International Labour Office

Extending maternity protection to women in the informal economy

An overview of community-based health-financing schemes

Working Paper

Strategies and
Tools against social
Exclusion and
Poverty

Social Security Policy and Development Branch

Conditions of Work Branch

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Preface

Social protection for all workers is a human rights issue for the International Labour Organization (ILO). The ILO actively promotes the extension of social protection to all groups in society across the full range of contingencies.

During the general discussion on social security of the 89th Session in June 2001, the International Labour Conference reached a new consensus. It placed the extension of social protection, including health care, to those who are not covered by existing statutory systems as one of ILO's highest priorities. The recommended action also ensures that gender equality is promoted in all of the ILO's activities on social protection.

As part of ILO's major campaign to extend social security coverage to all workers, the Social Security Policy and Development Branch, through its Global Programme STEP (Strategies and Tools against social Exclusion and Poverty), is involved in identifying concrete ways to extend effectively social protection, especially for health care, to workers excluded from access to statutory social security schemes. This pursuit has led to the examination of micro-insurance schemes and other community-based social protection initiatives around the world.

One of the contingencies to be addressed by social protection is maternity protection. Recently, the ILO adopted the Maternity Protection Convention, 2000 (No. 183), greatly broadening the scope of the earlier Convention and specifically encompassing for the first time, women employed in the informal economy, including those in atypical forms of work and the self-employed. The Social Security (Minimum Standards) Convention, 1952 (No. 102) and Maternity Protection Convention, 2000 (No. 183) spell out specific provisions for extending maternity protection to all women workers, including those engaged in atypical forms of dependent work.

The ILO, through the combined efforts of STEP and the Conditions of Work Branch, is therefore exploring possibilities to extend maternity protection to women in the informal economy using micro-insurance and other community-based health-financing schemes. Initial exploratory research has been carried out, which looks into how these community-based initiatives have integrated maternity protection within their offered services to their members and their families.

Information on how maternity benefits are included in different community-based health-financing systems has been gathered in nine countries from Africa, Asia and Latin America. The countries are, Argentina, Chile, Colombia, India, Nepal, Philippines, Senegal, Tanzania and Uganda. The collected information and the subsequent analysis have provided the evidence-base for the development of practical guidelines to be used as a tool to promote community-based health-financing schemes that embody relevant maternity protection services.

This paper, prepared by Shook-Pui Lee, forms part of the initial research which took place during the first six months of year 2001.

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CHAPTER ONE
A PRELIMINARY ANALYSIS OF 23 SELECTED COMMUNITY-BASED HEALTH-FINANCING SCHEMES

1.1 Introduction

This is the International Labour Organization's (ILO) first endeavour to carry out an overview of maternity care provided and/or insured by non-statutory, community-based health-financing schemes in Africa, Asia and Latin America. As recognised by ILO Maternity Protection Convention, 2000 (No. 183), the maternity care needs of women engaged in atypical forms of work have to be satisfied through both governmental and non-governmental health systems. This research was carried out in order to reach a better understanding of how certain innovative, non-statutory, community-based health schemes are attempting to meet these health care needs.

Initially, a maternity care questionnaire containing 14 key questions was prepared.[1] Then a number of health micro-insurance schemes were selected from the 130 schemes listed in "Health Micro-Insurance: A Compendium".[2] The selection was based on the following criteria: whether or not the schemes offered maternity care and/or cash benefits and the availability of contact details.

An extensive search on the Internet was also conducted in order to identify other community-based schemes offering maternity care and/or cash benefits, which were not listed in the Compendium. In addition to the search on the Internet, existing literature within STEP was also reviewed.

The maternity care questionnaire was sent to more than 40 health micro-insurance schemes, which were identified as containing a maternity care component. When contact details were insufficient, multiple requests for assistance were sent out to relevant institutions. These institutions include religious organizations working with missionary hospitals in Africa, technical and/or donor agencies supporting health micro-insurance schemes, specialists in the domain and other relevant non-governmental organizations.

In addition, telephone surveys were carried out on 11 schemes. Altogether information on 28 schemes was collected during the research, 23 of which provided meaningful information (see Chapter 2 of this report). Of the 23 schemes, 13 are operating in Africa and 9 in Asia, with only one scheme in Latin America described in the report.

Only 1 out of the 23 schemes mentioned explicitly that there was no demand for maternity care coverage. The rest either reported that there was a strong demand for maternity care,[3] or the comprehensiveness of the maternity care package they offered reflected the importance of these services.[4] Some schemes have been designed with the specific purpose of providing maternal and child health care.[5] These preliminary indications suggest that, in general, there is a strong demand from local women served by these community-based health-financing schemes for maternity care.

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[1] The maternity care components that were listed in this maternity care questionnaire (presented in Annex 1) constitute the definition of maternity care for this paper.
[2] ILO-STEP (2000) "Health Micro-insurance: A Compendium", Working paper.
[3] Ishaka Hospital, Kitovu Hospital and kiwoko Hospital, Uganda; and Gonoshasthaya Kendra, Bangladesh.
[4] La mutuelle de santé communautaire Oumou Dilly, and Mutuelle des Travailleurs de l'Education et de la Culture MUTEC, Mali; Rural Health Programme of Grameen Kalyan, Bangladesh; the Bustos LGU-PhilHealth Project and the ORT Health Plus Scheme, the Philippines, etc.
[5] The Safe Motherhood Fund, Tanzania, in May, 2001 and the Mother Child Rescue Project, Uganda, in mid-2000.

Much of the information collected requires follow-up work. As the research drew to a close, general information regarding 55 cooperatives offering health care services to their members was received. At the same time, the well-known SHINE Project in the Philippines generously offered an extensive up-to-date database on 35 schemes. SAMANATA in Nepal, a federation with around 75 organizations under its umbrella, also confirmed the existence of at least two organizations offering maternity benefits associated with regular savings,[6] and benefits covering transportation costs incurred when seeking maternity care. Several replies from schemes that provide maternity protection arrived too late to be included in this report.

Further exploratory work in this domain would enrich the understanding of the mechanisms used by women to counteract their difficulties to access maternity care offered by public health care systems. It would also allow more insights into the key elements that lead a health micro-insurance scheme to long-term sustainability and success, and ways of creating linkages between the public systems[7] and the various non-governmental, community-based mechanisms in order to better promote and extend maternity protection to women engaged in atypical forms of work.

1.2 Classification of community-based health-financing schemes

There are many different ways to enable members of established groups or organizations getting access to health care services. They can range from a very simple arrangement, whereby membership of an entity automatically entitles a member to free health care services, to more complicated financial instruments, such as insurance that requires risk analysis to determine premiums and benefits payment rates. The following explanation briefly clarifies the different types of health-financing schemes that are presented in this report.

Micro-insurance scheme:

- The scheme uses an insurance mechanism with risk pooling. In return for payment of a premium, members are provided with a guarantee of financial compensation or service on the occurrence of illness. The members renounce ownership of their contributions, which are primarily used to meet the cost of the benefits.
- The members or beneficiaries of the insurance scheme contribute to the financing of the benefits, at least partially, from their personal income.
- The members of the scheme participate in the decision making.
- The beneficiaries of the scheme are insured on a voluntary or automatic basis – in the latter case through an existing agreement with a group or organization of which they are also members.
- Most of the beneficiaries of the scheme are, in practical terms (averaged over a calendar year), excluded from existing (statutory) social security services and/or have an income at or below the national poverty line.
- The scheme is established outside the statutory social security system, by an entity that could be either public or private.
- The size of the premium and benefits is often small and limited.

