutory systems so as to move toward a national system of social protection. Such support can include exploring ways to ensure the sustainability of community-based systems of social protection and should include reform of the policy and legal contexts.

GOVERNMENT ENGAGEMENT IN SENEGAL

“...Uniform access without delay to quality [health] care demands a system where ... the population plays a role by determining its needs and by determining its relations with its partners. This is why we are so fond of health micro-insurance schemes...”

“...Today, I have the pleasure to inform you that the Senegalese law on health micro-insurance schemes has been finalized by the relevant government structures.”

Complete text available on:
www.concertation.org/atelier/forum2002/6annexes.pdf

In some countries such as Senegal, government has begun to explicitly take up this role. The excerpts from the speech of the Minister of Health exemplify the Government of Senegal's understanding of the contribution of health micro-insurance schemes. In the speech, the Minister stresses the Government of Senegal's commitment to support the schemes because of their role in improving financial access to quality health care. The law she refers to was officially

promulgated in 2003.

International development institutions – a variety of UN agencies, bilateral donors and other international development partners provide support to health micro-insurance. Within the UN, in addition to the STEP programme of the ILO which has developed specific expertise in this field, UNICEF, UNFPA and WHO are providing support to micro-insurance in different ways.

UNICEF is actively supporting the development of health micro-insurance and its interface with the revitalization of health care delivery systems in a number of countries in sub-Saharan Africa. It is particularly focussing on how micro-insurance can improve access to maternal and child health services, especially emergency obstetric care. In a number of countries in West Africa, it is exploring how community-based systems of social protection in health can go to scale by linking with the community co-management structures established in the context of the Bamako Initiative.¹⁰ This approach is promising insofar as it builds on and further strengthens established mechanisms of collaboration between communities and health service providers.

UNFPA, through the “Stronger Voices” initiative has begun to explore the role of health micro-insurance in the promotion of reproductive health and quality of care. At country level, UNFPA Mauritania has promoted the understanding among national stakeholders of the role of health micro-insurance in decreasing maternal mortality and in promoting coverage of other reproductive health services.

WHO is exploring how micro-insurance can contribute to reaching the objectives of its flagship programme “Making Pregnancy Safer” aimed at improving the lives of women and their newborns. It has also played an important role in the development of the contractual approach that is being applied to the relations between health micro-insurance schemes and health service providers. The contractual approach is increasingly being applied to the relations between central ministries providing different forms of stewardship for the extension of social protection in health and NGOs that provide direct support to communities.

In the last three years or so, there has also been increasing interest by international financial institutions, namely the World Bank and the regional development banks, which have noted the importance of health micro-insurance in the context of poverty reduction. In some cases, support is direct, as the support that the Asian Development Bank (ADB) is providing to SEWA in India. In others, such as in Nepal, the ADB is supporting the exploration of micro-insurance as a mechanism to be further developed within the national

social protection policy. Another type of support comes from the World Bank Institute, which covers health micro-insurance in its training courses on the revitalization of health systems.

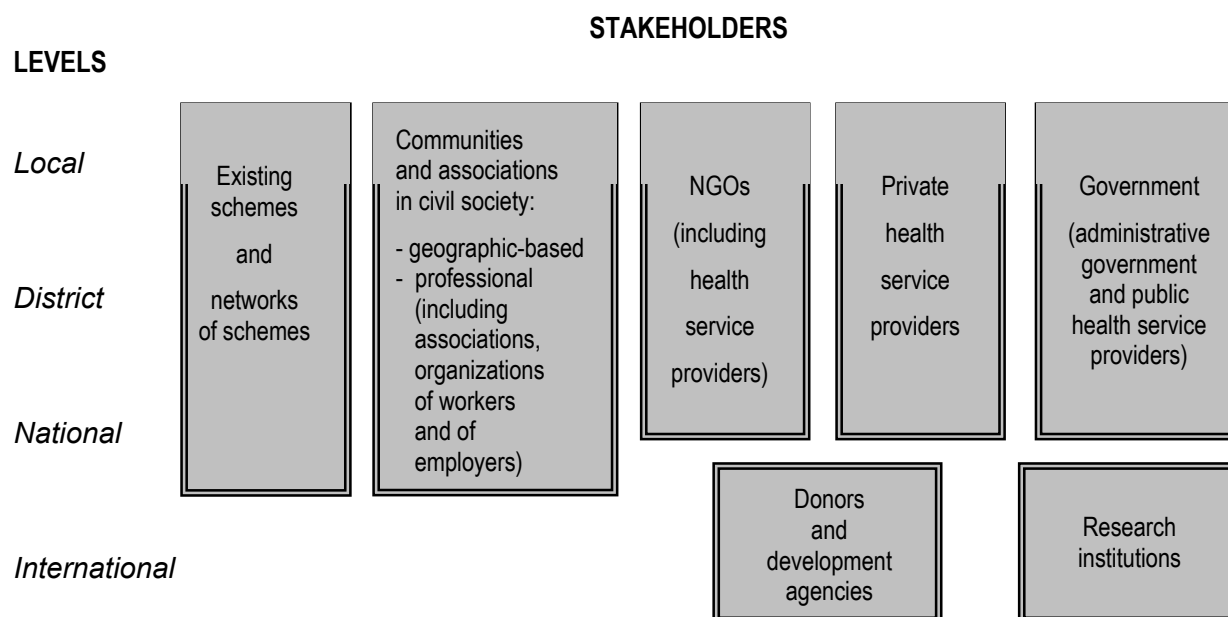
Besides UN agencies and international financial institutions, a number of industrialized countries are providing support both through their official development cooperation agencies and through national and international NGOs. In West and Central Africa, the international promoters of health micro-insurance have established a network to facilitate coherence and exchange of experience. The “*Concertation entre les acteurs du développement des mutuelles de santé en Afrique de l’Ouest et du Centre*” was established in 1999 by five organisations based in Europe and the United States. Three more organisations have subsequently joined and their number is expected to grow further.¹¹ Similar networks are under development in Asia and at a global level.

THE “CONCERTATION”

The “*Concertation entre les acteurs du développement des mutuelles de santé en Afrique de l’Ouest et du Centre*”, is a collaboration network that uses a web site <http://www.concertation.org>, bi-annual fora, workshops and newsletters to facilitate the exchange of information, experience and best practices among practitioners and promoters of health micro-insurance in 11 francophone countries. It also serves to stimulate reflection, discussion and the search for solutions for challenges faced by the micro-insurance movement.

The following figure illustrates how the various stakeholders span across the various levels – local, national, district (sub-national) and international.

Figure 1: Involvement of stakeholders at different levels



2.3. Establishment and operation

In order to appreciate the various ways in which health micro-insurance strengthens the capacity of women to face their priority health concerns, it is necessary to have some basic familiarity with the process that communities undertake to establish and operate schemes. The main steps for the establishment of a scheme are summarized below. This is followed by a brief description of their operation. It is important to remember that schemes vary enormously in size, membership and structure. In addition, there is no set “model” for the establishment and operation of micro-insurance schemes and more recent ones tend to have more refined processes, having directly or indirectly benefited from the experience of their predecessors. Therefore, the process described below does not necessarily apply to all schemes.

Pre-feasibility study – during this initial phase,¹² micro-insurance promoters contact community members, health service providers and administrative authorities to inform them about micro-insurance and to begin to explore with them whether basic conditions exist for the creation of a scheme. First and foremost, among these conditions are the expressed need among community members to cover health risks and their willingness to take action to do so.

The promoters may be local, external, or a mix of the two. The consultations can take the form of day-long events involving all future actors, separate meetings with community members, health service providers and administrative authorities, or both. They may involve individual and group discussions.

The consultations serve to stimulate reflection by community members, health service providers and administrative authorities on the local health situation and on whether micro-insurance is an appropriate mechanism to help address the priority health needs. They

therefore require awareness-raising on what micro-insurance is and on how it works. At this stage, however, no specific model is proposed. The specificities of the future scheme, such as the governance structure, the monetary amount and frequency of contribution and the benefits to be covered, can only be defined after a more in-depth feasibility study is carried out. While the awareness-raising begins at this point, it is not a one time activity; it continues throughout the rest of the process of establishment of the scheme and during its operation.

If the existence of a felt need to cover health risks is verified, the sessions with community members, health service providers and administrative authorities are therefore also crucial for gathering initial information on the following:

- existence of health care facilities of acceptable quality;
- access to health care, with special emphasis on its affordability by the population;
- trust of the population in the promoters and interest in further exploring the establishment of a scheme;
- level of solidarity existing within the community;
- the community's socio-economic characteristics.

