INDRA GANDHI NATIONAL OPEN UNIVERSITY
SCHOOL OF CONTINUING EDUCATION

The Study on Effectiveness of Community Based Micro Health Insurance Scheme attached with Women Self Help GROUP (SHG) approach in Ethiopia: the Case of Jimma Town Women SHGs

A THESIS

Submitted to Indira Gandhi National Open University in partial fulfillment of the requirement for the Degree of MA in Rural Development

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Addis Ababa, Ethiopia

DECLARATION

I hereby declare that the dissertation entitled ***"The Study on Effectiveness of Community Based Micro Health Insurance Scheme attached with Women SHG approach in Ethiopia, the Case of Jimma Town women SHGs"*** submitted by me for the partial fulfillment of the M.A. in rural development to INDIRA GANDHI NATIONAL OPEN UNIVERSITY (IGNOU), New Delhi is my own original work and has not been submitted earlier to INDRA GANDHI NATIONAL OPEN UNIVERSITY (IGNOU) or to any other institution for fulfillment of the requirement for any course of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

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CERTIFICATION

This is to citify that MR. ASHENAFI ABEBE Student of MA (RD) from INDIRA GANDHI NATIONAL OPEN UNIVERSITY (IGNOU), New Delhi was working under my supervision and guidance for the project work for the course MRDP-001. His project work entitled ***"The Study on Effectiveness of Community Based Micro Health Insurance Scheme attached with Women SHG approach in Ethiopia: The Case of Jimma Town women SHGs"*** which he submitted is his genuine and original work.

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ACRONYMS

CBMHIS……………….Community Based Micro Health Insurance Scheme

CBOs…………………..Community Based Organizations

CLA……………………Cluster Level Association

CSA……………………Centeral Statistics Agency

EDHS………………….Ethiopian Demographic and Health Survey

FC………………………Faciliator for Change

FMOH…………………..Federal Ministry of Health

FP…………………………Family Planning

GTP…………………….Gross and Transformaton Plan

HTPs……………………..Harmfull Traditional Practices

IGAs…………………….Income generation Activities

ILO………………………International Labour Organization

KNH……………………..Kindernothilfe

MA(RD)…………………Master's of Arts in Rural Development

MA……………………… Master's of Arts

MHIS……………………..Micro Health Insurance Scheme

NGOs…………………….Non Governmental Organizations

RH………………………..Reproductive Helath

SHG………………………Self HelpGroup

SPSS…………………….Statistical Package for Social Science

SSA………………………Sab-Saharan African

WHO……………………..Worl Health Organization

ABSTRACT

The study on Effectiveness of Community Based Micro Health Insurance Scheme attached with Women Self Help GROUP (SHG) approach is conducted as a case study on Micro Heath Insurance Scheme piloted in Jimma Town of Oromia National Regional State in Ethiopia. The main Objective of the Pilot project is to promote community based risk sharing approach on risks related to health through mutual support and self help. The project aimed to enhance the health knowledge of the community and capacity to cope when there is heath risks among the poor women and their children. Protection aspect of health, such as education, environmental and personnel hygiene, as well as home management skills are among the basic activities of this project beyond its promotion of curative aspect of the community based Micro Health Insurance Scheme.

This Community Based Micro Health insurance Scheme attached with the Self Help Group approach is implemented in Jimma Town, which is about 315KM away from the Capital City of Ethiopia, Addis Ababa. According to the year 2007 statistical abstract of CSA, the population of Jimma town is estimated to be 120,600 of which female population accounts for 60,011. The rate of population growth is 2.9%, which is higher than the national average of 2.6 %. The female headed families' accounts to 37% of the total households. Its altitude, average annual rainfall and temperature of the area are 1740 meters above sea level, 1533.6 mm and 29.2 degree Celsius respectively. Jimma is one of coffee marketing center in Ethiopia. In the town there are about 1060 women organized under 91SHG (primary level), 15 CLA (secondary level and where MHIS is managed) and a Federation (tertiary level which represent women at the Town level).

The overall objective of the study was to assess the effectiveness of Community Based Micro Health Insurance scheme attached with the SHG approach. It assess the impact of the scheme in reducing risks related to health, in promoting health education and protection and financial, managerial, and structural feasibility of the scheme.

The specific objectives of the study were to analyze the situation of the poor in accessing health care services, to study the effectiveness of the pilot community health insurance scheme attached with women SHG approach and to identify the opportunities and challenges of MHIS attached with women SHG approach. Therefore the study assesses health service accessibility of the poor by comparing accessibility before and after joining SHG. Accessibility to health service was assessed in relation to health education, information and medical care. In addition the study assesses the effectiveness of the MHI scheme in solving problems related to health service access. In this regard also access to education, information, and finance to get the service were considered. Moreover, the study tried to assess the opportunities and challenges in relation to the CBMHIS implemented attached with the SHG approach.

The main tools of data collection were employing structured questionnaire to interview individual sample members of the MHIS, FGD and secondary data review. FGD was implemented to gather information from the CLAs MHIS sub-committees and basic information collected based on a guiding question. Cases of non-MHIS members were also considered in the information collection process through conducting sample interview with open ended question. Secondary data was used as another source of information for the study. Local data from the implementing organization and the CLAs themselves, National policies, studies, and guidelines related to health and health financing, international reports, studies and experiences regarding health and poverty, health insurance and

community based health insurance strategies reviewed in the literature review part of this study.

The Findings of the study had indicated that poor women have got access to health information, education and coverage of risks related to health which they didn't have or have limited before joining SHG and MHIS. Awareness of women and their families on applying health protection skills enhanced. Their MHIS started to cover some part of their medical expense as per the developed by-law which encourages them to build trust on their self help and mutual support.

It is also found that the SHG approach is a very good structure in promoting the Community Based MHIS. The SHG approach promotes the enhancement of poor women to unleash their potential and start helping themselves and others to get out of poverty. This self help and mutual support attitude built in the SHG approach was a spring board for successful start of the MHIS. Women with their families became members of the MHIS and contribute money per month per individual.

There were some challenges and obstacles of the scheme. Long distance between the Members and the management of the MHIS created problems in transparency of information and procedures of claim settlement. Unable to meet regularly and take long time to settle the claim was among the challenges in the scheme. Moreover, since community based initiatives are mostly managed by the volunteer members, sub-committees, it was not taken as a serious business and this is one of the reason for the long procedure of settling claims. In addition the study finding indicated that MHIS needs skills in insurance management, finical management, linkage and networking and sensitization, which in turn is found very poor during the assessment.

CHAPTER 1: INTRODUCTION

1.1. BACKGROUND OF THE STUDY/PROBLEM

Different groups have agreed on the existence of relationship between poverty and poor health status. In one side, poverty is presented as a cause for poor health and on the other hand, poor health has been taken as a cause for poverty. However, all have agreed that there is a relationship between poverty and poor health status. Poor families stay away from health services due to lack of money or forced to take high cost loan or sell their asset to finance their health service need. Their poverty by itself makes them vulnerable to various illnesses associated with malnutrition and working and living condition. Poor health status, on the other hand, contributes to the poverty of a given family in two cases. The first one is, when the bread winner of the family is getting sick as most families living condition become destitute, and secondly, the ,cost, related to the medical services for a given family, may need the sale of assets and entering into high cost loan.

As in the case of all developing countries, Ethiopia's insurance business, especially, for health coverage, is very poor and can be said none. Some NGOs recognized these gaps few years before and have been trying to develop community based health insurance attaching with community based organizations in different parts of the country. These scheme was run informally, since there was no a legal frame work and policy guideline which recognize micro-health insurance. However, currently the Ethiopian government had initiated a community insurance approach and developed a bill and establishes an agency to promote the scheme based upon a pilot program undergone in different regions.

The main purpose of this study is, therefore, to assess the functioning, procedures, challenges, opportunities and effectiveness of the Micro health insurance scheme in the case of community based organizations, such as SHGs.

1.2. STATEMENT OF THE PROBLEM

Limited Health Insurance Service in the Country: A successful health insurance market is not only dependent on the income of potential insurance clients, but also on the availability (and proximity) of health infrastructure necessary for the servicing of clients. Health infrastructure in Ethiopia is limited, with services mainly provided by government (but not with sufficient reach) and by some limited private organizations. . This implies that long-term investment in the development of health infrastructure and facilities would be a prerequisite for the development of a vibrant health micro-insurance market. At this stage, it would also be difficult for Ethiopian insurers to successfully develop and sell health micro-insurance products on a commercially viable basis, given their limited capacity in even more basic types of insurance. Despite the strongly articulated need for health insurance, we do not foresee immediate opportunity in the area of health micro- insurance (Oxfam, 2013).

Different studies showed a wide variety of community based coping strategies are used to share risks and minimize vulnerability. Households tend to rely on community-based mechanisms, such as *Iddir* (funeral societies that help cover death-related expenses), *Iquub* (rotating savings schemes) and cooperatives (as a source of credit) to cope with unexpected expenses. *Iddir* and *Iquub* are the most popular risk management strategies for urban Ethiopians. These trends showed us the familiarity of the insurance by the community and can be easily understood when it comes to micro-health insurance scheme.

High prevalence of poverty: According to UNDP (2010) human resource index, about 39 % of the population of Ethiopia is unable to meet basic nutrition and non-food needs including health service. High population growth, and out of which, about 44 % are non-productive (dependant) aggravates the problem of poverty. Access to improved sanitation and safe drinking water is as low as 15% and 24 %, respectively, which is mostly concentrated on some main towns (World Bank 2004). As a result poor people are more vulnerable to various viral

and communicable diseases which can or can't be treatable. However, most poor people are becoming poorer and poorer, and passed away due to treatable diseases because of inaccessibility of health services. . Some tried to attend medical treatment by selling their assets or taking high cost private loan, and this also leads the family to a more severe poverty (Bangladesh Institute of Micro Finance, 2009).

Women are more Vulnerable to poverty and health related problems: Women are the most vulnerable to poverty. Most of them are less educated, have lower level of literacy and less exposure to mass media than their men counterpart (EDHS, 2011).Moreover most women are engaged in an informal economy like minimal agricultural activities and manual labor (ILO, 2004).

On the other hand, women are more vulnerable to health problems due to their biological reproductive nature. In addition, as mothers they are mostly responsible for giving care to their children and the family. Thus, poverty on women is more intense than the men.

1.3. OBJECTIVES OF THE STUDY

The objectives of this study are:

- To analyze the situation of the poor in accessing health care services;
- To study the effectiveness of the pilot community health insurance scheme attached with women SHG approach;
- To identify the opportunities and challenges of MHIS attached with women SHG approach.

1.4. SCOPE OF THE STUDY

The universe of the study is Jimma Town women who are organized under SHG approach. In Jimma town, a Local NGO called Facilitator for change (FC)

promoted SHG approach for about seven years with the support of kindernothilfe (KNH). There are 125 SHGs, 15 CLAs and one Federation with a total constituency of 1789 women. These women are able to mobilize Birr 447, 129 through their regular saving and rotate Birr 1,003,009 through internal loan. The project claimed that it addresses more than 3600 children through this approach.

Around five years before, FC introduced the concept of Micro- health insurance scheme in the SHG approach. Using the SHG structure and considering one of the roles of CLAs which is "***Planning and Implementing need-based projects"***, each member under SHG contributes some amount of money for the individual beneficiary whom they registered for the health coverage. The management of the MHIS is at CLA level, every month each SHG brings the contribution to the CLA. The CLAs have the by law to manage the scheme on which every member of the MHIS agreed upon. A separate subcommittee also formed to handle issues related the MHIS (Facilitator for Change, 2012).