Prepayment scheme:

- The scheme is usually administered by health care service provider, whereby an individual subscribed to the scheme could use an amount of health care services up to the value he/she has contributed for a specific period of time. There is no risk pooling among subscribers of the scheme.

Self-help scheme:

[6] Maternity benefit schemes for local mother groups of the Safe Motherhood Network in Nepal.
[7] Including legal, education, health care, financial and social protection systems.

- A group of people that pool their funds together for a purpose predetermined by the group. The group's members decide under which situations a member of the group can obtain help in the form of a service or credit from the group.

The following table lists the 23 health-financing schemes this report reviewed, according to the above-mentioned classification.

Table 1: Health-financing schemes according to classification

Classification	Schemes
Micro-insurance	La mutuelle de santé de Bobo Dioulasso, Burkina Faso Chogoria Hospital Health Insurance Scheme, Kenya Mutuelle des Travailleurs de l'Education et de la Culture (MUTEC), Mali Safe Motherhood Fund, Tanzania Ishaka Hospital Health Plan, Uganda Kisiizi Hospital Health Insurance Scheme, Uganda Kitovu Patients Prepayment Scheme, Uganda Kiwoko Hospital Community Based Health Insurance, Uganda Mother Child Rescue Project, Buhweju, Bushenyi District, Uganda Nyakibale Community Health Plan, Uganda Gonoshasthaya Kendra Health Care System's Community Insurance Scheme, Bangladesh Rural Health Programme of Grameen Kalyan, Bangladesh Action for Community Organization, Rehabilitation and Development (ACCORD), India Integrated Social Security Scheme of Self-Employed Women Association (SEWA), India Vijaya Youth Club Credit Union, Nepal Bukidnon Health Insurance Programme (BHIP), Philippines Bustos LGU – PhilHealth Project (Medicare Para sa Masa), Philippines Novaliches Development Cooperative, Inc. (NOVADECI), Philippines ORT Health Plus Scheme (OHPS), Philippines Asociación mutual S.M. LASPIUR, Argentina
Prepayment	La mutuelle de santé communautaire Oumou Dilly, Mali
Self-help scheme	La mutuelle de santé de Médina Gounass, Senegal
Not yet started	Association Maternité Sans Risques, Burkina Faso

1.3 Analysis of the characteristics of 23 community-based health-financing schemes with a maternity benefits element

1.3.1 The majority of the community-based health-financing schemes surveyed are health care provider-based schemes and few offer cash benefits

One important characteristic of 15 of the 23 schemes with maternity care components is that they were founded by organizations that already provide health care services to their members or to the local population. These organizations are hospitals, clinics, or organizations operating clinics as part of their services.

Eight out of the 23 community-based health-financing schemes[8] that contain a maternity care element are not managed by organizations that already provide health care services.

[8] La mutuelle de santé de Bobo Dioulasso, La mutuelle de santé de Médina Gounass, Safe Motherhood Fund; Mother Child Rescue Project, SEWA, Vijaya Youth Club Credit Union, Bustos LGU-PhilHealth Project and Bukidnon Health Insurance Project (BHIP).

Only two schemes offer cash benefits in lieu of maternity care benefits. They are both non-health care provider-based schemes[9]:

- *Integrated Social Security Scheme of Self-Employed Women Association (SEWA), India*
  Maternity benefits include a fixed lump sum of Rs. 300 to insured women before delivery.
- *Vijaya Youth Club Credit Union, Nepal*
  A fixed lump-sum of Rs. 300 is paid after delivery to qualified women members.

The rest of the non-health care provider-based schemes include partial or total coverage of the medical costs, including maternity care incurred at medical institutions.

Therefore **health care provider-based schemes** (which make up the majority of schemes in this report) with maternity care elements offer:

- Medical benefits only, in the form of medical services; with or without co-payments; or discounts to members of the scheme.

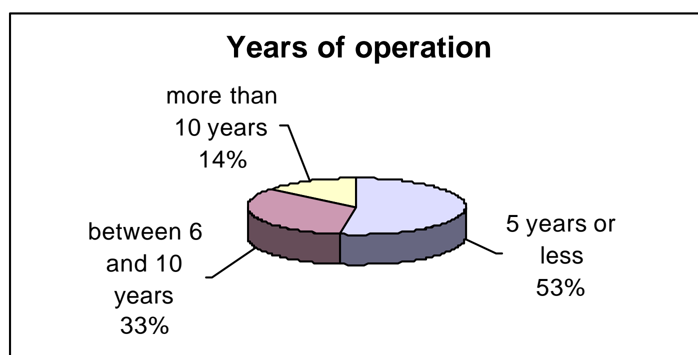
Whilst **non-health care provider-based schemes** with maternity care element offer:

- Partial or total reimbursement of certain medical costs incurred at designated or any medical institution; or cash benefits in the form of a lump-sum payment, either before or after delivery.

1.3.2 Years of operation and the number of women beneficiaries

Information on the year the schemes were launched is only available for 21 schemes - 11 in Africa, 9 in Asia, and one in Latin America. The oldest scheme is Gonoshasthaya Kendra Health Care System's Community Insurance Scheme in Bangladesh, with 26 years of experience in managing health micro-insurance. The youngest is the Safe Motherhood Fund's Community Insurance Scheme in Tanzania, which, at the time of writing, has only been prepared for operation for 2 months. Eleven out of the 21 schemes (53%) were five years old or younger, a third of them were launched between 6 and 10 years ago, and only three of them have had more than 10 years of operating experience.

Chart 1: Years of operation



The majority of the African schemes are relatively new. Nine out of the 11 reviewed in this report have been operating for no more than 5 years. The oldest African scheme is MUTEC in Mali, which has been operated for 11 years.

[9] Later information also shows that La Mutuelle des Conducteurs de Taxi-motos de la Station Gaitou in Togo also offers a small lump-sum of FCFA 25,000 to women members before delivery to purchase medicines.

Seven out of 9 Asian schemes have been operating between four and nine years. An Asian scheme is also the oldest schemes reviewed in this report.

The scheme from Latin America has operated for 11 years, a relatively long time when compared to the others in the sample.

Those schemes in the sample that have been in existence for a relatively long time may embody a number of strengths that are worth further research. It will be very useful to find out through further research how some of them have managed to overcome financial difficulties like cash flow and budget balance; despite the fact that they seldom apply actuarial calculation to determine the level of premium rates and benefit payments. In addition, what could be the mechanisms that have allowed them to balance their finances; in spite of the presence of various possible factors that could lead them to irregular and/or insufficient premium revenue[10] and/or excessive benefits expenditure?[11]

Table 2: The number of years the 21 health financing schemes have operated, as of June 2001