In addition, this phase serves to identify a community initiative committee. Such committees tend to comprise representatives of:

- the community itself;
- administrative authorities;
- health personnel consisting of staff from local facilities and of health administrators.

The administrative and health personnel will be from local, district, regional or national level, depending on the specific setting. The community initiative committee may also include representatives of the micro-insurance promoters. Typically, these provide support to the committee for future steps without being members. Once the initiative committee is set up, its members receive an orientation from promoters to enable them to undertake subsequent phases. This then leads to the final part of the pre-feasibility phase, which consists in preparing a plan of action for carrying out the feasibility study.

Feasibility study – this phase is undertaken by the community initiative committee and involves the participation of the population, health staff and managers and administrative authorities. It typically requires some external technical assistance. The feasibility study serves to assess and analyse the health situation and to determine how to best use existing resources to better cover health risks. Information is therefore collected on:

- characteristics of the population;
- priority health needs;
- availability of health services of an acceptable quality (in some settings there may be only one health service provider that is geographically accessible);
- linkage between local health service providers and higher level health facilities (systems of referral);
- utilisation of the health services;
- health service fees and the capacity of the population to pay for them;
- organizational capacity of the population, as reflected in existing community initiatives and structures (e.g. cooperatives, savings and credit schemes, local committees);

- existing forms of mutual support mechanisms (e.g. community funds) used to support individuals or households in times of need.

The data are collected from available health and administrative records and through focus groups and simple household surveys. Its analysis leads to conclusions regarding the major health risks being faced by the population and the degree to which they are currently seeking care for them. It also leads to a determination of how much the population is presently paying out-of-pocket for priority health services and their willingness to pay into a mutual scheme. This is then used to define different possible scenarios for benefits packages. At one end of the spectrum, are packages that cover many health risks in full. These imply a significant contribution by members and would exclude a sizeable portion of the population. At the opposite end of the spectrum are benefits packages that are affordable by virtually everyone, but that have very limited coverage for the health risks.

The findings of the feasibility study as well as the various scenarios are the object of discussion between the community initiative committee and the population through feedback sessions. The future members have the opportunity to question, for example, the ordering of the health priorities and the degree to which each would be covered by a future scheme. The feedback sessions thus help to validate the findings of the committee. In addition, they serve to increase the collective awareness of health needs and of mechanisms to address them.

Central to the participatory approach inherent in the feasibility study methodology is the discussion and choice of the benefits package by future members. The micro-insurance scheme is truly community-based to the extent that future members democratically decide the benefits package to be adopted. The actual degree of member participation varies across schemes.

Establishment of the scheme – a micro-insurance scheme is formally established during the first general assembly whereby its members select the benefits package. The general assembly officially adopts the health services to be covered, the degree of co-payment, if any, for individual services and possible ceilings on fees. The members also decide on the level and periodicity of contributions. Finally, they decide on the governance structure of the scheme and elect the members of the various committees that will be responsible for the operation of the scheme.

The establishment of the scheme also typically requires a contractual agreement between the scheme and each of the health facilities that agree to provide health services. The contractual agreements generally set out the services covered by the scheme, the fees that the scheme agrees to cover and the payment modalities. They may also contain clauses referring to the quality of services to be provided and to the procedure to be followed in case of disagreements.

Schemes that do not receive any external financial support need to accumulate funds before they can begin to pay benefits. A fairly common practice is to collect contributions from new members for a period of 6 months before they are eligible for benefits. Thus, a newly established scheme will wait 6 months before being fully operational.

Operation of a scheme – the operation of a scheme entails:¹³

- regular collection of contributions;
- coverage of benefits as per the agreed benefits package;

- carrying out of health promotion activities;
- routine monitoring of operations;¹⁴
- periodic feed-back to members;
- periodic adjustment of the benefits package and of the governance structure based on actual performance and on the evolving needs of members.

3. Reproductive health and rights

3.1. Perspectives of community groups

Raising the topic of reproductive health and rights among poor communities brought to light that their understanding of the topic only partially reflects the international level consensus. The perspectives reflected below are those encountered by STEP and its development partners providing support for the extension of social protection in African and Asian countries.

When the term “reproductive health” is introduced in discussion among communities, it appears to be generally understood to mean “maternal health”. When asked about reproductive health needs, women and men alike raise the need for services that cover pregnancy and delivery, including complications of delivery. It is not uncommon, however, that when these concerns are raised, they also lead to the discussion of reproductive health needs that arise during other parts of the life cycle of both women and men. These include the importance of accurate reproductive health information for adolescents and the needs of women undergoing menopause.

When broached, family planning is also included among reproductive health concerns. However, health micro-insurance schemes do not tend to include coverage of family planning services as a separate benefit. It is unclear whether this stems from insufficient awareness that access to family planning services is a right. When asked about the coverage of family planning services, some scheme managers note that they prefer to subsume it under “preventive consultation” so as to respect the confidentiality of members. Similarly, reproductive tract infections are recognised as reproductive health concerns, but their coverage is included under the general heading of “curative consultations”. This makes it difficult to ascertain the degree to which these services are actually covered.

With respect to rights, there is a general notion that the government has to play its role in the provision of health services and that communities should demand that it carry out this role. However, in poor settings, it is acknowledged that the government’s capacity to carry out its role is limited and it cannot, for example offer all health services free of cost. This is important insofar as health micro-insurance is then perceived as a way to work with health service providers to better perform their duties.

3.2. Consensus at the global level

The international consensus is laid out in the Programme of Action of the International Conference on Population and Development held in Cairo in 1994. The text reflects both a comprehensive definition and an objective.

Reproductive health – Reproductive health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to

have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted infections.” (Paragraph 7.2)

Reproductive rights – Reproductive rights “embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community.” (Paragraph 7.3)

Reproductive health care – In the context of primary health care, services under the heading of reproductive health care “should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding, infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in Paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted infections and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted infections and HIV/AIDS should always be available, as required. Active discouragement of harmful practices such as female genital mutilation should also be an integral component of primary health care including reproductive health care programmes.” (Paragraph 7.6)

The above statements of the ICPD have been interpreted by countries according to their specific contexts and have influenced the formulation of national policies and plans of action. Progress toward the implementation of activities and the achievement of these and other goals contained in the ICPD Programme of Action was reviewed at a global level in 1999 during the Special Session of the UN General Assembly for the five-year follow-up to ICPD.

4. Results from the outset: the pre-feasibility studies

Structured pre-feasibility studies began to be undertaken by promoters and practitioners of micro-insurance only in the last couple of years. There are therefore few examples that can be drawn from to determine the ways in which this phase contributes to strengthening the capacity of women to address their priority health concerns. Rather than give a variety of short examples, this section will analyse in detail the example of the pre-feasibility phase undertaken by the *Association d'Entraide des Femmes* (AssEF) in Benin, a women's association for mutual assistance. AssEF organises micro-finance activities and has a membership of about 25,000 women. Operating in Cotonou and its peri-urban areas, its main objective is to contribute to the sustainable improvement of the women's socio-economic status.

AssEF undertook a pre-feasibility study in 2002. Health personnel took part in the awareness-raising sessions organized with the women and used the opportunity to underline women's inadequate utilisation of maternal health services. They described the very negative consequences that women face because of this. They noted that, due to lack of readily available financial means or for lack of information or negligence, women come to the health centre to deliver without having previously come for antenatal care.

Sometimes they come with complications that might have been prevented with appropriate antenatal care. The health personnel acknowledged that, when there are complications, the costs of care are often high and not affordable by households with limited revenue. They also noted that since no medical record for the women exists at the health centre, obtaining the necessary information could delay the intervention even when they have the money to pay for it.

The information provided by the health personnel was validated by a review of the medical records in the maternity wards and other health facilities in two health districts. These showed that out of a total of 1,600 cases referred by health centres for pregnancy-related complications, some 700 never reached the higher level facilities. Further inquiry with communities elucidated that the major reason for this was the lack of financial means by households to cover the fees and the costs of transport to the higher level facilities.

During the initial awareness-raising sessions, the women also insisted on the importance of finding ways to better deal with problems related to pregnancy and delivery. They also emphasized that as their children enter into adolescence, they need to have information and counselling on reproductive health.

