

PROTECTING THE SPECIAL HEALTH NEEDS OF WOMEN

Jaitoonbibi lives in Ahmedabad, India and works as an agarbatti maker, earning 30 rupees per day rolling incense sticks. She lives in a small ten-by-fifteen foot room with three family members, in a house that does not have running water. Under these conditions, it is not surprising that Jaitoonbibi contracted typhoid and malaria. She spent most of her savings to pay for her medical expenses and recover from the illness. But Jaitoonbibi was fortunate. She had purchased insurance with VimoSEWA (see Box 1) and was reimbursed within a week.

The conclusion of Jaitoonbibi's story remains an exception in developing countries. Illnesses, even the most common, too often quickly deplete the family's assets, especially those living in rural and remote areas. Most health care systems are urban-based, elite-biased and curative orientated. Access is limited, cost prohibitive for low-income families, and risk-protection mechanisms such as insurance, which would enable them to cope with diseases and mitigate their consequences, are not yet widely available.

Women's health is particularly at risk due to an unhealthy environment, long working hours in hazardous conditions, and lack of income to invest in prevention. Seventy per cent of the world's poor are female and women face more violence, abuse and exploitation than men. In rural areas, cultivating family plots involves hours of backbreaking toil for no wage. In urban areas, women often work long hours in unregulated, unhealthy and unsafe conditions without the ability to protest or voice their opinions.

The most significant risks that affect women's health include: maternal mortality and complications surrounding pregnancy and childbirth, sexually transmitted diseases such as HIV/AIDS, exposure to waterborne diseases, and respiratory problems and burns due to household work. Gender inequality in most developing countries also negatively affects women's health. Low social status and harmful traditional practices in some societies (e.g. female genital mutilation and early marriage) have adverse affects; non-nutritious diet increases the risk of ill health, which can be exacerbated by the fact that women are often a lower priority in receiving medical treatment.

Despite their essential role in administering family health, women are often not considered as a primary beneficiary. Microinsurance providers tend to focus on male breadwinners as the main target for enrolment campaigns and policies design. In some cases, when schemes

Box 1 VimoSEWA

SEWA is a trade union of 1.1 million poor, self-employed women workers in India. Established in 1972, its main goals are to organize women for full employment and self-reliance. VimoSEWA is SEWA's insurance unit in which the workers themselves are the users and managers of all services. It was developed in 1992 in response to members' needs for risk protection mechanisms. VimoSEWA promotes an integrated insurance product of life, health, accident and asset coverage for poor workers and their families.



allow the policyholder to choose who will and will not be covered, women and girls are not enrolled because their health is valued less by household decision makers.

To overcome this issue, l'Union des Mutuelles de Santé de Guinée Forestière (UMSGF)- a network of mutual health organizations (MHO) in Guinea - designed a family product that gives incentives to the breadwinner to register his spouse. Membership in an MHO is family-based and registration of all dependants is compulsory. Group leaders are responsible for ensuring that no household members are excluded from coverage, which is also a good way to mitigate adverse selection. To ease their task, MHOs offer free coverage for children born during the budget year. In polygamous households, which are numerous in some areas, family registration is carried out separately for each wife and her dependants. One membership card is issued for each mother and her children.

Financial incentives can definitely encourage certain behaviours. For example, VimoSEWA, successfully offers a Rs. 20 (US\$0.45) discount to members who enrol their whole families.

Another issue concerns the design of a gender relevant product. Microinsurers need to cover women's specific health concerns, especially those related to pregnancy, delivery, and gynaecological diseases. However, some commercial schemes shy away from offering maternity benefits because, unlike in the case of illness or accidents, women may have (some) control over whether or not they get pregnant. Consequently, pregnancy is not a risk that can be risk-pooled in a pure insurance sense. For example, because of the high risk of death during childbirth, Delta Life in Bangladesh excludes women from taking out a policy during their first pregnancy. Furthermore, there is a significant adverse selection risk of women who know they are pregnant (but not yet showing) who then enrol in a health insurance scheme. The First Microinsurance Agency in Pakistan and ASSEF in Benin both experienced abnormally high rates of pregnancy and childbirth in their voluntary schemes.

A better way to include women's concerns in the policy design has been experimented through community-based health schemes, especially in Africa. These health mutuals are social and professional groupings in which members freely choose to join and pay their contributions regularly, thus enabling them to cover their health care expenses. However, their efforts to improve access to health care and extending social protection to vulnerable groups, including women, often involve only a small portion of the population in developing countries. In addition, many mutuals lack the resources to sustain their activities.

As low-income women are predominantly casual and seasonal workers, regular monthly premium payments can be difficult to pay, but a large annual lump sum may not be suitable either. Flexible arrangements are most appropriate to increase microinsurance access to low-income women. Microinsurers should offer a range of premium payment options, such as a grace period of several months or a flexible payment schedule that allows for irregular premium payments according to the particular financial situation of women.