Years	Scheme
26 years	Gonoshasthaya Kendra Health Care System's Community Insurance Scheme, Bangladesh
11 years	La Mutuelle des Travailleurs de l'Education et de la Culture (MUTEC), Mali
11 years	Asociación mutual S.M. Laspiur, Argentina
10 years	Chogoria Hospital Health Insurance Scheme, Kenya
9 years	Action for Community Organization, Rehabilitation and Developmnent (ACCORD), India
9 years	Integrated Social Security Scheme of Self-Employed Women Association (SEWA), India
8 years	Rural Health Programme of Grameen Kalyan, Bangladesh
8 years	NOVADECI Health Care Plan, Philippines
7 years	ORT Health Plus Scheme, Philippines
7 years	Bukidnon Health Insurance Programme, Philippines
5 years	Kisiizi Hospital Health Insurance, Uganda
4 years	Credit and Savings Programme of Vijaya Youth Club Credit Union, Nepal
3 years	Nyakibale Community Health Plan, Uganda
2.5 years	La mutuelle de santé de Médina Gounass, Senegal
2 years	La mutuelle de santé de Bobo Dioulasso, Burkina Faso
2 years	Ishaka Hospital Health Plan, Uganda
2 years	Kiwoko Hospital Community Based Health Insurance, Uganda
1.5 years	Bustos LGU-PhilHealth Project, Philippines
1.5 years	Kitovu Patients Prepayment Scheme, Uganda
1 year	Mother Child Rescue Project, Uganda
2 months	Safe Motherhood Fund's Community Insurance Scheme, Tanzania

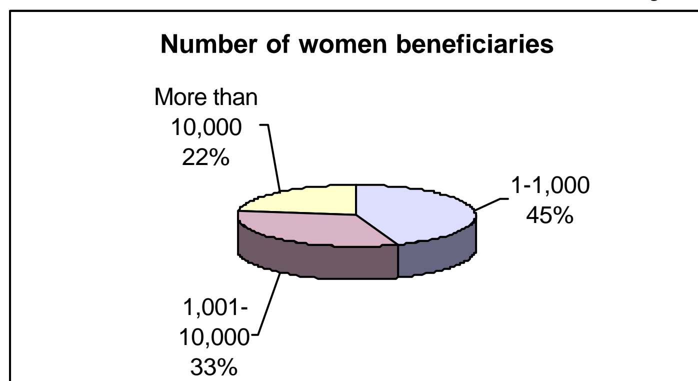
In order to assess the potential outreach of a scheme with a maternity care element, it is appropriate to look at the number of women beneficiaries in each scheme in the sample.[12]

Information on the number of women beneficiaries was collected on 18 health micro-insurance schemes – 10 from Africa and 8 from Asia. Eight out of 18 (45%) of the schemes with a maternity care element have 1,000 or less women beneficiaries. Six out of 18 schemes have

[10] For example, a lack of qualified management staff with accounting capacity or a lack of proper office equipment, large fluctuations in members' monthly income and membership number, delay payments etc.
[11] Such as the absence of an effective verification procedure on the status of a health care service user, excessive usage of health care services (moral hazard), lack of a mechanism such as a waiting period to minimise adverse selection, etc.
[12] Although all woman members are equally beneficiaries of the health care coverage offered by health micro-insurance schemes, a beneficiary does not necessarily have to be a member. It is therefore more suitable to examine the number of women beneficiaries rather than the number of women members.

1,001 to 10,000 women beneficiaries, and the remaining four schemes have more than 10,000 women beneficiaries. (See Chart 2)

Chart 2: Number of woman beneficiaries in 18 community-based health-financing schemes



In general, African schemes reviewed in this report that have a maternity care component tend to have fewer beneficiaries compared to Asian schemes. Six out of 10 African schemes have 1,000 or less women beneficiaries, while six out of 8 Asian schemes have more than 1,000 women beneficiaries. These African schemes also tended to be much younger than the Asian schemes.

A large pool of members-beneficiaries allows health risks to be spread wider than a smaller pool. Thus, a large number of members-beneficiaries is one of the key factors that contribute to the financial sustainability and long-term survival of a health micro-insurance scheme.

Table 3: The number of woman beneficiaries in some of the health-financing schemes

Number of members	Name of the scheme
Less than 100	La mutuelle de santé de Médina Gounass, Senegal (57) Safe Motherhood Fund, Tanzania (60)
101-500	Chogoria Hospital Health Insurance Scheme, Kenya (300) Mother Child Rescue Project, Uganda (500)
501-1,000	Kiwoko Hospital Community Based Health Insurance, Uganda (550) NOVADECI Health Care Plan, Philippines (720-800) ORT Health Plus Scheme, Philippines (800) Ishaka Hospital Health Plan, Uganda (1,000)
1,001-5,000	Bustos LGU-PhilHealth Project, Philippines (1,200) Kitovu Patients Prepayment Scheme, Uganda (1,300) La Mutuelle des Travailleurs de l'Education et de la Culture (MUTEC), Mali (1,927) Credit and Savings Programme of Vijaya Youth Club Credit Union, Nepal (4,000) Kisiizi Hospital Health Insurance, Uganda (5,000)
5,001-10,000	Action for Community Organization, Rehabilitation and Development (ACCORD), India (6,000)
10,001-100,000	Bukidnon Health Insurance Programme, Philippines (12,664) Rural Health Programme of Grameen Kalyan, Bangladesh (19,147) Gonoshasthaya Kendra Health Care System's Community Insurance Scheme, Bangladesh (55,586)
More than 100,000	La mutuelle de santé communautaire Oumou Dilly, Mali (370,821)

It would be misleading to select an ideal scheme based on only one of the above criteria (number of years of existence or the number of women beneficiaries). Examination of the two

criteria may show the dynamics and popularity of a scheme among women, as this type of scheme tends to survive or become more successful.[13]

There are also various other factors that need to be borne in mind when analysing these schemes. A large number of women beneficiaries could be due to a high population density in the areas operated by a scheme. A community-based health-financing scheme could be highly subsidised, or receive free medical staff or regular donations from other sources. With affordable rates on offer, the number of subscriptions will naturally tend to be higher. But a scheme of this kind may not be sustainable once subsidies and other forms of financial assistance are removed. Hence to identify (potentially) successful schemes, a closer look at selected schemes described in this report is desirable.

1.4 Types of maternity care covered by the schemes

1.4.1 Normal delivery and delivery with complications

The majority of the schemes (17) cover both normal delivery and delivery with complications. Only La mutuelle de santé de Bobo Dioulasso in Burkina Faso, Chogoria Hospital Health Insurance Scheme in Kenya and Kisiizi Hospital Health Insurance Scheme in Uganda specifically exclude insurance coverage for normal deliveries[14]. The latter two schemes reported that provision for normal deliveries could provoke an increase in premium rates across all categories. The management of the scheme feared that the membership of the scheme would shrink if premiums were raised. Higher premiums could also result in the exclusion of the very poor from the scheme.

There are a number of possible solutions to enable normal deliveries to be covered under a community-based health-financing scheme. One is to seek technical guidance from a qualified actuary. Another is to let the beneficiaries decide for themselves.

One good example is Kiwoko Hospital Community Based Health Insurance in Uganda, where the beneficiaries of the health insurance scheme designed the insurance package themselves. They opted to cover deliveries with complications from January 2000 and normal deliveries from 2001.

Another solution is to cross-subsidise from income generated from other sources, such as pooled capital[15] or profits generated from other business activities.[16] This enables a scheme to cover its members for essential services, especially those associated with normal deliveries and deliveries with complications. Cross-subsidisation also reduces the premiums, permitting poorer people to join the scheme.