HEALTH PROVIDERS DESCRIBE SITUATION

During the discussions, health service providers noted that:

- sometimes the women come to deliver with no money;
- because of lack of available cash, it is common to see husbands ask health centres to extend credit so that fees (e.g. for caesarean section) can be paid later;
- often patients come for the consultation but do not have enough money so they ask that the prescription for drugs be given in instalments. They say "I'll buy the more urgent drugs now - or the first dose - and I'll finish the treatment later" (AssEF feasibility study, Benin - July 2002)

WOMEN HIGHLIGHT THEIR NEEDS

...“The questions relating to reproductive health are of great interest to us in the sense that they touch us directly”...

...“Most of us are of childbearing age and are concerned about questions having to do with maternity”...

...“For those of us in the group who are more elderly, we are confronted by questions relating to menopause. We would like information regarding how to deal with the difficulties encountered during this physiological stage. At the same time, we are confronted with the problem of the information to give to our adolescent children who reach the delicate stage of puberty.” (AssEF feasibility study – Benin - July 2002)

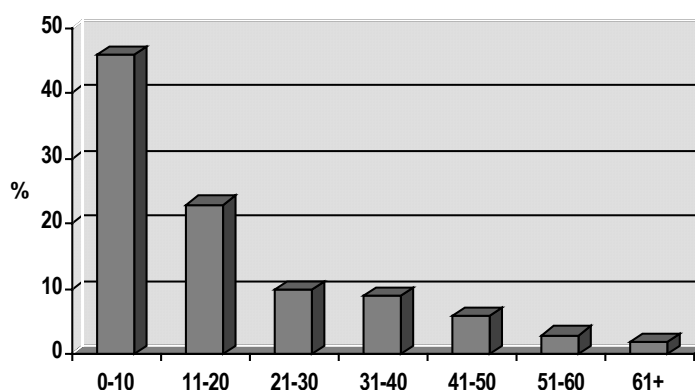
In organising the focus groups, AssEF spontaneously placed particular emphasis on reproductive health issues. The discussions by the groups enabled women to recognise that many of them did not undertake post natal consultations. They noted that a micro-insurance scheme should make available information regarding the availability of such services, what users should expect from them and their benefit to the women and their newborns. The women also said that some of them are aware of the need for medical

visits before, during and after a pregnancy. However, the costs of the consultations present an obstacle and, as a result, they tend to only go to the ones that they deem truly indispensable. They also strongly emphasized that reproductive health services should be included in the benefits package. In view of these initial findings, issues relating to reproductive health were given prominence in the design of the methodology to be used for the feasibility study.

5. Deepening awareness: the feasibility studies

Gathering of information - A major objective of the feasibility studies is to gain an understanding of the priority health needs of the community and of their overall health situation. This understanding is necessary to determine which services to cover. The feasibility study therefore entails gathering information on the type and frequency of health risks among the population. This is obtained by consulting health records held by health facilities and health managers at district and national levels and by relating these to information gathered through household surveys.

Figure 2: Distribution of cases of illness by age (AssEF feasibility study - Benin - 2002)



When AssEF undertook its household survey in 2002 it interviewed 480 households in three pilot areas. Some thirty interviewers carried out the survey after participating in training that included the testing and finalisation of the interview guides. The interviewers asked households to recount cases of illness during a specific period by all members of the household. The information collected was then differentiated by age (Figure 2) and sex (Figure 3).

By organising the household survey data in this way, AssEF called attention to the population groups most affected by illness, namely children and women. The data showed the relatively higher morbidity of women during child-bearing years and highlighted the importance of focussing on the specific health needs of this population group.

Figure 3: Distribution by sex and age of cases of illness (AssEF feasibility study - Benin - 2002)

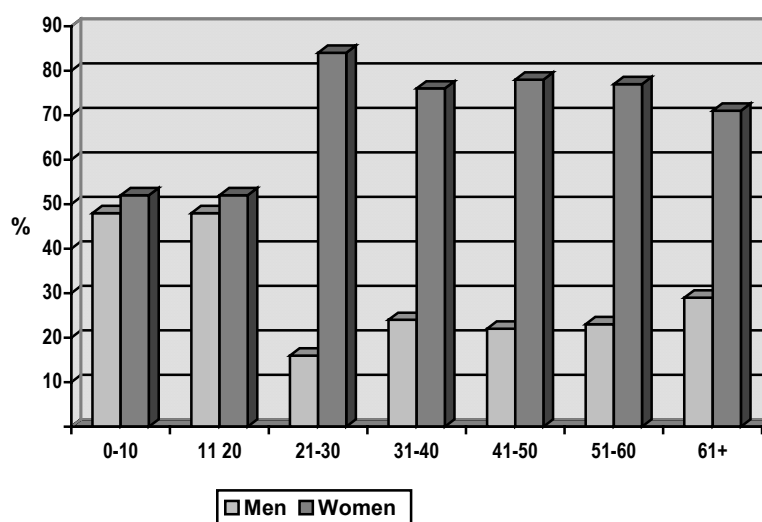
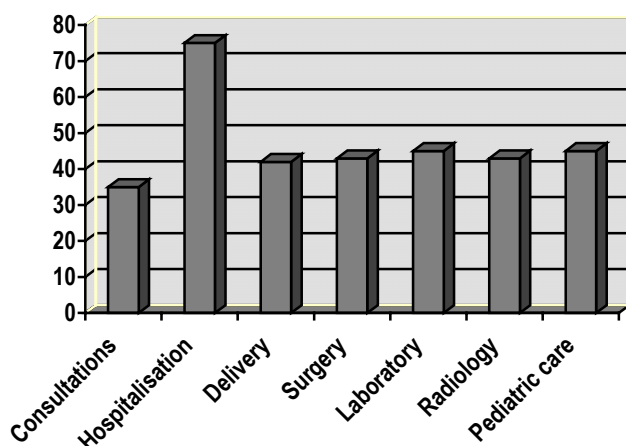


Figure 4: Health services for which coverage is most sought (AssEF feasibility study - Benin - 2002)



Feasibility studies also gather information from community members on what services they would like the future scheme to cover. The responses are not mutually exclusive.

In the case of AssEF, the highest number of responses refers to hospitalisations (Figure 4). This is not surprising insofar as hospitalisations pose the greater financial difficulties. Deliveries are also named among the top priorities.

These are typically understood to mean uncomplicated deliveries. The ones with complications and requiring emergency obstetric care are included under hospitalisation. Other pregnancy-related services are included under other categories: ante and post natal consultations are subsumed under consultations as are curative consultations for sexually transmitted infections; sonograms are included under radiology services.

Feasibility studies also look at the population's utilisation of the health services, as this will influence the composition of the benefits package and the calculation of the necessary contribution to cover the various health risks. As illustrated by the case of the El Mina scheme set up in a poor neighbourhood of Nouakchott, Mauritania, one of the methods for gathering information on utilisation of health services is to review medical records of health facilities used by the community and at district level. Reproductive health services are part of this assessment and analysis. Their relative importance depends, to some degree, on the way in which they are reflected in the records kept by the health facilities. These are typically governed by the national health information systems of the Ministry of Health.

The degree to which the information on reproductive health services is sought out is also

influenced by the presence of someone with a reproductive health background among the members of the community initiative committee. In Mauritania, committees typically include a nurse-midwife, thereby assuring this expertise. This may have helped the El Mina community initiative committee to focus attention on reproductive health services. In their feasibility study, they included information on family planning that, in the

FOCUS ON THE REPRODUCTIVE HEALTH SITUATION IN EL MINA

El Mina is a poor neighbourhood of about 95,000 inhabitants in Nouakchott, Mauritania. Based on the population figure, the number of deliveries expected in 1998 was 8,306, while the number of assisted deliveries was 2,271, indicating a utilization rate of about 27%. Approximately 41% of pregnant women use antenatal care while 48% undertake a post natal care visit. The immunisation coverage of pregnant women against tetanus is 26%. Only about 8% of women use modern methods of family planning. (El Mina feasibility study- Mauritania - May 2003)

Mauritania context, is not spontaneously elicited as a felt need. Preventive services such as family planning and ante and post natal consultations may also not be spontaneously

elicited among the services to be covered by future schemes if they are affordable or free of charge.

Quality of services is also examined in the context of feasibility studies. Where a variety of health facilities exist, one of the objectives of the feasibility study is to determine which facilities provide health services that are of the best quality for the best price. An analysis of this information may lead the community initiative committee to propose that the future scheme sign an agreement with a single health service provider or with multiple providers, some of which may be deemed best for a specific set of health services.