There are about 13 CLAs which run MHIS with a membership of about 1134 People. All Members of the SHG are not the members of the MHIS, only those who are interested become members. These MHIS members are also having a chance to register their families under this protection. This means that not only members of the SHGs are included in membership of MHIS; it embodies their families as well on the basis of their interest. Every month a minimum premium is paid per individual who is under the scheme. Since all SHG member women are not coming to the CLA, the monthly premium is collected at SHG level and sends to the CLA account through their representatives. The insurance claim process is also followed this SHG-CLA structure (Facilitator for Change, 2012).

In the by-law, the types of diseases to be covered under the scheme are specified. In addition, the minimum premium per month per individual is also indicated. They had set a maximum amount of insurance coverage for a given individual for a given period of time.

Table 1 General Information on the CLAs in which implement MHIS in Jimma Town

Jimma Town CLAs current status									**Total members of MHIs**		
No.	**Name of CLA**	**Date of establishment of MHI**	**No of Member SHGs**	**No of mothers under a CLA**	**MHIs yes & No**	**Minimum contribution per person per month**	**Total collected money**	**Max premium to be paid**	**SHG members**	**Their families**	**Total**
1	Tsehay weta	2005 E.C	8	122	yes	1	1262	70	45	26	71
2	Yeab sira	2002 E.C	8	98	Yes	1	1115	70	61	13	74
3	Melkam misale	2002 E.C	6	80	yes	1	630	70	57	34	91
4	Misale	1999 E.C	9	110	Yes	1	870	30	47	71	118
5	Gudeta	2000 E.C	5	70	yes	1	245	30	24	40	64
6	Andinet arbenyoch	1998 E.C	5	75	yes	1	800	60	41	78	119
7	Andinet Legehar	1999 E.C	8	97	yes	1	470	30	41	24	65
8	Kokeb	1997 E.C	6	70	Yes	0.5	80.5	25	87	122	209
9	Hullu akef	2002 E.C	8	109	Yes	1	1270	25	82	28	110
10	Medegagef	2002 E.C	7	106	Yes	1	94	30	47		47
11	Hibret	2003 E.C	8	124	Yes	1	1530	70	88	12	100
12	Metages	2002 E.C	6		yes	1	796	30	15	9	24
13	Befiker Enguwaz	2002 E.C	7		yes	1	1270	30	33	9	42
Total			91	1061			10432.5		668	466	1134

Source: Facilitator for Change annual report, 2013

1.5. DEFINITION OF TERMS AND MAJOR CONCEPTS

To create clear understanding of the study, it is good to have definitions and meanings of most important terms and concepts under this study.

Community Based Micro Health Insurance scheme (CBMHIS): According to Micro Insurance Academy of India, (2008) Community Based Health Insurance is ***"In which communities mutualize risks and resources into a locally-managed health care fund".*** On the other hand, the study conducted by Micro insurance Innovation Facility in collaboration with International Labor Organization (2009), define Micro insurance as ***" the protection of low income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved".*** In general, Community based Health insurance scheme is a system in which the people establish a health insurance within their own organization which may be established for this specific purpose or attached with their traditional or existing organizations. In Ethiopia, few NGOs piloted the scheme attached with existing traditional Community Based Organizations (such as Idirs) and other development oriented groups (such as SHG approach). Micro health Insurance Scheme is incorporated as one of their community service programs.

Community based organizations (CBOs): are institutions that can be formal or non-formal and mostly established by the will of their members to mutually solve common problems and/or satisfy their basic needs. It is a traditional way of risk sharing, mutually help and support in order to avoid vulnerability and risks. The most common, strong and influential traditional institution in Ethiopia is ***"idir"***, which were known for their focus on mutual support during death and funeral ceremony. Currently, these institutions are involved in their community social and economic development using their social acceptance and mass power. Health insurance is among the social agendas which attract these institutions (Ethiopian Journal of Health Science, 2009).

The Self Help Group (SHG) Approach: is a development approach originated from Asia based on a principle to unleash the potentials of the poorest community groups with the objective of initiating self employment using existing potentials. This approach is aiming in bringing social, economic and political empowerment of poor and vulnerable parts of the community. In the group, 15 to 20 poor people are organized together and form an informal association working on its members and community socio-economic empowerment. In Ethiopia, SHG was introduced in 2002 with the support of Kndernothilfe (KNH) and currently there are about 25 organizations who promote SHG approach all over the country. The approach was introduced to empower women in social, economic and political arenas. . The focus of the approach is women, by recognizing that women are the most vulnerable and at risk of poverty in most developing countries (Bezabih, 2007).

SHG has its unique future as it needs of conducting regular meeting, regular saving and raising social agenda and information exchange in every weekly meetings based on the demand of the members. Rotational leadership, producing internal by-laws, facilitating internal loan and promote individual IGAs; keeping financial and other records; and vertical development (CLAs and Federation) are also among the futures of the approach.

Institutional Development and Sustainability of the Approach**:** SHG is an informal community institution which will have its own horizontal and vertical growth and become a people's institution to influence their community and government for the safety and wellbeing of their own life, community and specially their children. In addition, this institutional development is a strategy to ensure the sustainability of the initiatives (Voluntary Operation in Community & Environment India, 2008).

Role of the People's Institution at each Level:

Grass root Level, SHGs: SHG is the primary level in the approach in which homogeneous individuals who are neighbors come together and work to satisfy their socio-economic interest. At this level, the effort is gone to improve the social

and economic status of individual members and their families through various capacity building activities, as well as, the group saving loan system. SHGs work to enhance the entrepreneurial skills of its members, encourage the individuals to engage in Income Generation Activities (IGAs), improve the participation, leadership and management skills of its members (KNH 2008).

Secondary Level, CLAs: CLAs are organized by the SHGs with the objective of expanding the groups concern at the community level. At this level, the focus of the people's institution is on creating safe, clean, better living condition for the community where it is situated. CLAs will take over the promoting organizations role of establishing and capacity building support of SHGs. In addition, various external linkages created at this level to mobilize resources, to bring social justice, to protect the right of vulnerable parts of the community (children and women), to promote environmental protection of their villages. In summary, the role of the CLAs is categorized as: (KNH 2008)

- Strengthening SHG: It is providing services to member SHGs and others which can strengthen their business at a group level. Some of the services to be undertaken under this role are auditing service, conflict resolution, capacity building training…etc;
- Formation of new SHG: CLAs take responsibility to address more poor women who didn't get a chance to be under SHG. By doing so, they contribute to the wellbeing of their community and reduce poverty;
- Mobilizing need based services and resources: The CLA is encouraged to establish linkage to access materials and social services;
- Planning and implementing need based projects: CLAs identify need based projects which benefit their constituency as well as the entire community. The CLA does a participatory need analysis exercise and prioritizes. Needs that have high priority are taken up for implementation. Examples of such projects are: pre-school for children, MHIS, Literacy classes, …..etc;
- Social transformation in the communities: Development aims at establishing value system in the community that respects rights and duties of

men, women, girls and boys. Likewise, that relationship among them are strengthened and restored. SHGs discuss social problems in their meetings. They soon come to a consensus on right and wrong values as well as helpful and harmful social customs and practices. Changing these values is not an easy task and CLAs play a great role in changing the attitude of the community;

- Participating in the Local Governance: CLAs participate in the local governance and make positive influence on policies for the benefit of their members and the community.

Tertiary level, Federation: It is an apex body of the SHG approach and a legal holder of the people's institution. It is responsible in taking over administrative and management role of the promoting organization (Kindernotelfie SHG approach Guideline manual, 2008). It has four main roles:

- To take over the initiatives from the promoting NGO and build strong Peoples Institution;
- To provide need based service to the community;
- To work towards peace, security and justice in the community;
- To positively influence peoples thinking and policies.

CHAPTER 2: REVIEW OF LITERATURE

2.1. SITUATION OF HEALTH SERVICE IN ETHIOPIA:

The world Health Report of 2010 identified three interrelated problems that limit universal health coverage in Ethiopia: 1) limited availability of health resources, 2) *over reliance on direct payments at the time people need care*, and 3) inefficient and inequitable use of resources (WHO, 2010). The limited availability of resources for health in Ethiopia is very clear. The total health spending in Ethiopia increased from about US $ 522 million in 2004/05 to about US$ 1.2 billion in 2007/08. However, overall health is under-financed, both in absolute terms and when compared to the sub- Saharan African Average, as evidenced by per capita health spending of US$ 4.5 in 1995/96 (FMOH, 2001) that reached only $16.10 in 2007/08 (FMOH 2007). On the demand side cultural norms, distances to functioning health centers, and *financial barriers* were found to be the major causes for not seeking health services in health facilities (FMOH, 2011). Recently the government recognized that the health cannot be financed only by government and underscored the importance of promoting cost sharing in the provision of health service.

The Ethiopian Health Care financing reform developed in 1998 that directs resources for the health sector to be mobilized from different sources and permit government to provide health services through its health facilities by means of a cost sharing arrangement with users. The Health care financing reform has about eight components, such as revenue retention and utilization, standardized exemption services, out sourcing of nonclinical services in public hospitals, Establishment of private wing in public hospitals, Health facility autonomy through establishment of government bodies, ***systematizing fee waiver system***, ***User fee setting and revision*** and ***initiation of health service***. Among the components, the last three highlighted ones are very important for the purpose of this study and discussed below.

Ethiopia Institutionalized mechanisms for providing service to the poor free of charge through a fee –waiver system, as well as through free provision of the selected public health services. However, it needs strong system and standard to avoid poor’s delay to access health service due to cumbersome procedures to get fee waiver certificates from the local authority which is practiced now. This current situation is not a case for better income individuals and the system therefore created health care inequalities.

The other component of the health financing reform is user’s fee setting and revision. The health care financing strategy clearly stipulated that the user fees needed to be revised to reflect the costs of delivering health care services, but also understood that individuals should be charged according to their ability to pay. Cost sharing between the government and users was one of the principles of the health care financing strategy.

The third one is initiating health insurance; Out-of-Pocket spending accounts for a significant proportion of health sector spending in Ethiopia. In 2007/2008, out-of-pocket spending accounted for 37 %of the total spending in Health (FMOH, 2010). Direct payment at the time of sickness is considered “unsuited” because it could inhibit access to, especially for the poor, and because of “the risk of impoverishment or destitution,” according to WHO 2010.

2.2. POVERTY IN THE COUNTRY:

Ethiopia is still one of the poorest countries in the world. Throughout its history, natural and human-induced hazards have caused disastrous droughts, floods, landslides, with an annual per capita gross domestic product of approximately USD 377 in 2009, according to the GTP. Ethiopia Ranked 157th on the list of the 169 countries in the United Nations Development’s program Human Development Index in 2010. In 2008, there were an estimated 39 percent of the

people unable to meet basic nutritional and non-food needs including health care. This figure is estimated to have declined to about 29 percent in 2010/11 (UNDP 2010)

Life expectancy at birth (42 Years) is slightly lower than the SSA average of 45 years. In 2007, Ethiopia's population was 73.3 million. It is the second most populous country in SSA. The population is growing at an average of 2 million annually representing a rate of 2.73 percent. The population is largely rural. However, with an urban population growth rate of 4.1 percent as compared to a growth only 1.9 percent in rural areas, the urban rural breakdown of population is slowly changing. Moreover, urban population growth is partly filled by internal migration. The population is young; with 44 percent under the age of 15. Such a structure results in high dependency ratio as well as a future rapid exponential population growth. Population density is very high in the highlands, and lowest in the eastern and southern lowlands. About 23.2 percent of the population is concentrated in 9 percent of the land areas putting pressure on cultivable lands and contributing to environmental degradation (World Bank, 2007).

Despite efforts made by the government to ensure basic social services, access to services such as water and sanitation is limited. Only 15 percent of Ethiopians have access to improved sanitation and compared to the SSA average 55 percent. Access to clean drinking water is slightly better at 24 percent but still much lower than the SSA average (55 percent) Fifty-nine percent of the adult population is illiterate and female have a high rate of illiteracy. More than 50 percent of Ethiopia also remains food insecure, particularly in rural areas (World Bank, 2007).