A further possible solution is to promote less costly but safe practices. The Rural Health Programme of Grameen Kalyan in Bangladesh offers trained traditional birth attendants (TBA), who are supplied with birth kits, to assist at normal deliveries at the women members' homes. ACCORD in India has also adopted a similar policy, but it employs 'health animators' who are trained for four to five years at the Gudalur Adivasi Hospital before assisting at normal deliveries at home on behalf of ACCORD's health micro-insurance scheme. These less costly practices allow essential maternity care like normal deliveries to be covered whilst containing costs. Women who earn wages may also favour home deliveries over hospital

[13] If a relatively young scheme is able to attract an increasing number of members while maintaining financially balanced, this scheme will have a better chance to survive or even become successful in the long-run.
[14] The rest of the schemes either offer a small cash benefits or do not cover for delivery.
[15] NOVADECI in the Philippines requires members to contribute a fixed deposit of at least P 2,000, a one-time Health Care Plan membership fee of P 200 and an annual premium of P 600 to obtain family insurance coverage. The interest generated from these pooled capital/ deposit are either used to finance more health care services for a given level of premium, or to reduce premium charges to all or to only a selected group of members.
[16] Gonoshasthaya Kendra Health Care System's Community Insurance Scheme, Bangladesh.

deliveries because they lose fewer days of wages if they deliver at home. In certain cases, home delivery may be a local custom.

1.4.2 Prenatal care

Nineteen community-based health-financing schemes (10 in Africa and 9 in Asia) revealed that they offer prenatal care to women beneficiaries. The following table shows the types of prenatal care they cover.

Table 4: Prenatal care offered by 19 health financing schemes

Name of scheme	Routine check-up	Medicines	Laboratory test	Referral
Africa				
Chogoria Hospital Health Insurance Scheme		X	X	
La mutuelle de santé communautaire Oumou Dilly	X	X		
MUTEC	X	Other: Ultrasound scanning at discounted price		
La mutuelle de santé de Médina Gounass	X (<FCFA2,500)		X	
Safe Motherhood Fund	X	X	X	X
Ishaka Hospital Health Plan	X	X		X
Kisiizi Hospital Health Insurance Scheme	X	X		X
Kitovu Patients Prepayment Scheme	Up to Ushs.15,000 of any prenatal care service			
Mother Child Rescue Project	X			
Nyakibale Community Health Plan		X(at discounted price)		
Asia				
GK's Community Insurance Scheme	X	X		X
Rural Health Programme of Grameen Kalyan	X	X	X	X
ACCORD	X (5 times)			
SEWA	X (Rs. 300 cash benefits)			
Vijaya Youth Club Credit Union	Rs. 300 cash benefits			
BHIP	(free at public hospital)		X (<P500)	X
Bustos LGU - PhilHealth	(free at public hospital)			
NOVADECI	X (3 times)			
Ort Health Plus Scheme	X (6 times)	X		X

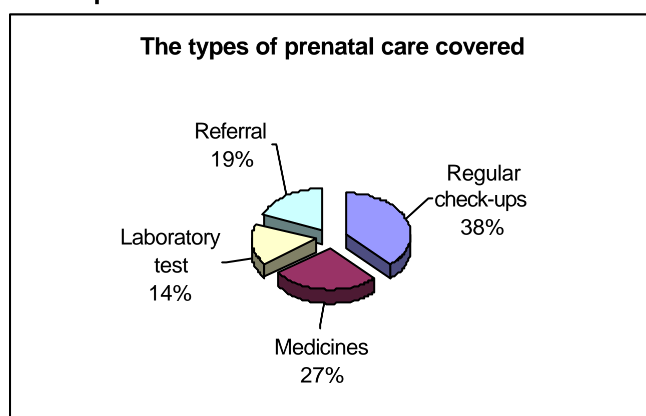
The Safe Motherhood Fund's Community Insurance Scheme and the Rural Health Programme of Grameen Kalyan have the most complete prenatal care coverage. Other schemes like the Ishaka Hospital Health Plan, the Kisiizi Hospital Health Insurance Scheme, GK's Community Insurance Scheme, the BHIP and ORT Health Plus Schemes also provide substantial prenatal care coverage.

Routine check-ups are the most common prenatal care covered by community-based health-financing schemes. Only 4 schemes in the sample do not cover routine check-ups. No information was offered by two schemes that do not cover prenatal care on whether or not government clinics and hospitals in their countries provide free or affordable routine prenatal check-ups. However, in the Philippines, the government provides free prenatal check-ups at public hospitals. Most Asian schemes covering prenatal care offer routine prenatal check-ups to women beneficiaries. Some of them like ACCORD, NOVADECI and the Ort Health Plus Scheme, insure women members for multiple routine prenatal check-ups.

Medicine is the next most common item covered by the schemes. The sample of African schemes reviewed in this report show a greater preference for coverage of medicines than Asian schemes.

Only seven schemes cover referrals as part of their prenatal care and only 6 out of 19 provide coverage for laboratory tests.

Chart 3: The types of prenatal care covered by community-based health-financing schemes in this report



Among all the schemes in this report, only two offer lump-sum cash as maternity benefits before or after delivery: (1) SEWA's Integrated Social Security Scheme, India - Rs. 300 before delivery and (2) the Vijaya Youth Club Credit Union, Nepal. Rs.300 after delivery.

1.4.3 Postnatal care

Fifteen community-based health-financing schemes revealed that they provide postnatal care (nine in Africa and six in Asia). The following table shows the types of care covered.

Table 5: Postnatal care offered by 15 health financing schemes

Name of scheme	Check-up	Nutritional Education	Medicine	Complementary nutrition	Lab test	Vaccination
Africa						
Chogoria Hospital			X		X	
Oumou Dilly	X		X			
MUTEC	X	X	X	X	X	X
Médina Gounass		X		X	X	X
Safe Motherhood Fund	X	X	X	X		
Ishaka Hospital			X	X		
Kisiizi Hospital	X	X	X	X		
Mother Child Rescue Project	X		X			
Nyakibale Hospital	X(for baby up to 3 months)	X	X(at discounted price)			
Asia						
GK	X	X	X	Other: hospital care		
Grameen Kalyan	X	X	X			X
ACCORD[17]	X			X		X
BHIP						X

[17] Babies up to 5 years old are covered by the postnatal care offered by ACCORD

Bustos LGU-PhilHealth	X	X	X	X		
ORT Health Plus Scheme	X	X	X	X		

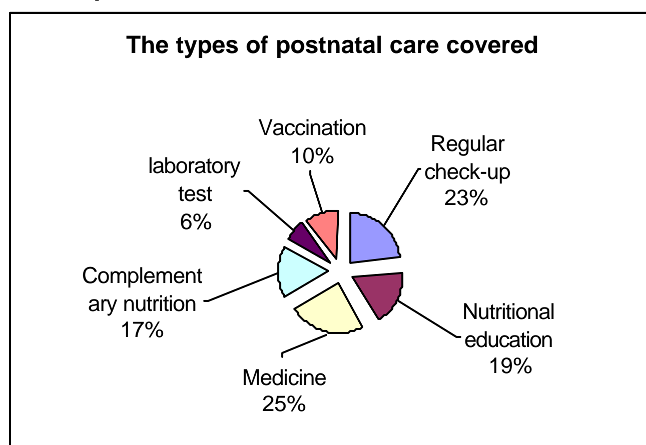
Among all the schemes providing postnatal care, MUTEC offers the most comprehensive range of services. Other schemes worth noting for their wide coverage are La mutuelle de santé Médina Gounass, the Safe Motherhood Fund, the Kisiizi Hospital Health Insurance Scheme, GK's Community Insurance Scheme, the Rural Health Programme of Grameen Kalyan, the Bustos LGU-PhilHealth Project and the ORT Health Plus Scheme. The latter two schemes' postnatal care packages provide four types of services in addition to free government vaccinations for infants.