The analysis of quality may look at different aspects considered of importance by the community initiative committee. This exercise was undertaken as part of the feasibility study by the *Mutuelle d'Epargne et de Cr dit de Icota f Boubess* (MECIB), an organisation whose aim is to improve the well-being of women in Pikine, a poor neighbourhood in the peri-urban areas of Dakar, Senegal. MECIB has approximately 9000 members, most of which are women, who are associated in a network of savings and credit schemes.

The data gathered during the feasibility study is summarised in Table 1. It indicates that geographical proximity weighs significantly in the choice of health service provider. Affordability is also an important consideration. Combined, they explain the greater utilisation of the health post, except in cases of emergency, when the hospital is strongly preferred.

Table 1: First reason for selection of health facility
(MECIB feasibility study - Senegal - 2000)

	Affordable price		Physical access to structure		Staff attitude		Perceived Quality of treatment*		Best for emergencies		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Hospital	12	17	3	2	5	19	30	27	32	70	82	20
Health centre	25	34	54	35	7	26	16	14	11	24	113	27
Health post	27	37	90	58	12	44	25	22	1	2	155	37
Clinic	9	12	7	5	3	11	40	35	2	4	61	15
Traditional practitioners							2	2			2	1
Total	73	100	154	100	27	100	113	100	46	100	413	100

* Perceived quality of treatment refers primarily to availability of drugs and supplies and to whether treatment given led to improvement in the situation of the user during past visits.

Information on quality of services was also collected by the community initiative committee that undertook the feasibility study leading to the establishment of the Umasida Scheme in Dar-es-Salaam, Tanzania. There also, future members discussed their perceptions of quality of geographically accessible facilities and their preferences with regard to the health service providers with whom the micro-insurance scheme should sign conventions.

Many poor communities that explore the establishment of health micro-insurance do not have more than one health facility to choose from. This is often the case for rural communities. In these cases, the basic issue is whether the health services available are of

acceptable quality. If they are not, there will be no incentive for communities to create a health micro-insurance scheme.

Discussions with the population

DELIVERIES AS PRIORITY

"The women were not fully able to express their needs during the household surveys because these were addressed to the heads of households. But they were able to do so during the feedback sessions." (And Faju – Senegal)

The discussions with the population of the information gathered by the community initiative committee are a crucial part of the feasibility study. Through these sessions, the information is validated and the initial analysis made by the community initiative committee is refined.

The experience of the And Faju scheme in Senegal is of particular interest. The scheme has been operating in Ouakam, a peri-urban neighbourhood of Dakar since September 2001. From the household survey data, it appeared that only 58% of households wanted the future scheme to include deliveries among the services to be covered. During the feed-back session, the women contested this finding. As a result of the discussions that ensued, when the scheme held its first general assembly in December 2000, members agreed that deliveries should be covered, especially complicated deliveries.

The experience in Dar Naim, a peri-urban area of Nouakchott, Mauritania, was similar. There too, the priority level assigned to deliveries increased as a result of the feedback session with community members on the findings of the household survey. In this case, the data collected during the household survey showed that deliveries were in fifth priority. During the session with community members, which lasted into the night, future members agreed that coverage of deliveries should be raised to second place. However, in contrast to the Senegal case, where most of the members of the scheme are women, in the Mauritania case, it was primarily the men that advocated for the change.

These experiences suggest that the feed-back sessions and, more generally, group discussions are better able to bring out concerns about safe motherhood and other aspects of reproductive health than household surveys. Indeed, some health micro-insurance practitioners have identified the lack of gender focus in the design of the household surveys as a weakness to be redressed. In Mauritania, the Dar Naim experience led promoters to revise the suggested household survey methodology.

The analysis of the schemes reviewed also suggests that when health services are discussed as components of a grouping rather than individually, communities tend to adopt most or all of the services included in the grouping. This encourages a comprehensive coverage of services promoting maternal health and newborn care.

In Burkina Faso, the community initiative committees use the standard Ministry of Health groupings when considering which services to include in the benefits package. All services related to safe motherhood and newborn care are listed in the “maternal and child health” grouping. Like other committee initiatives, the one in the rural village of Zabré examined which services were provided by the village health centre and collected data on the frequency of the health risks and the cost of each of the services in the maternal and child health category. Their findings are summarised in Table 2. The

committee then discussed these as a set with the community to determine which to include in the benefits package. As a result, there was reluctance to delete individual services.

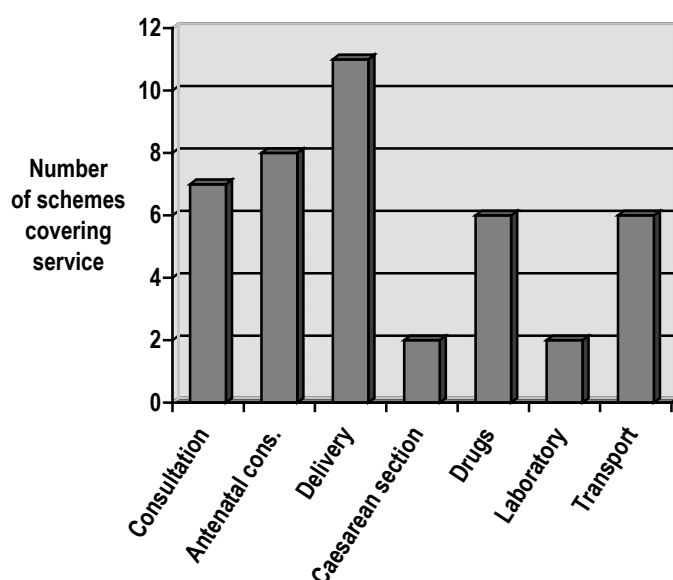
**Table 2: MCH services provided by the health centre
(Zabré feasibility study - Burkina Faso - 2000)**

Component of reproductive health service	Cases expected in 2001	Fee (in FCFA)**
Family planning consultation	584	100
Antenatal consultation	134	100
Delivery*	336	3,600
Caesarean section	29	50,000
Transport for caesarean	29	17,500
Birth registration	323	100
Post natal consultation	336	100
Induced delivery	34	1,000
Well-baby consultation	3,352	25
* Fee for delivery includes services provided by health personnel (200), supplies (450), drugs (2,650) and use of hospital bed (300) ** 1US dollar = approx. 600 FCFA in 2000		

6. On-going contribution: the operation of schemes

Services included in benefits packages

Figure 5: Benefits selected by schemes in West Africa



The benefits chosen by community-based schemes reflect their health priorities and their capacity to contribute into the scheme. They also reflect the availability of health services.

Figure 5 shows the benefits selected by 11 schemes in 4 countries in West Africa. All 11 cover simple deliveries and the schemes that cover secondary level care also cover caesarean sections. The majority of schemes also cover other services associated with maternal health. These include ante and post natal consultations and transport for emergency obstetric care. However, post natal consultations are sometimes included under the

category of general consultations and are therefore more difficult to identify. They appear to be covered less than antenatal care. The findings from these 11 schemes are consistent with those related to the feasibility studies, which indicated that the risks of pregnancy and delivery constitute a major preoccupation among the population.