High fertility is a major contributor to poverty in Ethiopia. An ILO study published in 2003 confirmed that a strong relationship exists in Ethiopia between demographic characteristics and the probability of a household being poor. Large family households with older heads are more likely to fall into poverty than

smaller households with younger heads. The addition of one more child increases the incidence of poverty (ILO, 2003).

2.3. WOMEN ARE THE MOST VULNERABLE FOR RISK:

The 2011 Ethiopian Demographic and Health Survey (EDHS) had shown data on background characteristics of women, such as age, education, and employment status. The report showed that Ethiopian women are less educated, have a lower level of literacy, and have less exposure to mass media than men. The EDHS data also indicate that women are predominantly engaged in agricultural occupations, have few manual skills, and are less likely than men to be engaged in professional, technical, or managerial fields. Educational attainment, literacy, exposure to mass media, and employment are critical contributors to women's empowerment and exert considerable influence not only on the development of their personality, but also on solidifying their position in the household and in society in general (EDHS, 2011).

Poor people are more susceptible to risks because of their lack of income and asset, insecure and often unsafe working conditions, and incurred exposure to health risks through poor housing, sanitation and so on. Among poor people, women are especially vulnerable.

Women Biological role make them vulnerable particular health risks associated with pregnancy and child birth. They are also at higher risk for certain diseases, such as HIV/Aids, driven not only by their physiological vulnerability. Furthermore, women face additional risks related to their gendered position in society. They are more vulnerable to domestic violence, divorce, and loss of support in old age than men. Such risks are aggravated by their unequal ownership of property (Dr. UMA NARANG, 2012)

Women's own income earning activities are also subject to a wide range of pressures. The responsibility for caring sick family members often means that the

ill health of children, parents and extended family members impinges on their ability to generate income. In addition to their responsibilities, most women in developing countries are dependent on their husbands' income, which intensify their vulnerability in the situation when their husband died or abandon them. Caring of children and other old age extended families will become on the shoulder of women (ILO, 2009).

2.4. CONCEPTS AND PRACTICE OF MICRO HEALTH INSURANCE SCHEME

Insurance is not the only way to deal with risks, and not all risks are insurable. However, health risks such as those relating to illness, injury, disability, maternity, and the like are considered to be eminently insurable, as these risks are mostly independent or idiosyncratic (i.e., not correlated among community members). Moreover, among the several risks that face poor households, health risks are considered to be crucial as they have destabilizing effects on household finances—directly, by forcing health expenditure and indirectly, by affecting the income earning capacity of households (Asfaw, von Braun, Admassie, & Jutting, 2002).

Hence the need for a two pronged strategy: (1) an aim at improving the health status of the poor, and (2) an aim at protecting the poor from the financial consequences of illness of other medical problems. For this reason, micro insurance that essentially protects households against the financial consequences of illness is regarded as a complement to, not as a substitute for, other health interventions. Amidst shrinking government budgets, the failure of markets to reach the poor, and the widespread criticism of levying user charges, community based arrangements have aroused much interest and hope that health care challenges facing the poor can be met. Micro insurance is considered to be an important financing tool to protect the poor from adverse financial consequences in the event of sicknesses or ill health. While the out-of-pocket expenditure on health care payments imposes great financial hardships on the

poor, community based health insurance is an effective way to finance health care costs. (ILO, 2005)

Health insurance that is determined by pooling the risks of members participating in health insurance lessens the financial burden of members affected by illness. Indeed, several types of community based health insurance schemes have emerged in sub-Saharan Africa (Wiesmann & Jütting, 2000; Atim, 1998), Asia (Krause, 2000) and other regions (Bennett, Creese, & Monash, 1998; Jakab & Krishnan, 2001). Some of these schemes are community based, while others are based on membership in a particular group.

Community health care financing schemes are usually based on the following characteristics: voluntary membership, nonprofit objective, link to a health care provider (often a hospital in the area), risk pooling, and reliance on an ethic of mutual aid/solidarity. These finance schemes have an advantage in their ability to reach low-income people in rural areas who work in the informal sector and are otherwise difficult to reach and their ability to exploit social capital to bring about greater awareness, correct for adverse selection and moral hazard problems, encourage preventive measures, and increase access to health care. But community based schemes also have certain weaknesses, such as a low capital base, a low level of revenue mobilization, frequent exclusion of the poorest of the poor, small size of risk pool, limited management capacity, and isolation from more comprehensive benefits.(ILO, 2005)

Concepts of Micro Health Insurance scheme:

Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor. (World Development Vol. 32, No. 2, pp. 273–288, 2003)

Micro-insurance is identified as one possible approach to extend social protection. It is aimed at community members who are excluded from formal

economy systems and who are often poor. These voluntary and contributory schemes are based on the mechanism of pooling a group's resource to share risks (health, death, pension, accidents) and organize protection directly for them. The micro-insurance scheme, further, provides an insurance benefit. It enables members to be covered for a number of (health) risks or for life cycle event (death), in line with a defined benefits package and payment of contributions. (ILO, 2005)

An ILO study showed that there are many grassroots-based health insurance schemes, that many have covered thousands of members, and that they typically combine primitive, preventative and curative care. It also appears that health care and its related insurance is the top priority of most workers and organizations in the informal economy as the chosen first tool for risk-management. (Lundand Srinivas, 2000: 109)

Philippines government and civil society organizations recognize that community based health micro- insurance schemes (HMIS) appeal to various sub-sectors of the informal economy because of the inherent features that such schemes possess, and which can be further maximized if they meet the following characteristics: (ILO sub regional office for south east Asia and the pacific, 2005)

a. Culturally sensitive - It is attached on and reinforces core values such as solidarity, shared responsibility and mutual support.
b. Closer to clients - Social dynamics can reduce transaction, information and enforcement costs. Hence, entry barriers are lowered compared to traditional and formal schemes.
c. Affordable and easy terms of contributions - Compared to commercial insurance schemes, the HMIS has the advantage of being less expensive for its members.
d. Simple, flexible and easy procedures - It adopts simple procedures that are not threatening to the members and that allow for needs to be immediately met.

e. Fewer qualifying requirements - Since people know each other, they know the earning capacity and spending habits of potential members and can vouch for their reliability in terms of payment of contributions.

f. Easy to access/ maximize benefits - Given the proximity of office and service providers, familiarity with personnel as well as simple procedures, members and their beneficiaries find it easy to immediately access and avail of their benefits.

g. Local government unit (LGU) support - An increasing number of LGUs are forging partnership with groups undertaking HMIS as it helps fulfill a basic need of their constituency, especially those most in need. This helps address the needs of the disadvantaged sectors in a more systematic way, instead of using a piecemeal or case to case basis.

h. Commitment (“participation” = “ownership”) of community members - People make more effort to pay contributions when they are part of the decision to get into HMIS or are convinced that such an undertaking fulfils their needs and those of their fellow community members.

i. Social pressure - When members know each other and are in many instances relatives by blood or affinity, there is pressure to contribute to prevent a collapse or bankruptcy of the HMIS which would affect their loved ones.

j. Taps existing structures, i.e., community groups, support structures, government, international donors and development organizations - These include but are not limited to the following: co-operatives, women’s associations, informal trade associations, health service providers, NGOs, municipal/ provincial councils.

k. In addition, the following characteristics are important to successful micro-insurance schemes:

- Builds on strengths of community;
- Provides mechanism that promote participation of communities in social matters and engender social empowerment;
- If participatory, communities can organize and influence service providers;

- Increases access to health services;
- Increases income security.

Basic Principles of MHIS

Different literatures indicate that MHIS scheme has to have the following basic principles for its success (ILO 2005 and World Development Vol. 32, No. 2, pp. 273–288, 2003)

(a) ***Solidarity:*** HMIS must be rooted on solidarity. Membership is neither compulsory nor dependent on the state of health of your future members. Through solidarity, the members of your HMIS express their desire to deal with their problems themselves by assisting each other. Their contributions signify the principle of mutual assistance and solidarity within the organization. This means that your members who are in good health and accept that their contributions are used to cover the expenses of other members who are ill. It entails pooling of these risks among themselves.

(b) ***Democratic and Participative Operation:*** In the HMIS, everybody must be free to join without racial, ethnic, sexual, religious, social or political discrimination. All the members should have the same rights and duties. These include the right to participate, directly or indirectly in the decision-making process.

(c) ***Autonomy and Freedom:*** Autonomy as a principle in the HMIS means that any public authority or any other party (political or religious groups, service providers) should not interfere in your management and decision-making process as an organization.

(d) ***Personal Fulfillment:*** In addition, the HMIS must support respect for the dignity of individual members regardless of gender, race, ethnic or social

origin. As an HMIS, it must encourage members to become truly socially committed to the sick and the most destitute.

(e) ***Service-Oriented:*** HMIS should devote its time to serving the members and not in making profit. It does not mean though that covering for operating expenses is not allowed in the HMIS. The extra income that the HMIS earned over expenditure can be used to improve existing services, or to meet the other needs of your members.

(f) ***Responsibility:*** While the HMIS emphasizes solidarity, autonomy and participative democracy, it equally underscores the importance of responsibility.

(g) ***Dynamics of a Social Movement:*** Members must become committed to an individual and collective development process and that they are group of individuals who seek to defend the common good and common interests of all.

(h) ***Preventive and Curative Health Services*****:** the HMIS shall endeavor to provide both preventive and curative health services to the members. It must be understood that enhancing preventive health services becomes more beneficial to the individual members and whole organization in the long run.

(i) ***Sustainable Operations:*** It is necessary for the HMIS to put in place the appropriate management structure, develop capabilities of its leaders and members, institutionalize essential support systems, and generate the needed resources to continuously run and adequately maintain its operations.

Organizational Structure

There are different organizational arrangements that can be set up. Usually, an HMIS is structured into four essential bodies, such as:

- General Assembly (GA)
- Board of Directors (BD)
- Executive Body (EB)
- Auditing Body (AB)

The HMIS may create additional committees to help carry out its programs and activities. Some HMIS may need to create separate structures for different bodies.

Beneficiaries

(a) Definitions: A "*beneficiary*" refers to individuals who have the right to the HMIS benefits. Beneficiaries include both the members and their dependents. A "*member*" refers to the one who joins the HMIS, who pays the membership fees, undertakes to observe the rights and duties and pay contributions. He/she is sometimes called the "policy holder." In your HMIS, anybody may join the organization if he/she has attained the minimum required age, without discrimination of any kind by reason of state of health, sex, race, ethnic origin, religion, philosophical or political views, provided that they observe the By-Laws and the Policies, Systems and Procedures (PSPs) and regularly pay their contributions (ILO 2005).

"Dependents," on the other hand, refers to individuals who are directly dependent on the policy holder or member with whom the right of HMIS benefits is extended. The dependents may include the spouse, children up to certain age and orphans who have been officially fostered. Family members however may not be considered dependents unless they are indeed financially dependent upon the policy member (ILO 2005).

(b) Categories of Members: Though in principle, membership to the HMIS is not conditional to the state of health of individual members, HMIS must take a conscious effort to consider memberships of the older persons, those who are chronically ill or sick individuals or Some HMIS have addressed the "older

persons" issue by setting a certain age limit for participation (Micro Finance Focus 2008)

(c) Membership Fees: With regards to membership fees, it should be incorporated into the MHIS by- Laws, a provision for payment of membership fees upon registration of a member, and that the fees can be changed periodically. Note that the membership fee is used primarily to cover the cost of the registration process (Micro Finance Focus 2008).

(d) Membership Contributions: members' contributions are the main source of income of HMIS. These should be sufficient to allow the organization to:

- grant benefits to members;
- finance its operations;
- build reserves in order to reinforce its financial soundness from one financial year to the next.