Twelve out of 15 (80%) of the schemes also offer medicine coverage. Again, the African sample shows a greater preference for coverage of medicines over their Asian counterparts.[18]

Eleven out of 15 (73%) schemes offer postnatal check-ups. The Nyakibale Hospital's Community Health Plan covers regular health check-ups for babies up to three months old, and ACCORD covers regular health check-ups for infants up to five years old.

Only 9 out of 15 (60%) of them provide education on nutrition. Even fewer of them (53%) cover complementary nutrition. Only 5 of the schemes reported to cover vaccinations for infants.[19] Laboratory testing is the least likely benefit to be included in postnatal care coverage.

Chart 4: The types of postnatal care covered by community-based health-financing schemes in this report



As shown in the above chart, medicine is the most common item offered under a postnatal care package, followed by regular postnatal check-ups and education on nutrition.

1.4.4 Transportation costs

Only three community-based health-financing schemes cover transportation costs as part of their maternity care and an additional three schemes arrange members to use their ambulances at their personal expense, even though the lack of transportation and hence its associated high cost often hinders women living in rural areas from seeking maternity care at clinics or hospitals. Many women have no choice but to deliver at home where they are

[18] Eight out of 9 African schemes that offer postnatal care cover medicines.

[19] It is not clear why so many schemes do not cover vaccination for infants. One possible reason, which remains to be certified, is that vaccination for infants are generally freely provided at public hospitals in many countries. Another verification that needs to be done on those schemes that claim to cover vaccination for infants is whether their vaccination coverage is in addition to those provided by the government.

assisted by traditional birth attendants, who often have little or no formal training. Also, conditions for home delivery are often not hygienic, resulting in a greater risk of infection. According to a report released by the Safe Motherhood Fund, Tanzania, most maternal mortality occurs during or after home delivery. Another major cause of maternal mortality during a home delivery is post-partum haemorrhaging,[20]which was contended by the MaterCare Maternal Health Project in Ghana. Therefore, if transportation costs for normal deliveries and deliveries with complications were covered by the schemes, it would give women a greater incentive for delivering at a health facility, provided some other conditions are satisfied too.[21]

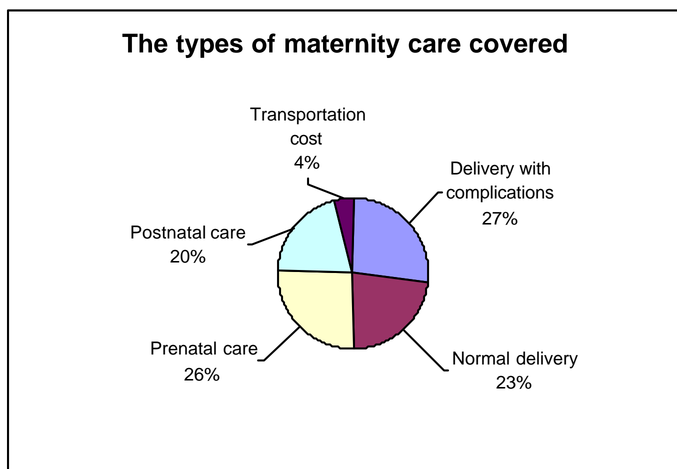
Only MUTEC in Mali covers transportation costs for all deliveries. The Mother Child Rescue Project and the Kisiizi Hospital Health Insurance Scheme in Uganda cover transportation costs only for deliveries with complication. ACCORD, La mutuelle de santé communautaire Oumou Dilly and Kiwoko Hospital Community Based Health Insurance offer an ambulance service, which is paid for by insured members.

The sample schemes in this report have revealed that coverage of transportation costs for normal delivery and delivery with complications as part of maternity care is still relatively rare, when compared with coverage for deliveries, prenatal and postnatal care.

The survey also shows that even in isolated and mountainous area, reliable and swift transportation can be secured using innovative method. The Mother Child Rescue Project set up a solar powered radio transmission network between the satellite clinic, the *matatus* (a private taxi service), and the main hospital (Bushenyi Medical Centre), which ensures a swift transportation service for its members when needed.

The review found that most common maternity care covered under the schemes in the sample is delivery with complications (20), followed by prenatal care (19), normal delivery (17), postnatal care (15), and transportation costs (3).

Chart 5: The types of maternity care covered by community-based health-financing schemes in this report



[20] MaterCare Maternal Health Project is equipping St. Theresa Hospital at Nkoranza, Ghana, with a modern Blood Bank to prevent maternal deaths due to haemorrhaging. The Project also finances a fully equipped ambulance service for urgent cases. The ambulance also has a radio transmission link to the rural clinics and the hospital.

[21] Some of these conditions include: 1) The availability of timely transportation; 2) No major cultural barrier for hospital delivery; 3) Quality health care services at maternity clinics or hospitals; 4) Women beneficiaries and their spouses understand the danger associated with home delivery.

1.5 Some good practices implemented by selected community-based health-financing schemes

There are certain good practices used by several community-based health-financing schemes that are worth noting, because in general they ensure the long-term financial sustainability of a health micro-insurance scheme.

Group insurance[22] was adopted by five of the schemes in Uganda[23] reviewed in this report. This arrangement has the advantage of reducing adverse selection.

Waiting period for benefits entitlement is generally being considered as a crucial factor in reducing adverse selection. A no waiting period gives a woman flexibility acts to join a scheme once she has become pregnant in order to benefit from the insurance coverage. If she has to wait, for example 9 months before she is entitled to the benefits, adverse selection can be avoided[24].

Preventive and maternity care training, as well as awareness-raising on reproductive health care, which are provided by local women health workers in the communities, were proven to be very important in encouraging women to join a health micro-insurance scheme (e.g. Rural Health Programme of Grameen Kalyan; ACCORD's health micro-insurance scheme). Awareness-raising activities naturally need to be carried out at a place and time convenient to the women's place of work and working schedule.

In addition, it was found that family planning programmes are being incorporated into the maternity benefits offered by the schemes. For example, ACCORD only grants insurance coverage for the first and second deliveries.

Other complementary work such as disease prevention and general health education for the target groups is both cost-effective and reduce the general health risk of insured members and/or target groups. Extra savings gained from a general reduction of health risk would allow more scope for maternity coverage.

As mentioned in section 1.4.1, cross subsidisation and cost effective practices also allowed for either a wider range of maternity care to be covered at given premium rates or for a reduction in premium rates. These strategies normally could attract more women to join a scheme, which in turn could improve risk pooling, provided mechanisms to reduce adverse selection are put in place.

. . . .

[22] Health insurance memberships are only granted when at least 60 per cent of the members of a group subscribe.
[23] Ishaka Hospital Health Plan, Kisiizi Hospital Health Insurance Scheme,
Kiwoko Hospital Community Based Health Insurance, Mother Child Rescue Project and Nyakibale Community Health Plan.
[24] Some of the schemes that have adopted waiting period are: Chogoria Hospital Health Insurance Scheme, La Mutuelle de santé de Médina Gounass and Bukidnon Health Insurance Programme.