COVERAGE OF "SENSITIVE" REPRODUCTIVE HEALTH SERVICES

"The benefits package covers the general consultation and reimburses a percentage of the analyses without seeking information on the reason for the consultation." (And Faju - Senegal)

Except for Burkina, where family planning services are listed within the maternal and child health grouping, the coverage of these services are identified clearly in only a few benefit packages. The same is true for consultations for sexually transmitted infections. When information was sought from members about this, they responded that these services are covered under general

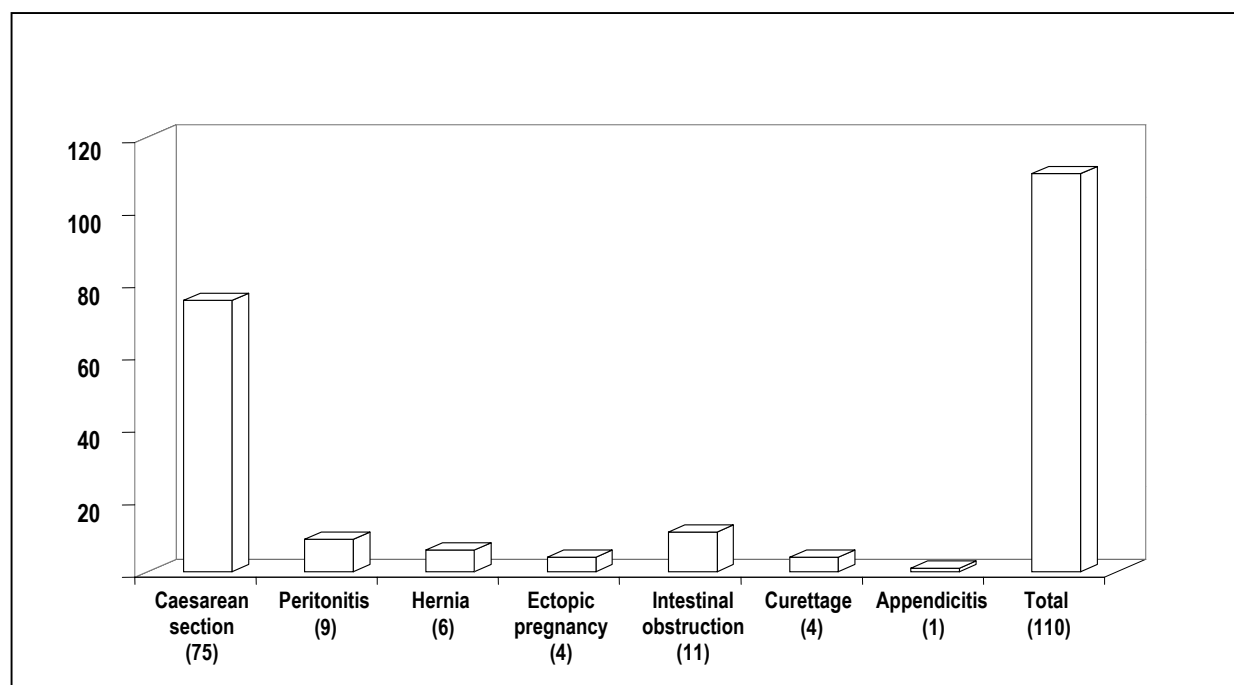
consultations in order to respect the right of members to confidentiality. They pointed out that although these services are not explicitly identified in the benefits package, this did not prevent women from going to see the nurse-midwife for information on ways to space births, or to have laboratory tests for sexually transmitted infections, including HIV/AIDS.

In Guinea, there are health micro-insurance schemes known as MURIGA, the French acronym for health micro-insurance schemes for reproductive health. These schemes were established with government support to only cover services related to pregnancy and delivery, including emergency obstetric care. The experience with them is mixed and there

is pressure on them to extend their services to cover other priority health needs in order to avoid facing declines in member contributions.

In a district of Burkina Faso, health authorities and health committees operating at health centre and at district level in the context of the Bamako Initiative have begun to experiment with the establishment of community-based systems of social protection to cover emergency obstetric care. The *Association Solidarité pour la Prise en Charge des Urgences Chirurgicales et Obstétricales de Bogandé* (ASUCOB), administers a district level fund that covers approximately 80% of the transport and health care costs faced by individuals in their catchment area for obstetrical or other emergencies requiring surgery. The contributions come from the Bamako Initiative funds obtained by health centre committees from the sale of drugs and services. As shown in Figure 6, the majority of cases covered by the fund during its first year of operation were for obstetrical emergencies.

**Figure 6: Breakdown of cases of surgery covered in one year
(ASUCOB – Burkina Faso)**



Within West Africa, health micro-insurance schemes in Burkina have been at the forefront in exploring ways to contribute to the fight against HIV/AIDS. The establishment of the Leere Laafi Bolem scheme in Zabré was in part motivated by the desire to take action against the spread of HIV/AIDS. When it was established in 2001, members agreed that the benefits package should limit the number of claims per beneficiary. In this way it could include services for persons living with HIV/AIDS, thereby enabling them to cure opportunistic infections. The measure would limit the amount of benefits that any individual could draw from the scheme, thereby preserving its financial viability. The number of claims is limited to four per annum per beneficiary which, if actually made, would represent a very significant increase from the average utilization rate in Burkina of approximately 0.2 contacts/annum/person.

Schemes being established more recently are going further in explicitly covering HIV/AIDS related treatments. The scheme in Komki-Ipala, a rural village approximately 40 kilometres from the capital, Ouagadougou, defined its benefits package in 2003. The scheme was set up to test an integrated approach that combined health micro-insurance with income generation activities and HIV/AIDS prevention and care action. Members agreed to contribute 20 FCFA per month, per person (approximately US\$0.50 per year) to help persons living with HIV/AIDS to gain access to treatment, including to anti-retroviral drugs. This is a significant amount with respect to the overall contribution of members. The decision to make this additional contribution reflects the community's awareness that it is exposed to the risk of HIV/AIDS. Moreover, it demonstrates a commitment to facilitating access to HIV/AIDS care and a willingness to cover the care of persons living with HIV/AIDS.

SATISFACTION WITH BENEFITS PACKAGE

"The felt needs of women are covered thanks to the coverage of antenatal care, deliveries, and vaccinations, but their expectations are limited to the services provided by the health post." (Bokk Faj - Senegal)

The West African case studies indicate that there is general satisfaction among scheme members regarding the degree to which the benefits packages cover their priority needs. However, they also indicate that the capacity of schemes to cover the needs of the community is restricted by the limited availability of health services that are geographically

accessible.

Evolution of benefit packages

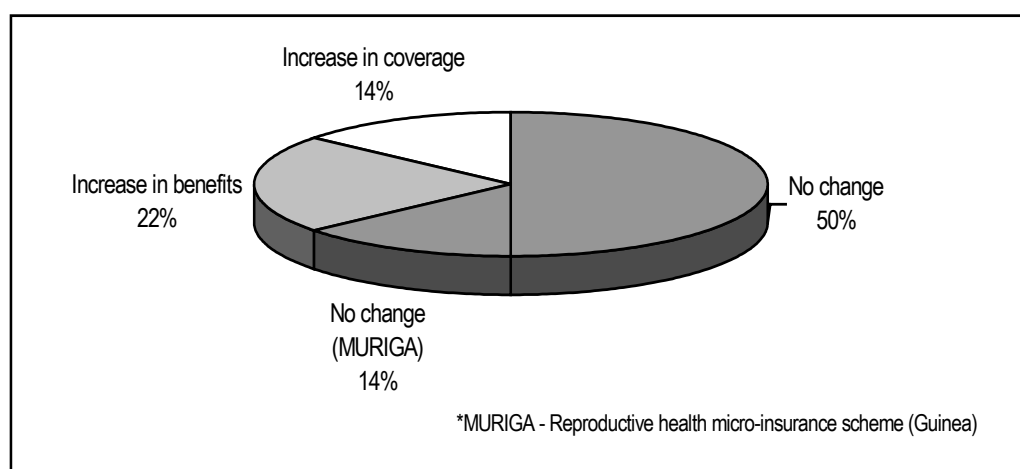
The majority of schemes make modifications to their benefits package over time. The benefits are initially based on predictions made from the information analysed in the course of the feasibility study. The modifications are introduced to better reflect the actual utilisation of health services by members and to conform to the evolving needs of the community.

For schemes in West Africa, modifications are often introduced after about two years of operation. By this time, schemes have typically gained greater confidence in their management capacity. Often, their initial choices are financially conservative to guard against the possibility of bankruptcy. This results in the accumulation of funds by the schemes since more revenue is collected in the form of contributions than is paid out in benefits and operational costs. To redress this and to better cover the needs of members, in settings where the fees for health services have not increased, schemes tend to increase their benefits package either by adding new benefits or by increasing the percentage of coverage for specific benefits.

The coverage of reproductive health services was increased in a number of the schemes surveyed. In looking at the findings, it should be noted that many of the schemes were very young – less than two years - and that the degree of change would likely be higher if the schemes were older. As shown in Figure 7, of the schemes studied in Burkina Faso, Guinea and Senegal, 36% of the schemes changed their benefits package: 22% added additional services while 14% increased the amount of coverage for reproductive health services already included in the benefits package. The other 64% of schemes introduced no change with respect to the benefits related to reproductive health. The MURIGA schemes in Guinea, comprising 14% of the total, were among those that did not increase their coverage of reproductive health services. This was to be expected since they had been

established from the start to only cover these services to the maximum. They, however, were under pressure from the population to increase their benefits to cover other priority health needs.