There are also four possible systems for paying the contributions: (source?)

- the policy holder and his/her dependents each pay the same amount of contributions;
- dependents pay a lower contribution than the members themselves;
- two contributions rates are applied, with or without dependents;
- a single contribution is paid, regardless of the number of dependents.

(e) Membership Card: The membership card serves two purposes: (a) to identify the member and the other beneficiaries; and (b) to serve as evidence that the member and his/her dependents, listed on the card, are entitled to the MHIS benefits. This card may take different forms.

(f) Probationary Period: The new member is usually asked to observe a probationary period established by the MHIS before becoming entitled to the MHIS benefits. This probationary period refers to the phase in which the new member pays contributions but is not yet entitled to the MHIS benefits. It is

otherwise known as the observation period or the waiting stage. Its purpose is twofold: to ensure that people do not join only when they are ill, and to allow the MHIS to build up its financial reserves to cover the costs of benefits to the members (ILO 2005).

Services

It is essential that the services offered by the MHIS are matched with the needs of the members, from the time of starting the MHIS and throughout its operations over time. It needs to regularly evaluate these services if they continue to be relevant and appropriate to the members' needs and if they are delivered in satisfactory manner. (IL0 2005)

(a) Choosing the Services to be offered: It is important that the scheme meets the needs of the beneficiaries, taking into account their ability to contribute and the existence of an adequate supply of care.

There are two approaches in identifying the services which the MHIS can offer to the members. The first is taking the available earnings of the MHIS as the basis and establish the corresponding services and the second option is identifying the priority needs of the members and assesses the level of contributions necessary to meet those needs.

(b) Type of Care that the MHIS May Cover: Generally, it is not possible for the MHIS to cover all health care from the start-up activities. Only part of the care can be taken into consideration, such as primary healthcare, secondary or specialist care, medicines, transport or other social risks. The following gives examples of health care that your HMIS can cover:

i. *Basic Health Care:* This package of services is the most common type of care that is usually provided by the health centers, which is the first point of contact between the target membership and the health care system. This package includes:

- Preventive and promotional care including pre-natal and post-natal consultations, monitoring of infants' health, vaccination, family planning, health education and counseling
- Curative care which primarily includes consultations, nursing care, supply of drugs and some laboratory analysis; sometimes it also includes minor hospitalization in health centers or assisted childbirth
- Coverage of chronic diseases like diabetes, high blood pressure, hemophilia, heart diseases, etc.
- Coverage of treatment of children suffering from malnutrition and their recovery

ii. *Hospital Care:* This covers both accommodation in the hospital and medical, surgical and technical procedures and drugs consumed.

iii. *Specialized Care:* This includes consultations (gynecology, obstetrics, and surgery) and technical medical treatment such as radiology and clinical biology.

iv. *Dental Care:* Some MHIS reimburse dental expenses; usually tooth extraction, sealant and prophylaxis.

v. *Spectacles*: There are some MHIS that reimburse the cost of spectacles if they are issued as part of the medical prescription. Most often, the coverage is confined to prescribed lenses and the frames are not covered.

vi. *Medicines:* As far as medicines are concerned, it is important that you list those that will be reimbursed by the MHIS.

vii. *Transportation of Patients:* In addition to meeting the cost of healthcare, the MHIS may organize and take responsibility for transporting beneficiaries who are ill to a health center or for transferring them to the nearest hospital, in accordance with a referral system (patient transferred to hospital after consulting a health centre).

2.5. MHIS ATTCHED WITH COMMUNITY BASED ORGANIZATIONS

CBMHI schemes are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations. It is argued that CBHI

schemes are effective in reaching a large number of poor people who would otherwise have no financial protection against the cost of illness (Dror & Jacquier, 1999).

Community- based insurance scheme are wide spread throughout the world and exists in different forms. A common demonstrator of this scheme is proximity to their members, the clients of the scheme. These clients are often involved in the administration and management of the schemes. Its proximity possesses a deep understanding of the economic s and social situation of their members and the risk they face.

Community-based health initiatives designed to improve the access through risk and resource sharing (Dror & Jacquier, 1999). Elsewhere, particularly in regions of Asia and Latin America, community-based health initiatives have come about independently and as part of income protection measures or to fill the void created by missing institutions.

It is however clear that community based insurance schemes also have downsides. As they usually cover a relatively small number of insured, they are exposed to higher fluctuations in their claims, making them vulnerable to collapse in bad years. Their ability to accumulate reserves or mobilize equity is also limited. Since it is also managed by the volunteer members, it lacks professional managerial skills.

In general community based insurance schemes can play an important role as a risk management tool for the poor or population in remote areas. However, in order to leverage their full potential they need technical assistance and help in achieving financial stability (Micro Insurance Academy, 2010)

CHAPTER 3: RESEARCH METHODOLOGY

3.1. DESCRIPTION OF THE STUDY AREA

As stated earlier in section 1.4, the universe of the study is Jimma Town women who are organized under SHG approach. In Jimma town, a Local NGO, named, “Facilitator for change (FC)”, promoted SHG approach for about seven years with the support of kindernothilfe (KNH).

3.2. TOOLS AND PROCEDURES OF DATA COLLECTION

Two methods were pursued to collect data:

Structured questionnaire: is a questionnaire which was prepared in advance to get information from sample individuals. In order to grasp all necessary information, close-ended questionnaire was used. This questionnaire was designed to collect information on individual personal data, family information, source of family income, their participation status in MHIS and their attitudes towards MHIS.

In addition to the questionnaire, it is planned to collect information through case studies. Sample individuals who are members of the MHIS and some sample individuals who are members of SHG, but not members of the MHIS was considered under this case study.

Documents and Records review of the sample CLAs is also another way of gathering information for the study. Financial Management, case handling, their MHIS by-law, are among the main information to be reviewed from documents and discussions held with MHIS committee members.

Appropriate care was taken to ensure the quality of data collection. Data collectors were briefed on the questionnaire in advance and a pre-test on the effectiveness of the approach was conducted.

3.3. DATA PROCESSING AND ANALYSIS

The collected data through questionnaire was processed through a computerized statistical analysis program called SPSS. Each question in the questionnaire was coded, formatted in advance and the data obtained from the field was filled on prepared forms for processing.

Moreover, information collected through case studies, observation and document review were used for triangulation.

3.4. LIMITATIONS OF THE STUDY

The study may not reflect the situation of CBMHIS fully in this country and It may have some limitations due to the following reasons:

I. The study is limited to Jimma Town, on five CLAs, due to shortage in time, cost and capacity of the student researcher;

II. There is a limited research work and reference material on this subject. Therefore, most of the references regarding CBMHIS reflect the Asian experiences.

CHAPTER 4: RESEARCH FINDINGS

***Poverty Situation of women*:** Most women are socially and economically disadvantageous due to social and cultural set up of the community. Among the interviewed, 35% were unable to read and write and only 31% were able to read and write. This has implication on the activities where women are engaged for their livelihood. With regard to the activities, 60% of women are engaged in petty trade, and the remaining are daily laborers, house wives, expecting family support from someone or they are pensioners. Whereas, 60% of the interviewed were heads of the family and bread winners having an average of 2.22 children each who were under the age of 18 years (Fig. 1).

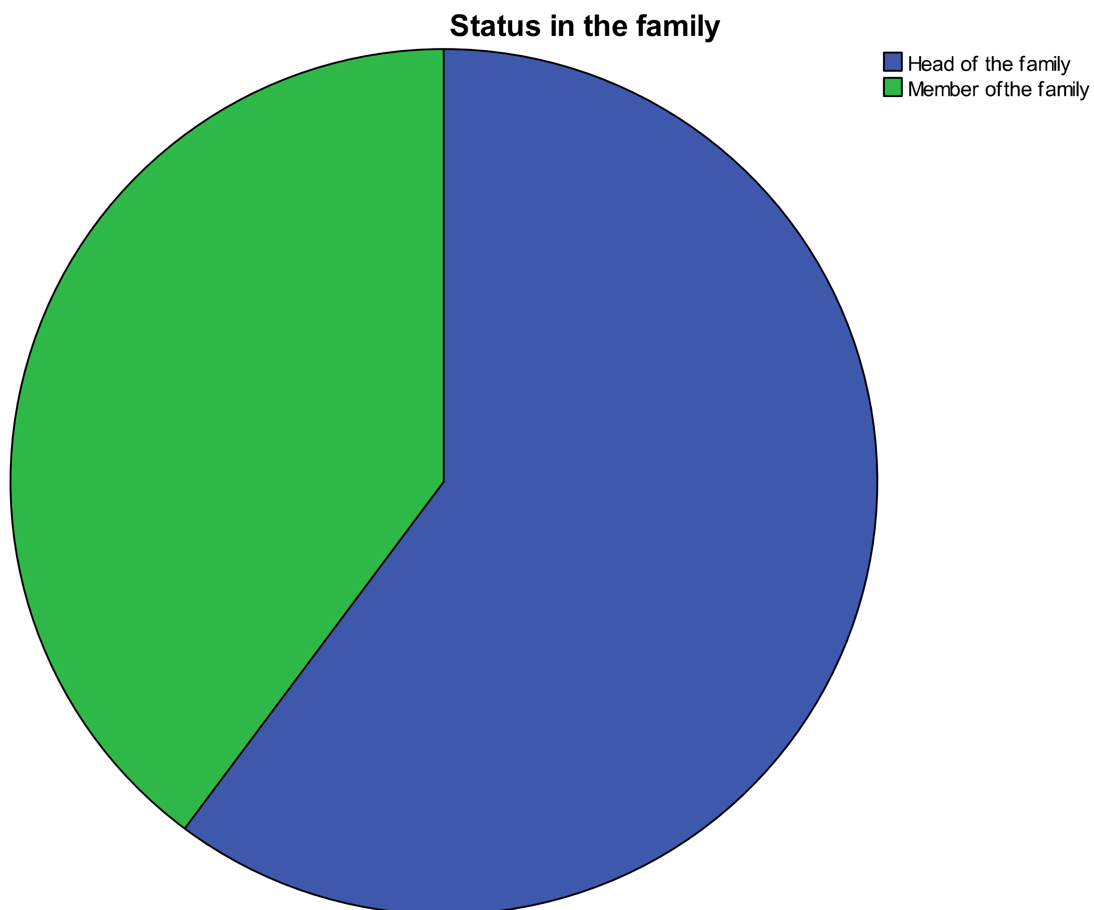

Fig.1. Status of the family – (Source: own survey)

Access to health service**:** Poor people have no or limited access to health services. They have limited capacity to finance their medical need out-of-pocket expenses. Under serious cases, they tend to visit health centers. Otherwise they resort to traditional herb medicine or religious blessings to cure them from their illnesses. According to the sample study, 81.8 % of the respondents had claimed that they had no medical treatment for ordinary sicknesses prior to being organized under SHG. A large majority (76.8%) had medical treatment only under serious sicknesses (Table 2).

Table 2. Medical treatment for the family, before being organized under SHG for ordinary sickness

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	18	18.2	18.2	18.2
No	81	81.8	81.8	100.0
Total	99	100.0	100.0	

Source: own survey

Table 3. Medical treatment for the family, before organizing under SHG, for serious sickness

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	76	76.8	78.4	78.4
	No	21	21.2	21.6	100.0
	Total	97	98.0	100.0	
Missing	System	2	2.0		
Total		99	100.0		

Source: own survey

On the other hand, 68.7 of the respondents would prefer traditional medications for any illness in the family. Among those who had medical treatment, they were using public health centers where the costs for check-up were comparatively reasonable. But most of them had indicated that patients were referred to private pharmacies for their medication, and because of the cost, the poor either failed to buy or forced to take expensive loans or sell their assets.