CHAPTER TWO: DESCRIPTION OF COMMUNITY-BASED HEALTH-FINANCING SCHEMES WITH MATERNITY PROTECTION ELEMENTS

Altogether, 23 community-based health-financing schemes are described in chapter two. Among these schemes, two of them have not yet started (AMASAR in Burkina Faso and Safe Motherhood Fund's Community Insurance Scheme in Tanzania).

The schemes are classified by region and by country.

3.1 Africa

There are altogether 13 African schemes described below. The majority are health care provider-based schemes. Five out of 13 schemes are situated in Francophone countries and the rest in Anglophone countries. However, no inference should be given to these facts, as the replies received are relatively random. For example, six Ugandan health micro-insurance schemes are described in this report, but it would be misleading to speculate that there are more such schemes in Uganda than in other African countries.[25]

Most African schemes cover both normal delivery and delivery with complications. Only La mutuelle de santé de Bobo Dioulasso, Kisiizi Hospital Health Insurance Scheme and the Chogoria Hospital Health Insurance Scheme do not cover normal delivery.

When it comes to prenatal care, African schemes seem to give higher priority to medicines than Asian schemes.

The schemes reviewed in the report that cover transportation costs are all found in Africa.

The average length of operation of the African community-based health-financing schemes tends to be shorter than the Asian schemes. They also tend to have a smaller number of women beneficiaries compared to Asian schemes.

3.1.1 Association Maternité Sans Risques (AMASAR), Burkina Faso

This association aims to cover a comprehensive range of maternity care but has not yet started its programme due to a lack of support. The following is a description of the planned maternity care to be covered by the health micro-insurance scheme and its proposed functioning methods.

<u>SERVICES</u>

Prenatal care:

Medical assessment; regular check-ups by qualified medical personnel (government mid-wives, nurses and doctors); high-risk pregnancy; pregnancy with complications or with dangerous symptoms; medicines and hospitalisation.

Transportation:

Between the home of the patient and the clinic/hospital.

[25] This is because the Ugandan schemes described in the report are under the umbrella of the Ugandan Community Based Health-financing Association (UCBHFA). UCBHFA provided very good contact details and consequently more information was collected from these schemes.

Delivery care:
By qualified medical personnel; health care services provided by nurses and/or surgeons and/or doctors; access to generic and specialised medicines; provision of food prepared at AMASAR headquarters.

Postnatal care:
Basic health care like vulva cleaning, dressing of the umbilical cord, administration of medicines; medical check-ups for mother and baby; vaccinations for the babies; provision of meals following delivery.

Other:
Medicines for the prevention and/or treatment of malaria and anaemia.

FUNCTIONING METHODS
Three functioning methods are proposed:
1. Facilities at AMASAR will provide free health care to members.
2. Implementing a health insurance scheme whereby insured members who seek maternity care at public maternity clinics would be reimbursed fully or partially.
3. Implementing a medical savings account whereby members can save regularly. A member may withdraw her savings partially or fully to pay for maternity care costs.

AMASAR has the possibility of creating partnerships with community-based women's associations to manage the mutual health insurance for maternity coverage.

3.1.2 La Mutuelle de santé de Bobo Dioulasso, Burkina Faso

Set up in 1999, this mutual health fund provides insurance covering medical examination, radiology, prescribed specialised and generic medicines, and hospital care. The total cost of delivery with complications is covered under the scheme; but, prenatal care, normal delivery, and postnatal care are not covered.

There are two types of family memberships, covering up to 9 family members, with two different benefits packages:

1) FCFA 12,000 per family per year
   - It covers 100% of the cost of hospital care.
   - It covers 25% of the cost of prescribed specialised medicines.
   - It covers 100% of the cost of prescribed generic medicines.

   The insured members front the cost of services and medicines and are then reimbursed by the mutual health fund.

2) FCFA 24,000 per family per year
   - It covers 100% of the cost of hospital care.
   - It covers 50% of the cost of prescribed specialised medicines.
   - It covers 100% of the cost of prescribed generic medicines.

   The mutual health fund pays directly to the hospital where the insured member receives his/her hospital treatment. The insured members can purchase their medicines from pharmacies of their choices and are then reimbursed by the mutual health fund.

The most common health care services sought at the hospitals are for malaria, diarrhoea, other common infectious diseases and road accidents. The manager of the mutual reported

little or no demand from women beneficiaries for insurance coverage of prenatal and postnatal health care services. Furthermore, only 15 per cent of the beneficiaries are women.

3.1.3 Chogoria Hospital Health Insurance Scheme, Kenya

Chogoria Hospital Health Insurance Scheme in Kenya is one of the earliest known provider-based health micro-insurance schemes in Eastern Africa. The scheme was started in 1991 by Chogoria Hospital, a non-profit making missionary hospital. It manages the insurance scheme and offers members medical services, external dispensaries and clinics.

The scheme has been providing coverage for a range of out-patient and in-patient care. Until 1998, medical costs related to normal delivery and delivery with complications were not covered by the scheme. Now, the first caesarean intervention of a beneficiary is included in the benefits package, while normal delivery is still not insured. Maternity care benefits also include laboratory tests and medicines.

Any adult, or couple with children under the age of18, with no chronic or pre-existing illnesses may join the scheme. The waiting period is only two weeks for both out-patient and in-patient care. However, there is a longer waiting period for the first caesarean section.

Currently, there are approximately 300 women beneficiaries who are entitled to maternity care benefits. The scheme could include normal delivery in its benefits package. However, premium rates for all categories may rise as a result, which would exclude the poor from accessing quality health care services. In addition, more expensive premiums could also mean a smaller membership base, and hence an inadequate spread of risk.

3.1.4 La Mutuelle de Santé Communautaire Oumou Dilly, Mali

La Mutuelle de Santé Communautaire Oumou Dilly is the first community-based, member-owned, pre-paid health plan offering affordable health care to the poor in Mali. Based in Bamako, the mutual's subscription fees are affordable to school students, union members and most informal economy workers. With major cutbacks in official subsidies to public health systems in Mali, La Mutuelle de Santé Communautaire Oumou Dilly is an alternative to the overcrowded public hospitals that lack basic medical equipment and pharmaceutical supplies.

The mutual's membership fee is FCFA 100 (US$ 0.18) per day per adult and FCFA 200 (US$ 0.36) per month per child. It is open to everyone. Once the membership fee is paid, a member can benefit from the health care services covered under the plan.

The mutual offers a range of free maternity care provided by its own nurses, obstetricians, gynaecologists, midwives and doctors, to women members from the beginning of their pregnancies until after delivery. These services include:

- Prenatal care: check-ups carried out by the mutual's qualified medical personnel; medicines.
- Delivery care: by the mutual's qualified medical personnel; hospital care; medical equipment; pharmaceutical products and medicines; meals not included.
- Postnatal care: for mother and infant until the latter reaches six years old; medicines.
- Transportation: ambulance service is available to transport woman members from home to the hospital, but costs are borne by the members.

The number of women members is continually growing as shown below:

1996: 54,836
1998: 201,154
2001: 370,821

Maternal and neonatal mortality rates are very high in Mali. This is why the mutual has decided to offer maternity care under the scheme. It believes the vast majority of people can access health care if they pool their resources carefully and if medical services are delivered with a proper mix of incentives and efficiency. Apart from using membership fees to finance health care services, the mutual also has access to schools' infirmary budgets.