Figure 7: Evolution of benefits packages with respect to coverage of reproductive health services



Increases in coverage or of services included in the benefits packages do not always entail an increase in the contribution by members. In the Wothié scheme in Mauritania, the coverage for all the services included in the benefits package was initially set at 50%, with the members having to pay the other 50% out-of-pocket at the time of service use. During the second general assembly, members voted to increase the coverage of the cost of a delivery to 90%. The decision can be directly attributed to the change in community perspectives resulting from the educational session on reproductive health organized by the scheme in cooperation with the nurse midwife of the health post. The increase in coverage was deemed possible without an increase in contributions because the scheme had accumulated significant reserves in its account.

When the Wer Werlé Thies scheme completed its monitoring exercise for 2001, they noted that the scheme had been functioning well and had accumulated reserves. They therefore explored the possibility of expanding the benefits package to include maternity services that were being called for by women during their group sessions and when they made their monthly contributions. The modifications subsequently introduced enabled the scheme to cover the entire cycle of pregnancy and delivery.

The scheme And Faju in Senegal found a different way to better cover the needs of its members. Women had experienced complications with delivery and had not had the benefit of coverage for the costs of hospitalisation, which were onerous. Following discussions, members agreed to lower the coverage of normal deliveries to 50% of the cost incurred by the member while adding the coverage of hospitalisation for pregnancy complications, also at a rate of 50%. This was deemed to be fairer to all women.

As with the initial determination of the benefits package, subsequent modifications are influenced by the availability of services and the fees being charged. Since the contributions are low, schemes can only afford to cover costly services if they are infrequent and if their membership base is sufficiently large. In the case of the Wer Werlé scheme in Thies, Senegal, members expressed their desire to include ultrasonography

during pregnancy in the benefits package. However, when they included the coverage of deliveries, they deemed that also including ultrasonography might jeopardize the financial viability of the scheme. After two years, when they had gained greater confidence in the management of the scheme and proven their credibility with the local private not-for-profit hospital, they were able to negotiate a 50% reduction in the costs of laboratory tests and radiology, in which ultrasonography is included, and were then able to add them in the benefits package.

Effect on utilisation of health services

INCREASE OF DELIVERIES ATTENDED BY TRAINED PERSONNEL

“Since the scheme began to operate in our village, all women have delivered at the health centre with the nurse midwife. Previously, many delivered at home with no specialised assistance.” (Wothié – Mauritania)

“It seems as though all the women have become members of the scheme. Since it was established, no woman has given birth in the village.” (Fatako – Guinea)

The case studies were not designed to collect information from the health facilities on utilisation of services. Nonetheless, interviews with health personnel indicated their appreciation of the micro-insurance schemes noting that they brought about a noticeable increase in utilisation of the modern health facilities, bringing it closer to the levels deemed appropriate by WHO. In some cases, health personnel emphasised that this impression was confirmed by their routine monitoring activities as well as by

their financial records. For example, the monthly revenue of the health post used by the members of the Fatako scheme in Guinea increased from 540,000 FCFA to 880,000 FCFA when compared to the same month in the previous year before the scheme was operational. Health service providers and micro-insurance scheme members from different countries and different settings underlined the increase in utilisation of health services for deliveries.

The findings from the case studies also suggest that once micro-insurance schemes are in place, members modify their health-seeking behaviour. Health service providers interviewed noted that patients came for consultations earlier in the case of an illness

EARLIER UTILISATION OF HEALTH SERVICES

“Prevention as well as recourse to the health service at the beginning of illness or at the first sign of complications has decreased hospitalisations.” (Soppante – Senegal)

episode than they did prior to the existence of the scheme. Some members also indicated that they went to the health centre “at the beginning of the sickness since we do not have to pay” and used the centre more frequently. For some schemes, the replies also indicated that members used the health facilities for services that they had not used prior to the

operation of the micro-insurance scheme.

Influence on quality of services

The quality of care provided by health facilities appears to be a central concern of health micro-insurance schemes.¹⁵ When the issue is raised, scheme managers note that quality of services provided is an important element of satisfaction among members and it is essential to increase membership.

There are various formal and informal mechanisms that enable scheme managers to be aware of their members' perception of quality. Most common is that members voice their opinions when they pay their contribution, usually on a monthly basis. Concerns relating to quality are also voiced during general assemblies. Some schemes routinely ask their members about the care they received, especially for the more expensive services, such as those requiring hospitalisation. Likewise, scheme managers tend to discuss quality concerns with health service providers at the time when they settle financial aspects. Many also undertake "courtesy visits" to discuss issues raised by members.

Health micro-insurance schemes appear to focus in particular on two elements of quality, both deemed of priority among members: the attitude of health facility staff, including how they receive and interact with users of the health service, and the availability of drugs. A number of schemes in different countries have taken action to enable the health facilities with which they had signed agreements to have a steady supply of drugs. This is often done by making available a revolving fund that the health staff can use to buy drugs when there are stock-outs. In other cases, the scheme purchases the drugs and then subtracts their costs from the reimbursement made to the health facility for consultations. In the case of the Wothié scheme in Mauritania, the scheme pressured district health staff and local government authorities to rehabilitate the health post in their village and contributed the initial stock of essential drugs so that the centre could begin to operate rather than wait for the first delivery of drugs from the government allocation.

The experience of the Dar Naim scheme in Nouakchott, Mauritania provides an example of how a health micro-insurance scheme can lead to improvements in the way services are delivered. Not long after the scheme became operational, it asked for a meeting with the health centre staff to discuss the way reproductive health services were offered. The concern raised by the scheme was that women were uncomfortable with walking into areas designated for family planning and for maternity care since they did not wish to render their condition or their intentions known to other community members. As a result of the discussion with scheme representatives, the health centre reorganised the layout so as to ensure greater discretion and confidentiality. Managers of the health centre noted that the reorganisation also led to greater efficiency and were appreciative of the scheme for having raised the issue and for having worked together to introduce the improvements.

Overall, the increased interaction and collaboration between health staff and the community which results from the presence of micro-insurance schemes appears to favour improvements in the quality of services. Health staff tend to value their relationship with the schemes because it facilitates the attainment of their goals. They appear generally inclined to work with the schemes to address their concerns in order to maintain good relations with them. Indeed, interviews with scheme members and managers indicated that the quality of the relations with health service providers were good and had improved since the micro-insurance scheme had been established.

Health promotion

Health micro-insurance schemes can contribute to health promotion in two major ways: by encouraging the utilization of preventive services through the design of their benefits package and through health promotion activities within their community.

The utilization of preventive services is encouraged by some schemes by linking the payment of benefits for certain services to the prior use of preventive services. For example, some schemes will cover childhood illnesses that are part of the expanded programme of immunisation only if the child is up-to-date on immunisations as per the accepted norms.

DESIGN OF BENEFITS PACKAGE

In order to qualify for coverage for deliveries, members of the micro-insurance scheme in Sapone, Burkina must attend antenatal consultations and children that are not up-to-date on their vaccinations cannot benefit from coverage. (Sapone – Burkina)

In the safe motherhood realm, some schemes require women to attend antenatal visits (typically three) in order to qualify for coverage of the costs of deliveries. This is done in an effort to promote the use of antenatal care and decrease the number of high risk deliveries by identifying and addressing problems at an early stage.

However, some schemes choose to provide benefits without setting pre-conditions, noting that they prefer to avoid measures that may restrict access to benefits by its members. This seems particularly true among the younger schemes who are working to ensure understanding and acceptance among existing and prospective members.

Yet other schemes strike a balance between encouraging members to follow norms that are recommended by the health centre and providing coverage also when these are not followed. For example, the Niou scheme which is in a rural area of Burkina, reimburses 50% of the fee when women deliver at the health centre. It reimburses 25% of the fee when women deliver at home with the assistance of a traditional birth attendant, but only if the distance between the woman's home and the health centre is more than 10km. Some schemes limit the number of deliveries that can be covered. It is unclear whether this is motivated primarily by health promotion concerns or by an effort to limit the payouts to single households made by the scheme.

Either way, it may serve as an incentive for family planning.