Access to health service had improved after the interviewed were organized under SHG. This may be because of either the improvement in the economic status of the women or access to loan for medical expenses or the establishment of MHI or increase in knowledge and awareness of the members. The finding had indicated that more than 84% of the interviewed had stated that they had received medical treatment whenever there is sickness in the family. Only 18 % had used traditional means of treatment when there is sickness and only 4 % were not using medical services at all after being organized under SHG approach.

Situation of women after being organized under SHG approach: SHG approach is an approach promoted in Asia and Africa to promote the social and economic empowerment of the poorest of the poor people who have no access to information, capital, services and market. This study was conducted on women who were organized under SHG approach in Jimma town. Among them, more than 85% of the interviewed had been in the SHG for more than five years, and of this group, 55% and 32% had joined the group after the promotion exercise by external agency, and with a desire to change their livelihood, respectively.

The average number of members of the SHGs was 12.84 and all members meet regularly every week. More than 60 % save Birr 1.00 to 3.00, 23 % save Birr 0.25 to 1.00, 15% of the members save more than Birr 3.00 per week regularly, and the mean total saving of each member was Birr 475.00 (Fig. 2).

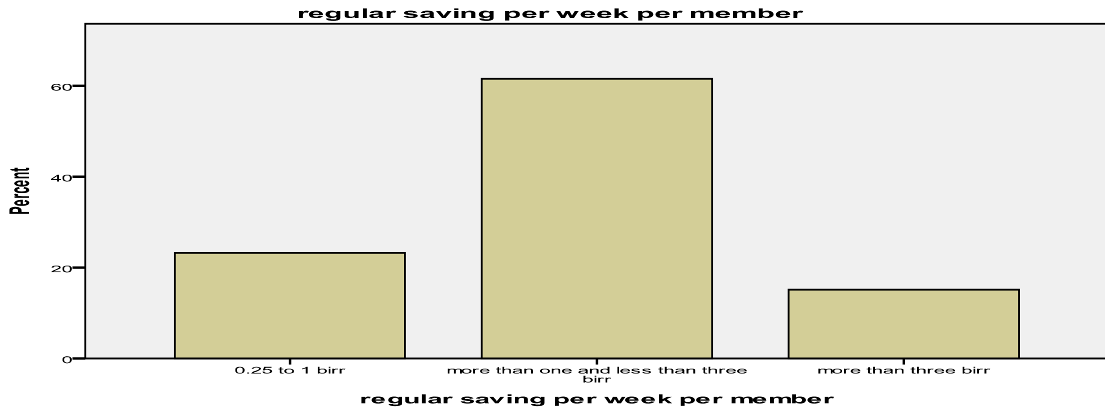

Fig. 2 Regular savings per week per member (Source: own survey)

One of the roles of SHG was getting access to capital for its members so that they can start their own income generation activities. The study found that more than 92% of the interviewed had taken loan from their group and about 76.8 % of the loan was used for the purpose of initiating or expanding income generation activities. It was also found that consumption loan and medical expense loan, on the average, was 6% for each.

The minimum and maximum loan size varied from group to group and it was depending on the members' interest, capacity of the members, as well as, the group status and business type. In most groups, the loan system is progressive in that members start with small loan and increase their intake according to their business performance and their loan track record. The statistical analysis of the loan trend in the target group is shown below (Fig. 3).

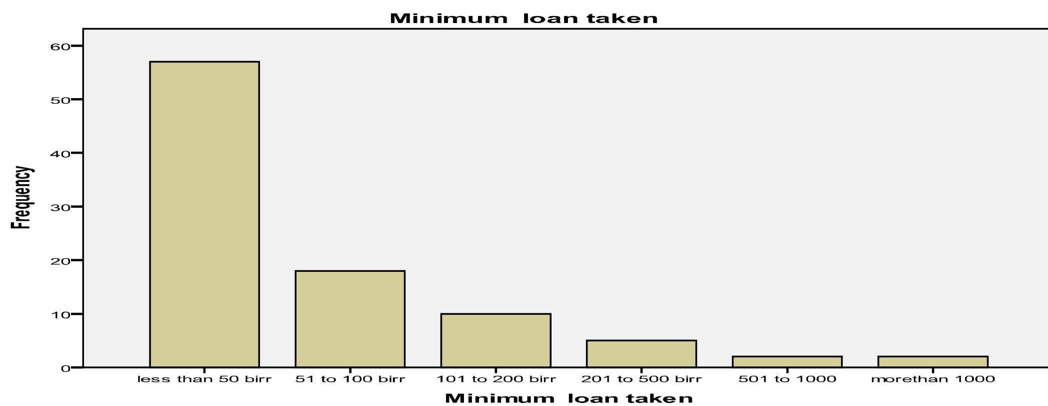

Fig. 3 The Trend of Minimum Loan taken by Members (Source: own survey)

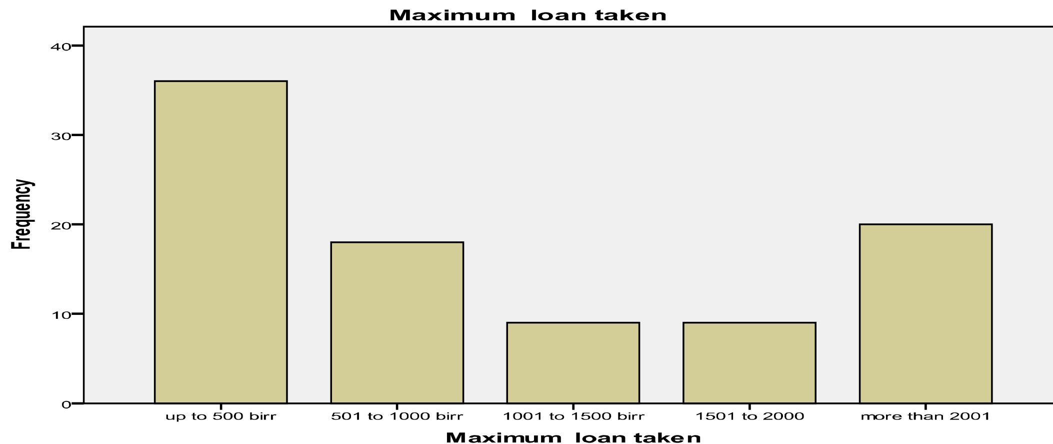

Fig. 4 The Trend of Maximum loan taken by Members (Source: own survey)

Access to capital is a critical and vital issue when we discuss about poor women. Most of them did not have access to money or they are forced to enter into high cost loan. Some had decided to take this high interest loan and had initiated businesses, but they failed to repay and were forced to sell their properties. In this study, it was noted that no one went to commercial banks to access capital, only 3% went to MFI, 14.4% to local lenders and 71% had accessed loan from relatives.

In the SHG approach, CLA is the second level structure working in addressing women's interest which is beyond the capacity of the SHG and it is the level where women start looking for their community socio-economic improvement. The study found that CLAs are working on the following main activities:

- Linkage with MFI, service providers and the market;
- Education on health, child development, HTPs and gender;
- Facilitate training on business development, group management;
- Create access to external loan;
- Facilitate MHIS;
- Experience sharing among groups and members;
- Establish and strengthen SHGs.

Most of the interviewed women had stated that access to external loan when members need increases beyond the capacity of their groups is facilitated by the CLA. Various trainings, organized and facilitated by the CLAs, is identified as a second most important activities which had helped in the development of members' skill and knowledge in managing their livelihood.

The study had analyzed the changes occurred in the life of the women using different parameters and the results are presented as follows:

Parameter one: Change in the economic Status of women

The petty trade, as source of income, for women, was 41 % before organizing under SHG approach and it was changed to 82 % after having organized under SHG approach (Table 4 & 5).

Table 4. Source of income-before organizing in SHG, petty trade

	Frequency	Percent	Valid Percent	Cumulative Percent
yes	41	41.4	41.4	41.4
no	58	58.6	58.6	100.0
Total	99	100.0	100.0	

Source: own survey

Table 5. Source of income-after organizing in SHG, petty trade

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	79	79.8	82.3	82.3
	No	17	17.2	17.7	100.0
	Total	96	97.0	100.0	
Missing	System	3	3.0		
Total		99	100.0		

Source: own survey

On the other hand, about 15% of women were engaged as daily laborers to support their family before being organized in SHG and this was reduced to about 2% after membership in SHG. In addition, about 23% of women were housewives and dependent on their husbands' income before being organized into SHG and this was reduced to 2% after being organized into SHG.

Table 6. Source of income-before organizing in SHG, Daily labor

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	15	15.2	15.2	15.2
No	84	84.8	84.8	100.0
Total	99	100.0	100.0	

Source: own survey

Table 7. Source of income-after organizing in SHG, daily labor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.0	2.1	2.1
	No	94	94.9	97.9	100.0
	Total	96	97.0	100.0	
Missing	System	3	3.0		
Total		99	100.0		

Source: own survey

Table 8. Source of income-before organizing in SHG, house wives

	Frequency	Percent	Valid Percent	Cumulative Percent
yes	23	23.2	23.2	23.2
no	76	76.8	76.8	100.0
Total	99	100.0	100.0	

Source: own survey

Table 9. Source of income-after organized into SHG, house wives

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.0	2.1	2.1
	No	94	94.9	97.9	100.0
	Total	96	97.0	100.0	
Missing	System	3	3.0		
Total		99	100.0		

Source: own survey

Their monthly income has also indicated changes as we can see this on the bar graph below:

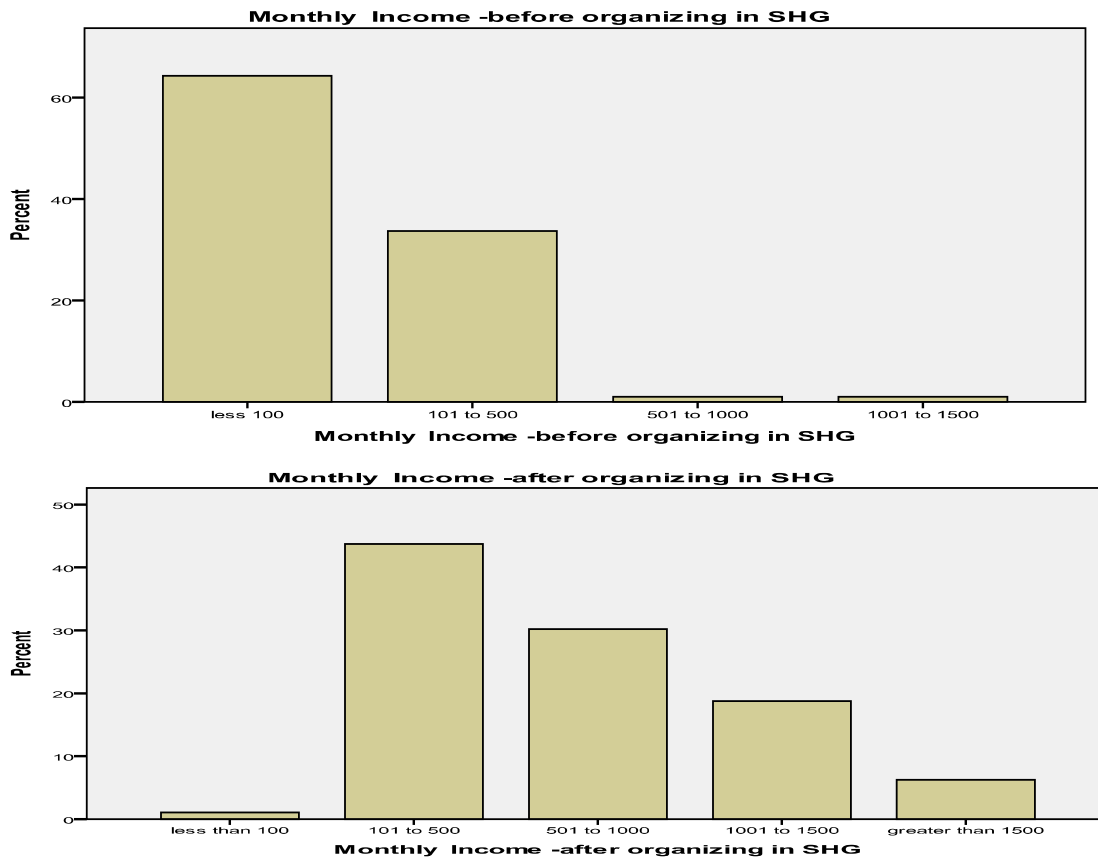

Fig. 5 Monthly income before and after organizing IN SHG (Source: Own Survey)

Parameter Two: Capacity of Buying Services

Under this parameter school for children and medical attendance of the family are taken as the main services. In general, around 95 % of the sample of interviewed women stated that their capacity of paying for services had increased after they became SHG members.