3.1.5 Mutuelle des Travailleurs de l'Education et de la Culture (MUTEC), Mali

The MUTEC health centre was set up in 1990 to offer discounted or free health care services to members. However, non-MUTEC members can also seek health services at its health centre. They simply pay slightly more expensive co-payments than MUTEC members. Interestingly, non-MUTEC members request the majority of the consultations at the centre.

In total, the MUTEC health centre offers out-patient and in-patient care, maternal and reproductive health care, medicines, an ambulance service, dental treatment, radiology and laboratory tests.

Members enjoy the following maternity care covered by the health centre:

- Prenatal care: check-ups by midwives; ultrasound scanning (members pay: FCFA 2,500; non-members pay: FCFA 6,000).
- Delivery care: by midwives or doctors (member pays: FCFA 2,000; non-member pays: FCFA 10,000); coverage also includes pharmaceutical products; meals at the hospital; and medical equipment.
- Transportation: costs are covered.
- Postnatal care: check-ups for mother and baby; maternal and infant health records (members pay: FCFA 500; non-members pay: FCFA 500); education on nutrition including encouraging mothers to breastfeed; complementary nutrition for mother and baby; vaccinations for babies; medicines.

The mutual had a total of 700 women members in 1996. By 2001, this number had increased to 1,927.

Health care coverage for mothers and children is of crucial concern among members of the mutual. The selection of the type of maternity care to be covered depends on the need and financial capacity of members. MUTEC health centre also works with l'Union Technique de la Mutualité Malienne, which is also a health care service provider.

If possible, MUTEC health centre intends to enlarge the range of maternity care and to cover gynaecological and obstetric interventions.

3.1.6 La Mutuelle de santé de Médina Gounass, Senegal

The community-based Médina Gounass mutual health fund was set up in 1998 to facilitate the local population's access to health care services. It has adopted the name of the town of Médina Gounass in order to encourage local residents to join the mutual. The Wally Daan

Association, which promotes women's concerns, and the youth wing of the Mission de Coopération Française, assisted in the establishment of the mutual.

Maternal mortality is very high in Senegal. The majority of women have great difficulty in gaining access to finance. Most of the members' lives are very precarious. Many of them are visually handicapped.

The principle of solidarity and self-help is the main foundation of the mutual. Anybody who lives in and around Médina Gounass may join voluntarily and there is no premium.

With a waiting period of 6 months, the mutual covers a number of maternity and other health care services that are provided by a health post and a health centre. These services are:

- Prenatal care: up to FCFA 2,500 of primary health care services and prenatal consultations.
- Delivery care: 50 per cent of the costs.
- Postnatal care: vaccinations for babies against childhood diseases if the parents pay for it; nutrition and maternity education to mothers which encourages them to breast-feed; provision of food after delivery; 100 per cent of the cost of hospitalisation for 7 days; minor surgery; medical analyses and dental care except dentures.

There are currently a total of 57 women beneficiaries in the mutual.

The nature of maternity care is decided at the annual l'Assemblée Générale Ordinaire according to the financial capacity of the mutual and its members to contribute. The mutual plans to extend maternity care coverage to 100 per cent of delivery costs and postnatal check-ups to reduce maternal and infant mortalities.

3.1.7 Safe Motherhood Fund, Tanzania

The Safe Motherhood Programme at Archdiocese of Dar es Salaam started in 2001 and aims to provide better and affordable health care for pregnant women by involving 13 health facilities in the locality.

Although the Ministry of Health developed strategies and activities in 1997 aimed at reducing maternal mortality and morbidity by 50 per cent by the year 2010, the current difficult national economic situation means that government facilities are unable to guarantee adequate obstetric care to all Tanzanian women.

The Safe Motherhood Programme at Archdiocese of Dar es Salaam focuses on:

- Strengthening prenatal, delivery and postnatal care.
- Enhancing the capacity of health facilities to manage obstetric problems.
- Enhancing efficiency of the referral system.

The programme has identified a non-profit making Community Insurance Scheme as a means of achieving financial and "momentum" sustainability, as well as spreading the risk and burden of health costs across the whole population.

In addition, the programme will support the Diocesan Medical Store, which is to be run as a revolving drug fund.

The Community Insurance Scheme under the Safe Motherhood Programme will cover the following maternity care:

- Prenatal care: all consultations from the first month of pregnancy until delivery; all tests and medicines related to pregnancy available in their health facilities; referrals for pregnancies with danger symptoms, complications and sexually transmitted diseases.
- Delivery care: qualified midwife at the fully-equipped, newly-built diocesan maternity centre.
- Postnatal care: routine check-ups for mother and baby; education on nutrition including encouraging mothers to breast-feed; nutritional supplements for mother and baby; and medicines for up to 42 days after delivery.

The Community Insurance Scheme is open to all women who pay an agreed premium. The premium set at 2001 is Tshs. 10,000 per person per year, and women can choose to join a Parish Safe Motherhood Fund. There is no waiting period before maternity care is covered.

The main referral maternity hospital in Dar es Salaam (Muhimbili Medical Centre) and other public hospitals do not charge for mother and child health and maternity care. However, due to lack of medical supplies, patients often have to buy and bring along a delivery kit of: 4 pairs of gloves, 4-6 maternity pads, 2 ampoules of ergometrine, 2 ampoules of syntometrine and a pair of kanga/ loin cloths, at a total value of approximately Tshs. 8,000.

3.1.8 Ishaka Hospital Health Plan, Uganda

When Ishaka Hospital Health Plan first started in mid-1999, it was designed to cover mainly acute infectious diseases like malaria, respiratory and urinary tract infections, and gastrointestinal infections. There was no insurance coverage for chronic diseases such as diabetes and hypertension, and neither for normal delivery. It was thought by the health plan manager at that time that there would be too many normal deliveries to be covered; and hence, it would be too costly. In addition, the Ministry of Health had recommended that maternity care should not be covered by the health plan. However, in the face of popular demand from the communities, normal deliveries and deliveries with complications have been covered since July 2000. In addition, Ishaka Hospital has a brand new maternity ward, which is funded by ADRA. It is equipped with an operating theatre for caesarean section, an incubator and an ultrasound machine.

The health plan also covers:

- Prenatal care: routine antenatal check-ups by midwives; medicines; referrals and treatment for pregnancy showing dangerous symptoms; major complications and sexually transmitted diseases.
- Delivery care: normal delivery and delivery with complications will be handled by qualified medical personnel; hospital care and medicines.
- Postnatal care: medicines and some multivitamins and iron tablets.

The hospital health plan premium per person for 2001 was set at Ushs. 10,000 (US$ 6). An estimated 1,000 women are beneficiaries of the health plan and between January and March 2001, three women benefited from maternity care coverage.

This insurance scheme is open to families who are already members of established groups or institutions. Groups that are currently members of the plan include burial societies, dairy cooperatives, employers/employees groups, school teachers, students, and hospital contract workers.

Ishaka Hospital intends to continue covering maternity care under the plan for some time while continuously monitoring its cost-effectiveness. It also intends providing coverage for a

more comprehensive postnatal care. There is no free government maternity care in Uganda. Women join the plan because the hospital provides better health care services than the government or other private clinics and nursing/maternity homes.

3.1.9 Kisiizi Hospital Health Insurance Scheme, Uganda

Kisiizi Hospital is a missionary hospital owned by the Church of Uganda. The health insurance scheme was designed and set up in October 1996 with the involvement of the local communities. Similar to other missionary hospitals in the country that have implemented insurance schemes, Kisiizi Hospital aims to offer local communities better access to quality health care at affordable prices. It is also hoped that the scheme will increase the numbers using the hospital and improve the hospital's cash flow.