HEALTH EDUCATION

"The needs are identified and a plan of action is developed. Our first action was to increase the awareness of the population on how to prevent the cases of malaria by proper management of water containers and of latrines so as to minimize mosquitoes. We also encouraged them to visit the health centre as soon as symptoms appeared in order to obtain the needed medicines. We will be getting together soon again to discuss on the subject of maternity." (Soppante - Senegal)

All health micro-insurance schemes engage in some form of health promotion activities, typically in collaboration with health service providers or with specialized NGOs. Often, the contact with specialized NGOs is not spontaneous, reflecting the relative degree of exclusion of the communities that establish health micro-insurance schemes. The contact needs

to be initiated by the NGO or facilitated by the national or international structures that provide support to the schemes.

On issues relating to maternal health and other reproductive health concerns, health micro-insurance schemes in West Africa have forged alliances with national affiliates of the

International Planned Parenthood Federation (IPPF) which provide reproductive health services as well as support for educational activities covering reproductive health topics.

In Senegal, the partnership began with the organization of a workshop in Dakar that brought together staff from the *Association Sénégalaise du Bien-Etre Familial* (ASBEF), which is the national affiliate of IPPF, and women from a number of micro-insurance schemes. The workshop was organised as a training of trainers so that the women could then hold sessions with other women in their community. It covered information aimed at enabling women to better understand their bodies and to recognize and address health problems that may affect them and their children. It also familiarized the women with the health services provided by the ASBEF clinic so that the micro-insurance schemes could consider forging agreements with the clinic. Within the following months, three of the schemes signed agreements with the clinic for the provision of reproductive health services.

**COLLABORATION WITH
REPRODUCTIVE HEALTH PROVIDERS**

"The sessions held within the community on STIs and gynaecology in general encouraged the women to use the ASBEF clinic for consultations. Women were ashamed to go to the hospital and looked for a health facility that assured greater discretion." (Wer Werlé – Senegal)

The workshop also served to elaborate plans for health promotion activities covering reproductive health to be undertaken by the schemes in their communities. Two of the schemes led the way in the organization of community gatherings. These entailed educational activities through theatre skits covering sexually transmitted infections, post natal care and the vaccination of newborns. The schemes also organized group sessions with the staff of ASBEF. The community-based activities were very successful and led to requests for more such activities. However, the schemes faced limitations in their ability to meet these requests because the educational activities required resources that were not always available within the scheme.

The AssEF scheme in Benin also worked together with the national IPPF affiliate, the *Association Béninoise de Promotion Familiale* (ABPF), to respond to the requests for reproductive health information and services voiced by its members. The collaboration between the two organisations was a direct result of the process of establishment of the health micro-insurance scheme. The feasibility study enabled the concerns on reproductive health to emerge and stimulated AssEF to find ways to respond to them.

**COMMUNITY-BASED SESSIONS
ON REPRODUCTIVE HEALTH**

"Starting from the questions and concerns raised by the women, the sessions covered STIs, HIV/AIDS, methods of contraception and menopause. The sessions were of great interest for the women and brought to light the deficit of information. Women asked that the sessions of this sort be held again and that they be organised also with their spouses so that they also could better understand the health problems faced by women and be more supportive in preventing and addressing them." (AssEF – Benin)

When the micro-insurance scheme was launched in June 2003, AssEF organized a series of sessions with groups of women to discuss with reproductive health professionals on their specific health problems. The ABPF made available one of its Cotonou clinic staff specialized in STIs and HIV/AIDS and in community-based educational activities. She was assisted by an obstetrician-gynaecologist. In the next four months, some thirty sessions were organized, each attended by 50-80 women. All women from the community

were welcome, irrespective of whether they were members of the scheme. The success of the community-based sessions led Assef to organize sessions for its own staff (managers, staff responsible for the savings and credit activities) and for the members of its executive board. The session was meant to serve as an orientation and was scheduled to last 3 hours. It went on for twice that long in view of the keen interest from the participants.

In Guinea, the IPPF national affiliate *Association Guinéenne pour le Bien-Etre Familial* (AGBEF), and the USAID-supported PRISM project aimed at strengthening reproductive health and HIV/AIDS interventions, both supported the establishment of MURIGA schemes that cover only reproductive health services. The MURIGAs are routinely used by AGBEF and PRISM for the promotion of reproductive health. For example, the Coyah scheme, established with the support of AGBEF, trained peer educators who undertake awareness-raising activities within their communities. PRISM's Information, Education and Communication Unit often works with the schemes that it helped establish to reach its own objectives of improving the quality of services and increasing the utilization of reproductive health services.

In Burkina, the affiliate of International HIV/AIDS Alliance, *Initiative Privée et Communautaire contre le VIH/SIDA* (IPC), is working with the Leere Laafi Bolem scheme in Zabré in carrying out educational activities on HIV/AIDS and on community-based distribution of condoms. Without the presence of the scheme and its capacity to regroup a number of rural villages, IPC would not have been able to reach this rural population with its prevention activities. Thanks to the collaboration, it can cover 83 villages where Leere Laafi Bolem

CONTRIBUTING TO THE FIGHT AGAINST HIV/AIDS

"On 1 December, on occasion of the day devoted to the fight against HIV/AIDS, we organised theatre skits with the neighbourhood theatre group. We used a mix of humour and realism to address the problem of stigma but also informed the public on the manifestations of the illness and how it can be prevented." (And Faju - Senegal)

has members, reaching well beyond the scheme's membership of approximately 5,000.

Educational activities on HIV/AIDS are not unique to schemes in Burkina. Action on this topic was noted in all of the other West African countries where schemes were studied. National HIV/AIDS prevention programmes are beginning to take interest in the role that community-based systems of social protection can play in helping to fight the pandemic by fighting stigma, encouraging prevention and facilitating access to care.

AWARENESS-RAISING ON SENSITIVE ISSUES

"*Naître et Grandir* helped organise an education campaign with the scheme located in Sekba, a poor neighbourhood of Nouakchott. Health centre statistics show that the campaign led to increases in attendance of family planning consultations. However, as the practice is looked down upon by many in Mauritania [use of modern contraception is estimated at 6%] many of the women are visiting the centre without informing their spouses." (Sekba - Mauritania)

In Mauritania, where the establishment of health micro-insurance schemes has been supported by the National Programme for Reproductive Health of the Ministry of Health and Social Affairs (PNSR) as part of its programme to decrease maternal mortality, educational activities on reproductive health issues have been consistently encouraged. In the rural area schemes, sessions were organised by the schemes in collaboration with the staff of the health post. It was after one of these sessions that the general assembly of the

Wothié scheme voted to increase the coverage for deliveries from 50% to 90%. Two of the schemes in the peri-urban areas of Nouakchott who are receiving support from the NGO *Naître et Grandir* have organized educational activities that use a mix of group sessions and individual discussions.

Representatives from the PNSR point out that the opportunity for health promotion does not only come from community-based activities. They note that the schemes lead to increased utilisation of health centres for deliveries and that this translates into more opportunities for health staff to be in contact with women and advise them on reproductive health issues, including the importance of post natal consultation both for the woman and the infant and the planning of future pregnancies.

7. Conclusions and implications for programming

The community-based systems of social protection reviewed point to the conclusion that these systems strengthen the capacity of women to raise and address their priority health concerns. They further indicate that women's increased capacity to raise and address their health concerns begins with the steps entailed in setting up a scheme. These conclusions have programmatic implications for the way support is provided during the establishment of schemes. It can be inferred that if the methodologies used in the pre-feasibility and feasibility studies are participatory and gender-sensitive, they can enhance the raising of awareness on health issues. With respect to reproductive health, it can be inferred that participation of individuals with expertise in this field can be useful in stimulating in-depth discussion of reproductive health topics, especially of the ones that are either not spontaneously expressed as being of priority or which are deemed sensitive.

The findings indicate that pre-feasibility studies provide an opportunity and a stimulus for communities to raise and discuss their health needs and to explore ways to address them. When women have the opportunity to voice their concerns, they consistently raise the problems linked to pregnancy and delivery as a priority concern. In varying degrees, they also raise other reproductive health concerns including adolescent health, infertility, sexually transmitted infections and family planning. HIV/AIDS is also raised as a concern among many groups, especially where prevalence rates are significant.

The findings also indicate that feasibility studies go much further in raising awareness and in stimulating discussion of health priorities. As the feasibility studies generate information on the actual situation of a community, they are more real than general health statistics. The in-depth assessment and analysis deepens community understanding of its priority health needs, of the availability of health services to meet those needs and of its capacity to access the services. Issues relating to safe motherhood are assessed and analysed in all the feasibility studies. If they are designed to differentiate by age and sex, the studies can also increase awareness on the degree to which recourse to health facilities among women of child-bearing age is related to reproductive health.