Education for children had shown improvement. Among the respondents, 24% of the women had expressed that their children were not attending school before being organized in SHG group, but, after organization, this figure was reduced to 4%. Only 13% of the children get their basic education before being organized under SHG and this was changed to 90% after having been organized under SHG.

Those who get medical attention for ordinary sicknesses were 28% before organizing under SHG approach and it rose to 86% after joining the SHG. Using traditional treatment for sickness was reduced from 78% to 18% after membership in the SHG.

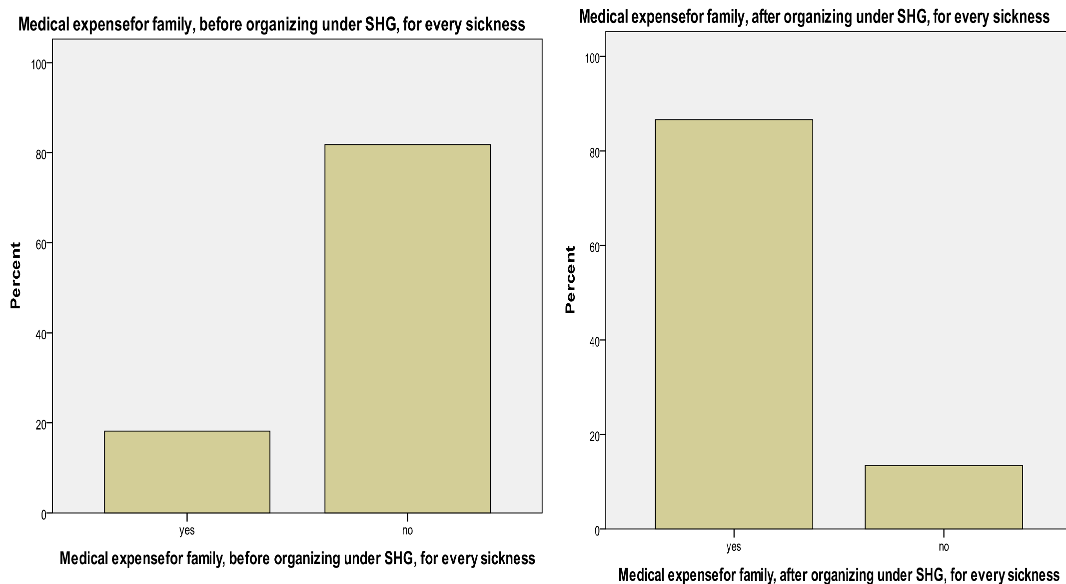

Fig. 6 Medical treatment before and after joining SHG for ordinary sicknesses (Source: own survey)

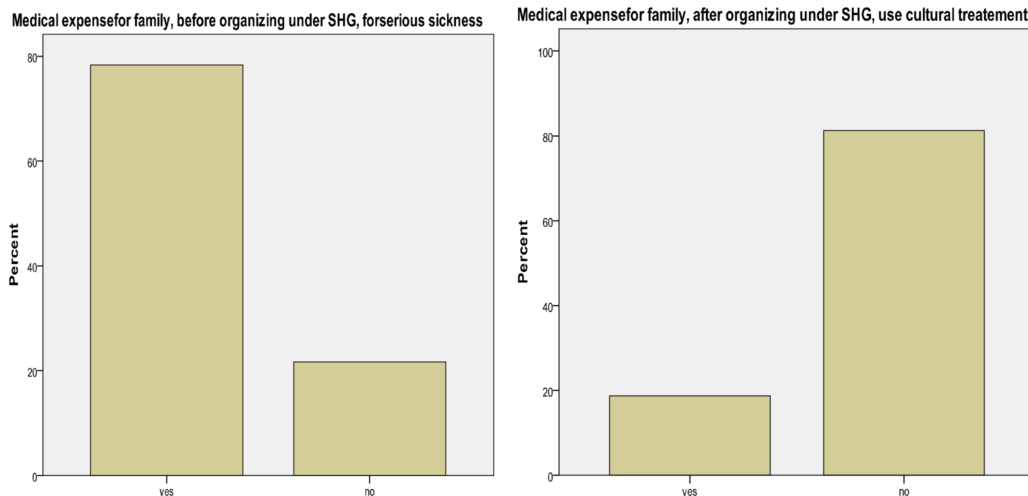

Fig. 7 Medical treatment before and after joining SHG for serious sicknesses

(Source: own survey)

Parameter Three: Purchasing power

Under this parameter the main points raised to the interviewee was their capacity to buy basic necessities, such as food, shelter and clothing. In general, 96% of the respondents stated that their purchasing power has increased after joining SHG. Among the respondents, 47% had stated that their food buying capacity was low before joining SHG, but after joining the group 62 % of them had claimed that their capacity was very good. Clothing purchases and shelter building capacity had also changed for majority of the respondents from poor to very good condition (Table 10).

Table 10. Buying capacity of goods

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Increased	94	94.9	96.9	96.9
	Decreased	3	3.0	3.1	100.0
	Total	97	98.0	100.0	
Missing	System	2	2.0		
Total		99	100.0		

Source: own survey

Parameter Four: Access to education

Under this parameter the study focuses on accessibility to education and improvements (if any) either in formal education or integrated functional adult education. In general, 30% of the respondents had attended schools, 31% can read and write, and 35% were illiterate. After organizing under SHG approach the illiteracy rate has been reduced to 11% through the implementation of IFAL with the facilitation of their CLAs.

Parameter Five: Access to Health service

Under this parameter, the study had assessed respondents' accessibility to health education, medical service, clean water and sanitation, personal and environmental hygiene. Health education includes reproductive health, family planning and others. Accordingly, the accessibility to health education for the majority of women had changed from poor condition to very good due to facilitation by CLAs (Fig. 8).

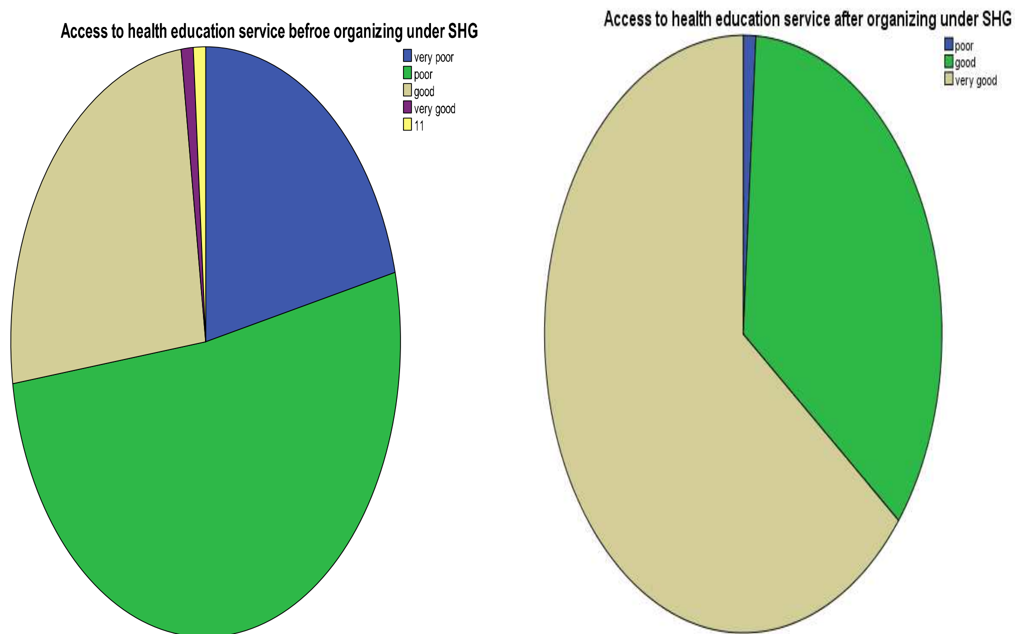

Fig. 8 Access to health education before and after joining SHG

(Source: Own Survey)

Access to medical services has been enhanced after the women are organized under SHG approach. This result is a contribution of enhanced health education as well as increase in income of the women (Tables 11 & 12).

Table 11. Access to medical service before joining SHG

	Frequency	Percent	Valid Percent	Cumulative Percent
very poor	12	12.1	12.1	12.1
Poor	50	50.5	50.5	62.6
Good	35	35.4	35.4	98.0
very good	2	2.0	2.0	100.0
Total	99	100.0	100.0	

Source: own survey

Table 12. Access to medical service after joining SHG

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Good	32	32.3	32.7	32.7
	very good	66	66.7	67.3	100.0
	Total	98	99.0	100.0	
Missing	System	1	1.0		
Total		99	100.0		

Source: own survey

Access to clean water, personal hygiene and environmental sanitation had improved from 5%, 2% and 4% to 72%, 68% and 59%, respectively, after being organized under SHGs (Tables 13, 14, 15, 16, 17 & 18). Health education, economic and social status improvement as a result of being organized in SHG and CLAs contribute a lot in the improvement of families' access to clean water, personal hygiene and environmental sanitation. CLAs were also organizing campaigns for environmental sanitation in addition to facilitating various trainings on personal hygiene and home management skills. (Table 13, 14, 15, 16, 17, 18)

Table 13. Access to clean water before organizing under SHG

Rating	Frequency	Percent	Valid Percent	Cumulative Percent
very poor	18	18.2	18.2	18.2
poor	44	44.4	44.4	62.6
good	31	31.3	31.3	93.9
very good	5	5.1	5.1	99.0
33	1	1.0	1.0	100.0
Total	99	100.0	100.0	

Source: own survey

Table 14. Access to clean water after organizing under SHG

Rating		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	2	2.0	2.0	2.0
	Good	24	24.2	24.5	26.5
	very good	72	72.7	73.5	100.0
	Total	98	99.0	100.0	
Missing	System	1	1.0		
Total		99	100.0		

Source: own survey

Table 15. Access to personal hygiene before organizing under SHG

Rating		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very poor	3	3.0	3.1	3.1
	Poor	46	46.5	46.9	50.0
	Good	47	47.5	48.0	98.0
	very good	2	2.0	2.0	100.0
	Total	98	99.0	100.0	
Missing	System	1	1.0		
Total		99	100.0		

Source: own survey

Table 16. Access to personal hygiene after organizing under SHG

Rating		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	1	1.0	1.0	1.0
	Good	28	28.3	28.9	29.9
	very good	68	68.7	70.1	100.0
	Total	97	98.0	100.0	
Missing	System	2	2.0		
Total		99	100.0		

Source: own survey

Table 17. Access to environmental sanitation before organizing under SHG

Rating		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very poor	16	16.2	16.3	16.3
	Poor	51	51.5	52.0	68.4
	Good	27	27.3	27.6	95.9
	very good	4	4.0	4.1	100.0
	Total	98	99.0	100.0	
Missing	System	1	1.0		
Total		99	100.0		

Source: own survey

Table 18. Access to environmental sanitation after organizing under SHG

Rating		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Poor	3	3.0	3.1	3.1
	Good	35	35.4	36.1	39.2
	very good	59	59.6	60.8	100.0
	Total	97	98.0	100.0	
Missing	System	2	2.0		
Total		99	100.0		

Source: own survey

Parameter Five: Access to Information

Under this parameter, information access through mass media, CBOs and local governments are taken as a measurement for assessment. The majority of the respondents reflected that their access to information through mass media has changed from 3% to 68%. In addition, their information access had increased to a very good level due to their membership in the SHG. Moreover, since women are empowered through their groups they get recognition from the community and local government and as a result their access to information was enhanced.