Eventually, "women-friendly" products and delivery channels can make a great difference to expand health protection among low-income women in developing countries. To overcome financial illiteracy that prevents women from understanding the concept of insurance, and to increase trust relations between the insurer and the clients, direct and regular contact is necessary. The field staff of grassroots organizations, such as trade unions, NGOs and MFIs, committed to reduce the likelihood of misleading sales practices and confusion about insurance contracts, are the best change agents. In fact, savings and credit groups - essentially composed and administered by women - remain one of the most widespread mechanisms for distributing insurance to low-income households.

Let's not forget that a disease often involves more than health. "Women, more often than not, are the family's primary caregiver. During a health event, there's more than just medical expenses ; lost wages, childcare, even transportation to and from the hospital, all add pressure on that household during a tough time" says Mary Ellen Iskenderian, the CEO of Women's World Banking.



Microinsurance products would be more efficient if they covered collateral implications of an accident or illness which can have catastrophic consequences. For example, according to the Director of the Yomou Hospital in Guinea, one low income woman, "Madam Seni Pohomou, from Yalakpalé village, was in labour for 3 days. There was no transportation at night and the family had to wait until the following day to find a taxi. When they arrived at the hospital, we operated on her but the baby had already passed away."

Products would also have a greater impact if they included illness prevention strategies. Voluntary health microinsurance schemes worldwide face difficulty in retaining their clients. One reason for this is because the bulk of clients do not need to make a claim in a given year, and thus see no tangible benefit in the health insurance product. Calcutta Kids, an Indian based NGO working in slum areas, aims to create value for non-claimants through an «outpatient counselling service» - an additional service that seeks to enhance prevention and avoid hospitalization. Similarly, Microcare distributes insecticide-treated bednets at subsidized rates to its policyholders so that they can see a tangible benefit of their insurance coverage even if they do not make a claim, which has the added advantage of reducing the incidence of malaria.

IMPROVING THE STRATEGIC CONDITIONS OF WOMEN

Considering the needs and current experiences with microinsurance, a number of measures are required for providing more comprehensive protection to women. While several practical needs can be taken up through improved product design at the micro level and improved operations at the meso level, other strategic interests require long-term changes in the labour policy and the status of women in society.

The notion that grassroots organizations working towards the empowerment of women automatically consider the gender perspective in their microinsurance operations is not always the case. Greater attention to gender-specific needs and risk-management instruments is required. Additionally, community-based risk pooling mechanisms are particularly vulnerable because of their limited financial resources. Catastrophic losses, repeated idiosyncratic risks and poor controls may deplete their resource pools and lead to their collapse. When these schemes fail, poor women are likely to suffer more than men because of their lower earning capacity and limited assets.

However successful microinsurance might be, it will never be in a position to provide full protection. Private mechanisms have a supplementary role - comprehensive social protection is the responsibility of the state. Recognizing this responsibility, the state-run microinsurance schemes in Peru, Bolivia and Paraguay all started by focusing on the most important epidemiological needs of maternity - risks that private insurers are less likely to address.

Women's participation in the monitoring, management and planning of government programmes such as healthcare centres would also increase the likelihood that these services meet the needs of women.

CONCLUSION

In developing countries, women are subject to greater vulnerability than men since they predominantly work in the informal economy, without any social protection. They earn less than men on average, have little ownership of and control over assets, are more likely to care for children and the elderly, are more likely to live in poverty, and are less likely to have access to health insurance and pension coverage.

Experience has revealed the need for customized insurance products reflecting the characteristics and preferences of women. However, even if products are jointly developed with female clients, their needs are not necessarily addressed; insurance providers often exclude benefits such as gynaecological diseases and treatment related to pregnancy. In these cases, other risk-management instruments such as preventive measures or microfinance can complement microinsurance products.

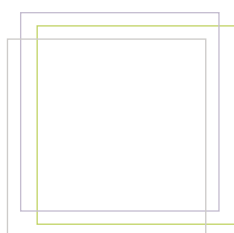
Furthermore, private microinsurance should be seen as complementary to the social protection responsibilities of the state. In most cases, microinsurance can only address the symptoms of women's specific risks, such as covering treatment for those who are ill, but it cannot solve the root causes. For microinsurance to be effective, there is a need for strategic changes towards gender equality in society. Structural causes for gender discrimination, such as legal, social and economic policies, have to be addressed to improve the position of women in the society and their capacity to benefit from health insurance. While some risks can be addressed through appropriate products, changes in the institutions involved, through gender mainstreaming and gender participation, are also required. Eventually, microinsurance can only reach its maximum impact if improvements in the status of women in society are achieved through macro-level policy interventions.

This article has been compiled from several sources, the main reference being Meeting the special needs of women and children (Mosleh Ahmed and Gabriele Ramm) in Protecting the poor: A microinsurance compendium Edited by Craig Churchill - ILO - 2006, pp 130-144

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Box 2 The Microinsurance Innovation Facility

Many of the microinsurers described in this article, including VimoSEWA, Finca and Microcare, UMSFG and Calcutta Kids, are grantees of the ILO's Microinsurance Innovation Facility. Founded in 2008 thanks to a grant from the Bill & Melinda Gates Foundation, the ILO's Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low-income families to help them guard against risk and overcome poverty. For more information, check www.ilo.org/microinsurance



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