Analysis of the operation of health micro-insurance schemes suggests that there are a number of ways in which schemes can enable women to address their needs. By covering priority health needs in the benefits package, they facilitate their satisfaction. This is substantiated by indications that health micro-insurance schemes lead to increases in the utilisation of health services and encourage early recourse to health facilities in case of illness. They also stimulate health promotion activities and promote improvements in the quality of services.

The analysis further suggests that the underlying force of community-based systems of social protection is that they increase interaction, mutual respect and collaboration between health providers and communities. Thus, they encourage people's participation, promoting the fulfilment of this human right. They could therefore also contribute to the better functioning of the health system. This has significant programming implications. It calls attention to the importance of providing support to mechanisms such as health micro-insurance schemes that, by enabling a stronger community organisation around health, provide a "bridge" between community members and health service providers. By increasing dialogue and collaboration, such mechanisms can play an important role in

bringing together initiatives stimulated at the national level with community-based initiatives and accelerating progress toward fulfilling the Millennium Development Goals. Among the most important national level initiatives is the provision of health facilities of acceptable quality. Without them, there is no incentive to set up micro-insurance schemes.

It should be emphasized that micro-insurance is an initial but insufficient response to the unmet collective responsibility of ensuring the right of social protection. It tends to pool resources and risks among a limited group of people and is therefore not necessarily a guarantee of equity for the poor. Hence, it is essential to provide support to community-based systems in ways that increase their linkages to national programmes and systems that channel resources to women, children and men with the most unmet needs.

The strengths and limitations of community-based systems are evident in their capacity to undertake educational activities. These same strengths and limitations reflect opportunities for linkages with government and non-government institutions whose goals include improvements in the health situation of communities and the fight against HIV/AIDS. Educational activities require technical expertise that is not found within the schemes. They also require financial resources for materials and supplies. On the positive side, the schemes play the important role of stimulating interest in health and reproductive health and its members and managers demonstrate a willingness to devote significant time and energy in organizing activities to respond to this interest. In this context, governmental and non-governmental institutions can channel resources much more effectively to reach communities and households. The power of these partnerships has already been demonstrated in a number of West African countries.

The benefits of this type of collaboration are becoming apparent to national programmes including those aimed at improving reproductive health, reducing maternal mortality, improving infant and child health, and national programmes against HIV/AIDS – all of which are of particular importance to women. These programmes often have resources but are confronted with the difficulty of reaching poor communities. Community-based systems of social protection strengthen the organisational capacity of communities – especially women – around health concerns, enabling them to work with such programmes.

The sources of information that informed the analysis contained in this document were mostly from West Africa. It would therefore be premature to draw global conclusions. Nonetheless, based on the findings in West Africa and the more limited experience from health micro-insurance schemes in Asia, it is legitimate to retain the working hypothesis that community-based systems of social protection would also empower women in other parts of the world. Further research should be undertaken in East and Southern Africa as well as in Asia. Simultaneously, more research should be undertaken on the gender dimensions of the schemes, addressing questions that include whether the membership is primarily of women or of men and the degree of decision-making by women. The research should examine the degree to which these factors affect the capacity of women to express and address their health concerns. Further research and experimentation is also needed on the role of community-based systems of social protection in helping families, communities and governments make headway in both the prevention and the treatment of HIV/AIDS. Finally, and perhaps most fundamental, additional research should be undertaken to gain further understanding of how community-based systems of social protection contribute to the fulfilment of the human rights of women, children and men. Such additional research would contribute to the further improvement of the schemes and, more broadly, to the improvement of national systems of social protection.

The coverage of community-based systems of social protection is still very small compared to the number of women, children and men in need of social protection. However, it is increasing rapidly and, in at least one country, appears to have surpassed the coverage by statutory systems of social protection.¹⁶ As efforts towards the fulfilment of rights and the achievement of the Millennium Development Goals continue at national and international levels, it is encouraging to note that community-based systems of social protection are further developing in a number of countries, with schemes organising into informal and formal networks and with civil society organisations that already have national-level networks beginning to explore how to cover their significant membership. It is also encouraging to note that governments are increasingly recognising the value of such systems, and looking for ways to support them and link them to national systems of service provision aimed at reducing infant, child and maternal mortality and morbidity and at reducing poverty. The development community can play a strategic role in accelerating progress.

Notes

- ¹ Article 9 of the International Covenant on Economic, Social and Cultural Rights states, “The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.” The Covenant links the right to social security to “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. With respect to the linkage to people’s participation, the Committee on Economic Social and Cultural Rights noted, “A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.” (General Comment No. 14, 2000). The most widely ratified human rights convention, the Convention on the Rights of the Child, also devotes a full article on the right to social protection.
- ² For full study see: Atim, Chris, “The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries”, 1998.
- ³ For a summary of the findings see Preker et al, “Effectiveness of community health financing in meeting the cost of illness”, Bulletin of the World Health Organization, 2002, 80 (2).
- ⁴ See “Improving Access to Maternal Health Care through Insurance” PHRplus Insights for Implementers, No. 3, June 2003.
- ⁵ “The World Health Report 2000 – Health Systems: Improving Performance”, World Health Organization 2000
- ⁶ Additional information on this topic is available of the STEP web site <http://www.ilo.org/public/english/protection/socsec/step/index.htm>
- ⁷ The following schemes were studied: Burkina Faso – Bouahoun, Gombousgou, Kumi-Taaba, Leere Laafi Bolem and Tekehie; Guinea - Batè Nafadji, Faranah, Fatako, Hamiyara and Kérouané; Senegal - Bokk Faj, Fagaru de Hann, Kounghoul, Mutuelle des Volontaires et Maîtres Contractuels and Wer Werlé Thiès.
- ⁸ Information was gathered from the following additional schemes: Benin - Association d’Entraide des Femmes; Mauritania - Dar Naim, Diudié, Wothié, Sebkha, El Mina; Senegal – Soppante, Wer Werlé Dakar. From the French original by Isabelle Renaud and André Mora.
- ⁹ From the French original by Isabelle Renaud and André Mora
- ¹⁰ The Bamako Initiative was launched in 1987 by the African Ministers of Health and was implemented in Africa as well as in countries in other continents with the support of WHO and UNICEF. Central to the BI was the concept of co-management of health facilities by users and health personnel. Guinea and Benin were among the first countries to implement the BI and provided an initial model of co-management whereby community health management committees with representatives of the community and of the health facility were created for each health centre and ensured a joint control by health staff and community representatives of its financial transactions, including the sale of essential drugs and services. Other countries followed in similar fashion, albeit with some differences in the mechanisms and procedures of co-management.
- ¹¹ Presently the 8 promoters that are actively collaborating in the “Concertation”: STEP, the United States Agency for International Development through its Partnership for Health Reform Plus programme, the *Association Internationale de la Mutualité*, the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ), through its Health Insurance project, the Belgian *Alliance Nationale des Mutualités Chrétiennes* (ANMC), the Belgian NGO World Solidarity (WSM), the French *Réseau d’Appui aux Mutuelles de Santé* supported by the French cooperation agency and the Belgian *Union Nationale des Mutualités Socialistes* (UNMS).
- ¹² A manual covering feasibility studies for setting up health micro-insurance schemes has been developed by STEP. The French version is in final editing and is expected to be available by end 2004 and forthcoming in English.
- ¹³ For more information on the management and administration of health micro-insurance schemes refer to “Guide de gestion des mutuelles de santé en Afrique” available in French (2003, ILO/ STEP). Information is also available from web site www.ilo.org/step.
- ¹⁴ For more information on the monitoring and evaluation of health micro-insurance schemes refer to “Guide de suivi et d’évaluation des systèmes de micro-assurance santé”, vol. 1 and 2, available in French (2001, ILO/STEP), and forthcoming in English. Information is also available from web site www.ilo.org/step.
- ¹⁵ A manual on health micro-insurance and quality of health care entitled “Quality care for communities: A Manual for Mutual Health Organizations” is under development by PHRplus and STEP, with support from the

Stronger Voices project to assure coverage of quality concerns specific to reproductive health care. It is expected to be published in 2004.

- ¹⁶ Preliminary results of the inventory of health micro-insurance schemes currently being undertaken by the “*Concertation*” in West Africa indicate that in Senegal the coverage of health micro-insurance schemes may have surpassed that of the statutory system. Results of the inventory should be available by end 2004.