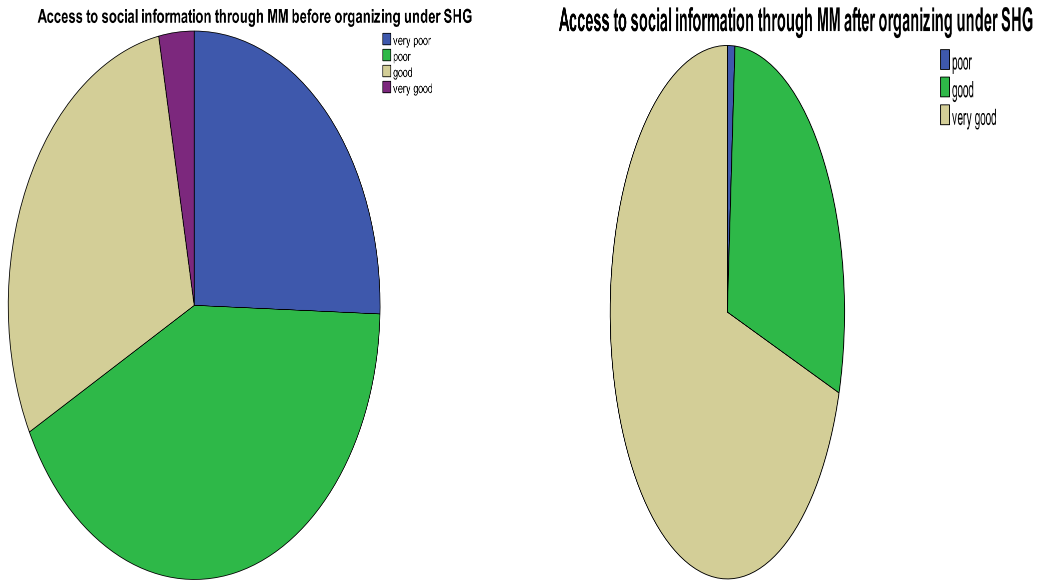

Fig. 9 Access to social information through MM before and after joining SHG (Source: own source)

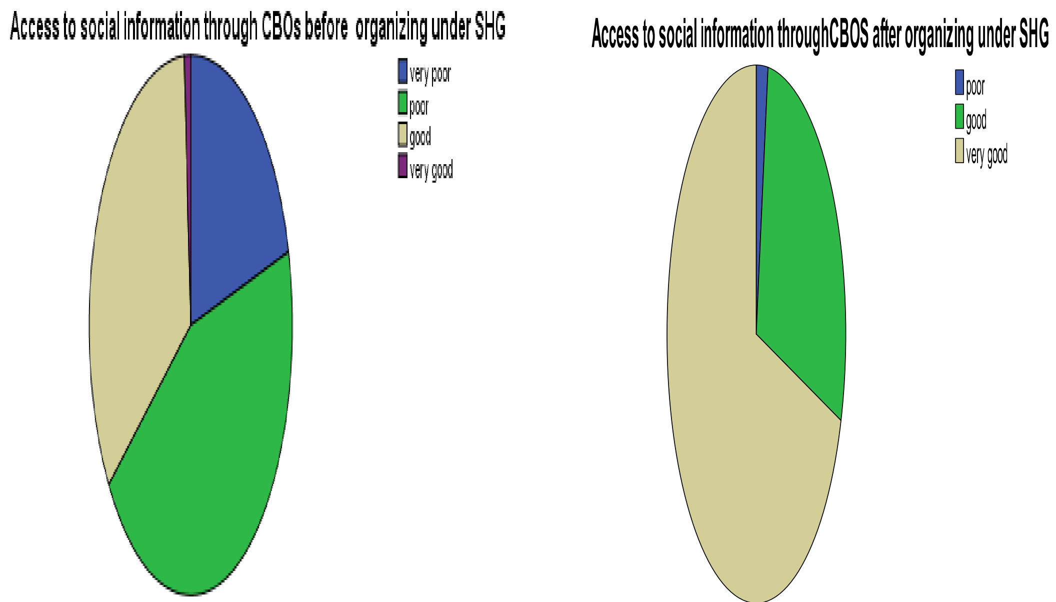

Chart 10 Access to social information through CBOs before and after joining SHG (Source: own source)

Micro Health Insurance scheme and practice: The micro-Health Insurance scheme is managed at CLA level and membership is based on volunteerism. In this study, CLA members include those who are members of the MHI and those who are not registered under the MHI scheme.

The majority of interviewed women had stated that they joined the MHIS together with their families with the objective of avoiding risks of financial shortage during illness. The second reason they gave was the promotion by external agency, Facilitator for Change, to the community. The third, fourth and fifth reasons for joining MHIS were to avoid using local lenders, IGA capital and friends.

Table 19. For members, reason for joining the MHIS

Reason	Frequency	Percent	Valid Percent	Cumulative Percent
Learning from my friends	3	3.0	3.0	3.0
Advice from the project staff	2	42.4	42.4	45.5
In order to avoid the risk of financial shortfall during illness	5	45.5	45.5	90.9
To avoid using local lenders	7	7.1	7.1	98.0
To avoid using IGA capital	2	2.0	2.0	100.0
Total	99	100.0	100.0	

Source: own survey

The average number of individuals covered under the MHI scheme per CLA was 3.03. Among the women, 57% had stated that there was a family member who failed to register under the scheme. The most common reason for failing to register some members of the family from the scheme was that they either depend on their own income or because of capacity limitation of the family head.

Almost all (92 %) of the contribution for the scheme was on monthly basis and 96% of the contribution per individual was birr 1. There were CLAs who receive contribution weekly and fortnightly and there were CLAs whose minimum contribution of each individual was less or greater than birr one.

Only 21% of the respondents get insurance coverage and the average coverage was birr 44.06. About 90 % of those who received the insurance coverage stated that the money they get is too small to cover their expenses. Therefore, 68% of them were forced to use additional money from their business capital to cover all their medical expenses (Fig. 11).

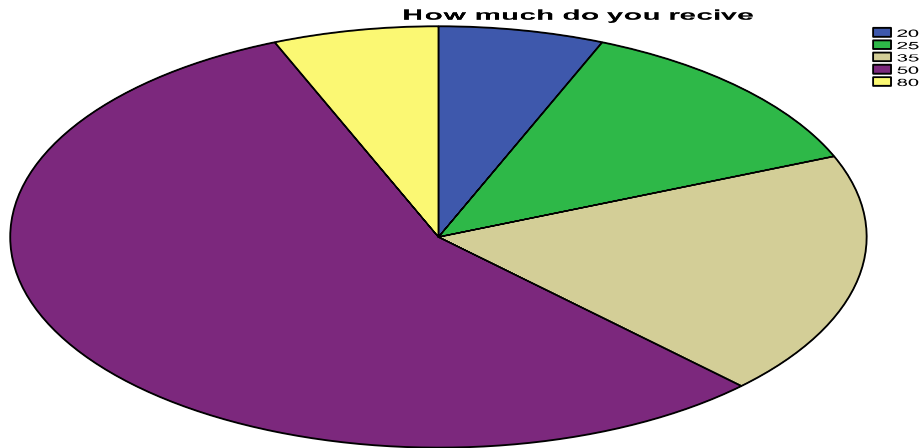

Fig. 11 Amount of money received from the insurance (Source: Own Survey)

Around 78% of the sample women didn't have any insurance coverage and five reasons are indicated (Fig. 12).

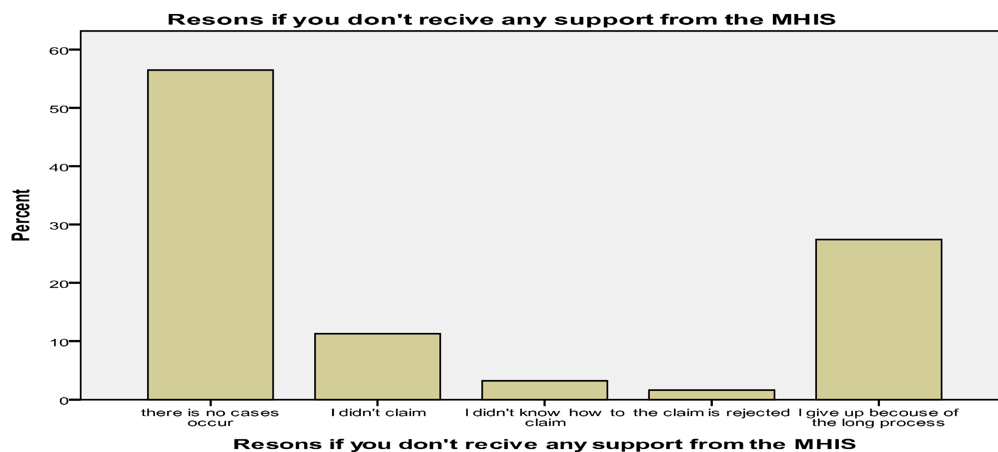

Fig. 12 Reasons for not having any insurance coverage (Source: Own Survey)

Among the respondents, 27% had claimed that they gave-up due to the long process and procedures of the MHI coverage system. Around 3% had stated that they didn't know the procedures for claiming insurance coverage.

For the questions raised regarding their knowledge on the rules and regulations of MHI, 88.8% had claimed to have known them. With regard to specific knowledge of the members on the MHI maximum premium payment, only 80% of them were aware of it. Those who know the maximum premium of the MHI realize that the average amount was birr 50.38.

The study had also assessed the illness type eligible for insurance coverage. The majority of the respondents listed Malaria, Typhoid, and Typhus diseases which were covered under the scheme. However, for the question raised about the claiming process, almost all of them stated the procedures for refunding but not aware about the subcommittee which manages the process.

Among the respondents, 44% had stated that they were not satisfied with the service of the MHI because of its poor performance and its inability to increase its coverage, as well as, the quality of work. Whereas, 42 % expressed that they were satisfied with the service and the existing poor quality service can be improved through time and support from promoting organizations.

Finally, most respondents believe that the existence of the MHI service is important and they advise non-members to join the scheme. But all of them stressed the importance of re-strengthening and support, follow-up and awareness raising program.

4.1. CASE STUDIES OF NON- MEMBERS OF MHI

The study includes case of sample women who are members of the CLA but not registered in the MHI scheme of the CLA. Five women from five CLAs were interviewed with a structured questionnaire to understand their view or attitude towards the MHI scheme in their CLAs.

Regarding the question about their knowledge of MHI, all of the interviewed members were aware of the insurance scheme. Since they are members in the SHG, awareness program was organized at group level and also the groups had discussed on the concept. However, they were reluctant to register for membership.

Regarding the question "what is the source of money during illness?" A large majority, 80%, responded that they had used money earned from their petty trade, and the other 20% had claimed that they are taking loan from the SHG. In addition, some also expressed that they used public health centers for their health service needs.

The final point raised for this group was "why didn't you be a member of the MHI?" All gave different reasons. Among the reasons, the most common ones were:

- ✓ "Since I didn't understand the benefit clearly, I want to stay back until I see the benefits others get";
- ✓ Members are not committed to contribute, to meet and discuss regularly and to increase the monthly contribution;
- ✓ "I was joining initially, but I quit after some days observing it was not functioning properly as intended";
- ✓ "I was joining the group after MHI was established and I didn't know the procedures for accepting new members in the MHI";

In general, all were not convinced in joining MHI as It was not considered to function well and benefiting the existing members.

4.2. FOCUS GROUP DISCUSSION WITH MHI MANAGEMENT COMMITTEE

The focus group discussion with CLA MHI sub Committee was focusing on the overall function of the MHIS, its challenges, opportunities, lessons and risks. Two

focus group discussions were conducted in two CLAs and a total of 10 women on each FGD attended, representing their KITO and HIBRET CLA and MHIS. The FGD result is summarized as follows:

A. Function of the MHIS:

***Create awareness about MHI for the members and the community*:** The discussants understood that awareness rising is a continuous activity focusing on promoting the MHIS objectives, benefits and procedures. However, they have admitted that the awareness raising activity for members and non-members were not conducted after the first introduction session. Initially, the CLAs had introduced the concept and the benefit and importance of the scheme in collaboration with the promoting organization (FC) and had established the scheme with those who are volunteers at that time.

Establish a Management system of the scheme: There is an MHI management sub-committee at each CLA level which has three members and this committee was responsible for the overall management of the functions of MHIS with close supervision of the CLA representatives. There is also a contact woman at SHG level who is also representing her group at CLA business. The discussants had agreed on the poor performance of the sub-committee and lack of commitment to play their responsibility effectively. Even some didn't remember their assignment and their roles in the sub-committee.

MHIS Guideline: the FGD indicated that every CLA has developed a simple by-law which is used as a guideline for the management committee of MHIS. The by-law was discussed upon with every member of the MHIS and approved by the representatives of SHGs at each CLA. In the by-law the following main information was included:

- ✓ Amount of contribution per member and frequency of contribution;
- ✓ The maximum premium to be settled for claims;
- ✓ Kind of sickness covered by the scheme;
- ✓ Roles and responsibilities of the MHI management Sub-committee.

Procedures:

Collecting the Monthly contribution: The monthly contribution of each member was collected at SHG level during their regular meeting and transferred to the CLA through a woman who represent SHG at that level. At the CLA level, one of the MHI sub-committee members was assigned as cashier who collects the money and deposits it in the bank in account opened separately for MHIS. The discussants mentioned also that there was an individual pass-book printed with the support of the promoting organization (FC), but the financial transaction has not yet filled and the passbook was not issued to members.

MHI claiming and settling procedures*:* All discussants were not very clear on the claiming and settling procedures. They all stated that it involves of bringing a receipt to the CLA sub-committee under the claiming and settling procedures. They were not even clear about where and when to take the receipt. In addition, they did not have any Idea on option two of health insurance system, which has to do of establishing an agreement with health centers in order to provide service to its members without any out- of- pocket cash from the members.

B. Challenges of MHIs

- Where to register the passbook of individual member: Since members are not directly in contact with the CLA MHI management during payment, it creates confusion and unable to fill members passbooks. The confusion is on identifying the signatory on members' passbooks; is it the SHG representative at CLA who collects the money from members and bring to the CLA MHIS main casher or the CLA MHIS main cashier?
- Unclear or long process of claiming and settling of insurance: the FGD raised this point as a challenge for the MHIS function and the reason for dissatisfaction of

most members and which led some members to quit altogether. Individual claimers were not able to get their insurance payment immediately, because the claim is passing through SHG and come to the CLA during their regular meetings, a process that takes more than a month for approval.

- Kind of sickness: Initially sicknesses were identified based on the recurrent diseases occurred in the area. As such all CLAs were covered for diseases like Typhoid, Typhus and Malaria. However, the discussants had asserted that these diseases were not problems of the community due to improvements in controlling the dissemination of mosquitoes and in the practice of sanitation both at household and the surrounding environment level.
- Out-of-pocket payment: In addition to long processes of the insurance claim settlement, members were mandated to pay from their pocket during medical visit and submit receipts to claim for refund. Some members may not have enough money in their pockets or some used their business capital for the medical bills. The MHIS had not resolved this matter with health centers.
- No review or amendment of the by-law: Since the establishment of the insurance scheme, the amount of contribution and the maximum premium offered was not amended. As a result, the MHIS had accumulated a small capital and pays very small premium that does not even cover the required medical expenses. During individual interview of members of the MHIs and those in the FGD, increasing the monthly contribution and then revising the maximum premium to be paid is one option to improve the performance of the scheme.

C. Opportunities of the MHI

- **There is organized structure:** The existence of the SHG approach is very important. Women know each other, discuss on their socio-economic problems regularly, work mutually to improve their living condition and to come out of poverty. This is an opportunity to establish MHIS and run it efficiently.

- **Similarities in characteristic:** SHG approach and community based MHIS has a similar characteristic. Both approaches depend on mutual support, solidarity, self help, and concern for others and so on.
- **Part of the CLAs role:** In the SHG approach CLAs are working for the benefit of the community and addresses issues which are beyond the capacity of the SHGs and demanded by the community. Therefore, MHIS is one of a solution for the community health accessibility problems.

D. Lessons Learned in MHIS

- This initial point shows that community can solve its own problem with organized manner and mutual support principle.
- It needs continuous awareness raising of members and the community.
- It needs clear, strong and committed management.

CHAPTER 5: CONCLUSION, RECOMMENDATIONS

5.1. CONCLUSION

Even though the idea of organizing both SHG and MHIS is an external initiative and was brought by the promoting NGOs (FC), the women took the approach seriously and able to form groups within their villages.

Women organized under SHG approach understood the importance of the scheme and had invested their money in order to be insured in case of health related problems occur on themselves and on their family.

MHIS is a good opportunity to change the attitude of people towards insurance business and develop experience in the field. Even if there were some exceptional procedures for providing free health services, we saw it has a long process and did not satisfy the immediate needs of the poor people. However, establishing MHIS can play an important role in solving the problems of accessing health service due to financial limitation.

Therefore, it is important to organize poor people under MHIS scheme to correct their deficiency regarding health services and become productive citizens to support themselves and their families.

Both SHG and MHIS approaches promote mutual support and self help, community ownership, addressing the poor and those who are vulnerable to poverty. They are concerned about their members, the families and the community as a whole. They both are based on changing the attitude of the community, especially the poor, through continuous capacity building and exposure to sell the idea of “I can do it” thinking.

SHG approach is a holistic and broader than MHIS. It is a process of empowering poor people socially and economically and therefore they can change their own life. The approach is a type of strategy in which it starts with unleashing the potentials of the poor through progressive trainings, discussions

and experiences. The agenda of the SHG is not a pre set rather, it is developed during their regular meetings following demand of the members and the community. The most common social agenda of the SHG approach are health, gender, education and HTPs. SHGs and their CLAs had organized various awareness raising programs for their members on different health issues (such as RH, FP, HIV/AIDs).

MHIS can be considered as one of approaches in addressing health service for the poor and those who are vulnerable to poverty. The MHIS approach needs people who are organized and know each other very well and can work together for mutual benefit and self help. It is important to attach this approach with the existing community based organizations which already have such mutual support and self help trends. This community based organizations have already developed trust and acceptance from their members and the community at large.

MHIS was well integrated with the SHG structure and was able to shelter a lot of member women and their families.

The system of integrating MHI with CLAs has its own advantages and disadvantages. One of the major advantages is resource mobilization, where at SHG level the membership is between 15 to 20, whereas, at the CLA level there are about 8 to 10 SHGs with an average membership of 150, which increases the CLAs MHIS program by having more capital to provide different services at considerable premium. Secondly, CLAs main objective is to fill gaps which can't be done at SHG level and to benefit its members and the community by using its mass people's voice and power. Therefore, not only for financial mobilization, but also for creating linkages with health service providers to find better medical services, health education and protection issues. On the other hand, the distance between the MHI members and the CLAs MHI sub-committee creates a challenge and inconveniences in the process of claiming insurance and getting transparent information.

MHIS has its own management team organized under CLAs as a task oriented Sub–Committee. This committee is the sole responsible body to manage the function of the MHIS with close supervision and follow up of the CLA representatives and members. The study finds that the scheme is not managed well, and almost all had agreed on the need of re-strengthening its activities.

The management is not transparent, has close membership and has no clear guideline to manage the scheme. Some of the members of the committee even forget their responsibilities assigned by the CLA. They don't have regular time known by all members in order to provide services to its members.

One of the main responsibilities of the MHI management is to create awareness and facilitate health education to the members and the community. However, the committees didn't do anything on this regard. This has led some members to lose interest on the scheme and dropped out from their monthly contribution.

The management team was weak in assessing the effectiveness of the scheme. Members feel that the scheme was not updating its operation based upon the current situations in their area. Information should be collected regarding the health condition in the area, members' capacity, effectiveness of health service providers, and other relevant issues and revise the scheme based on them.

The MHIS guideline has two basic limitations; one is it has limited information and the other is not updated based on the existing situation. The guideline has very limited information regarding the MHIS. The main point it has is monthly contribution, maximum premium to be paid up on the presence of the receipt and the type of diseases to be covered under the scheme. There are issues which are uncovered and this has contributed for its poor performance and member's dissatisfaction.

The study found that there are remarkable number of women who are requesting for an increase in the monthly contribution in order to increase the premium. Moreover, Malaria, one of the diseases to be covered under the scheme, was a serious problem during the establishment of the MHIS; however,

currently malaria is not a problem in the community. Therefore, these kinds of gaps had indicated that there was no updating in the guideline and also no transparent discussion with the members.

The case handling system was not well organized and not clearly known by the members. A large number of respondents had stated that they dropped the cases due to long process and unclear procedure. Most Members of the MHIs had acknowledged the importance of the MHIS. However, all of them realize that there are weaknesses and gaps in its operation which calls for re-strengthening in order to attract others to join the scheme to protect themselves from health related risks.

5.2. RECOMMENDATIONS

i. Separate, clear and holistic guideline is needed for the MHIS successful implementation. The guideline should include the following major points:
   - ✓ Organizational/ management structure;
   - ✓ Membership criteria, rights and responsibilities, probation time;
   - ✓ Membership fees, contributions and membership card;
   - ✓ Benefit packages: kind of health care provided, maximum premium, frequency per a given period of time;
   - ✓ Procedures of claiming and settling insurance;
   - ✓ Review and update: Regular GAs meeting, Auditing, reporting….

ii. Continuous awareness raising and health education: community based Micro Health Insurance Scheme is successful if the members and the community awareness is enhanced continuously. For feasible MHIS realization, the MHIS should work on protection aspect of the health for its members and the community. This protection aspect is about educating the community as well as members on personal and environmental sanitation and hygiene, home economics, reproductive health, family planning and so on.

iii. Linkage with health service providers: CBMHIS should be linked with different service provider public and private organizations. Through linkages, the scheme can improve its services for the satisfaction of their members and mobilize technical, financial and material resources. Linkages with Health service providers can help the scheme to establish an agreement of medical service for its members without out-of-pocket cash demanded from the member. Health education program and the protection aspect of the scheme can be realized through a linkage created with the government and non-government stakeholders who are working on health and related fields.

iv. Improve the capital of the scheme and increase the health care coverage: The effectiveness of the MHIS is highly dependent on the resources mobilized through member contribution. It has to increase its maximum premium payment to at least to cover 50% of the expenses on the receipt and widen its categories of services to be covered by the insurance.

v. Amend the by-law regularly: CBMHIS is system which is established to fulfill the demand of the members and not for profit. Therefore, the insurance coverage schemes and other benefits should be amended regularly based on the needs and situations of the community. Kind of sickness eligible for the insurance should not be fixed, rather they must be reviewed considering the real ground situation of the community.

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