Kisiizi Hospital Insurance Scheme has insured maternity care from the beginning. Maternity care provided by the hospital and its outreach clinics are:

- Prenatal care: routine prenatal check-ups by qualified medical staff at Kisiizi Hospital; medicines; referral for pregnancies showing danger symptoms, complications and sexually transmitted diseases.
- Delivery care: qualified medical personnel provide hospital care; medical and pharmaceuticals supplies; but food is not provided. Only delivery with complications is covered.
- Transportation costs: covered only when a woman encounters complications whilst delivering at home.
- Postnatal care: routine check-ups for mother and baby; education on nutrition including encouraging mothers to breast-feed; nutritional supplements for mother and baby; medicines.

Health insurance memberships are only granted when at least 60 per cent of the members of a group (engozi) subscribe. This rule is designed to minimize adverse selection and moral hazard by capturing existing solidarity among group members and ensuring health risks are broadly spread.

The total number of women beneficiaries of the scheme has reached 5,000, out of which 1,250 are women members and 3,750 are beneficiaries.

Reducing maternal mortality and morbidity rates among local women has been one of the scheme's main objectives. The scheme's manager and the hospital consider that insuring women for pregnancy with complications, labour and puerperium, as well as medicines, is the best way of achieving this goal. The health insurance also complements maternity care offered by the public health system, like antenatal care, medical care, health education and laboratory tests.

The health insurance will continue to cover maternity care, but it does not intend to expand the coverage of services. This is because the local population is too impoverished by famine and malaria epidemics to pay more for health care.

3.1.10 Kitovu Patients Prepayment Scheme, Uganda

The Kitovu Patients Prepayment Scheme provides comprehensive insurance coverage of antenatal care and delivery.

A premium payment of Ushs. 3,200 per family per month is charged for a family of up to 4 members. Each additional family member is charged Ushs. 800 per month. An insured woman is covered for antenatal care and delivery[26] costs up to Ushs. 15,000 and Ushs. 80,000 per visit respectively. This scheme currently has 1,300 insured individuals (an estimated 260 family memberships).

The scheme was started in January 2000 with financial and technical support from DFID and the Uganda Community Based Health-financing Association (UCBHFA), to provide a health care safety net to the poor in the catchment area of Kitovu Hospital. One of the reasons that Kitovu Hospital was chosen for such a scheme was that it has a large catchment population. The hospital provides out-patient services to inhabitants living within a radius of 20 kms, and in-patient services covering four districts, within a radius of 60 kms of the hospital.

An interested subscriber has to be a member of an established group with at least 60 per cent of the affiliates either wanting to join the scheme or have already become members. Only family membership is available.

Seventy per cent of the groups that join this health micro-insurance scheme are women's groups. In Uganda, women are far more organised than men, and they are more concerned about the health care of their families. Many of these women's groups carry out micro-finance activities. Some of the more famous women's groups, such as FINCA and UWESO (Uganda Women Efforts to Save Orphans), and a gender-mix group called MEDUNET (Micro Enterprise Development Network) are affiliated with the prepayment scheme. As a result, the demand for insurance coverage of maternity care is high.

3.1.11 Kiwoko Hospital Community Based Health Insurance, Uganda

Kiwoko Hospital Community Based Health Insurance scheme is a project, which was launched by CIDR in 1999. The major objective of the project is to offer the local rural population an affordable insurance scheme covering a comprehensive range of quality health care services provided at Kiwoko Hospital, a non-profit missionary hospital. A pre-project study revealed that the local population preferred missionary hospitals because they provide quality health care, better reception facilities for patients and medicines are more readily available.

Since the beginning of 2000, all hospital costs linked to complicated deliveries (including medically assisted deliveries, the use of forceps, caesarean sections, etc.) have been covered under the insurance. This is because they are unpredictable events and could have potentially heavy financial burden on the beneficiaries. Since then, following strong demand from the women members, some member groups have now also decided to cover normal deliveries providing a woman member subscribes for three consecutive years.

An insured member can benefit immediately from the health insurance after paying an annual premium of Ushs. 3,600. There are approximately 550 women members registered with the health insurance, which has covered 3 hospital deliveries with complications since inception.

The special feature of this scheme is that it is the different group of beneficiaries who decide the content of the benefits package.

[26] Both normal delivery and delivery with complications are covered.

3.1.12 Mother Child Rescue Project, Buhweju, Bushenyi District, Uganda

Buhweju is situated in a mountainous tea growing area with around 50,000 families. The nearest clinic is 52 kms away. A lack of transportation, an absence of a health care service provider in the locality and a lack of savings for health care, means the community has extremely inadequate access to health care services, especially for emergency cases related to delivery.

In 2000, a health micro-insurance scheme called Mother Child Rescue Project was set up and funded by different development agencies. Its main objective is to provide maternity care to mothers and children, as well as covering the health care needs of their husbands.

The health insurance covers up to four family members and for an additional premium, can also be extended to cover other family members, for example grandparents.

An insured pregnant woman must attend 3 free antenatal check-ups at a satellite clinic in Buhweju, set up by the Bushenyi Medical Centre (a private health care provider) to assess the mother's health before delivery. Comprehensive delivery care, routine postnatal check-ups for mother and baby and medicines are covered by the health insurance. It also covers transportation costs between the satellite clinic and the Bushenyi Medical Centre in the event of delivery with complications.

Serious illnesses and delivery with complications are referred rapidly to the Centre by using a reliable and rapid private taxi service *(matatus)* between the satellite clinic and the main hospital. A solar powered radio transmission is used to connect the *matatus*, the satellite clinic and the main hospital.

The scheme is open to families who are already members of established groups or institutions, for example, formal or informal economy workers' associations, community groups, micro-finance institutions, cooperatives, educational institutions, etc. To be eligible for membership, a group must have existed for a minimum of three years and at least 60 per cent of the group's members must join.

Insured members' coverage include out-patient and in-patient care at the satellite clinic of the Bushenyi Medical Centre. A family of four pays a fixed quarterly premium of Ushs. 15,000 (US$ 9.10). Each additional family member is charged a supplementary quarterly premium of Ushs. 3,000 (US$ 1.81). Co-payments are also charged for out-patient care: Ushs. 500 (US$ 0.30) and for in-patient care and delivery: Ushs. 2,000 (US$ 1.21).

The co-payment is designed to prevent unnecessary over-use of the insurance while not penalising patients with real health care needs. Currently, about 70 per cent of the benefits payment is covered by premiums.

Since 2000, around 1,000 families living within a radius of 5-10 kms have been insured, which includes approximately 500 women beneficiaries. So far, 93 women have benefited from the maternity care component.

Future plans for the project include setting up a mobile clinic, thus giving families living further than 10 kms away better access to health services and more incentive to subscribe to the insurance. In addition, the cost of setting up and running a mobile clinic is lower than setting up another satellite clinic. The project also intends to set up a fund with a village bank in the Buhweju area. Income generated from the fund would be used to subsidise premiums for very poor families. The village bank would be operational by end of 2001 and is supported by development agencies.

Other plans for the project, include promoting health information and education; establishing transport services between the homes of patients and the satellite clinic; providing education on nutrition and supplements for mothers and babies; recruiting local traditional birth attendants; and expanding the coverage of the existing radio communication network.

3.1.13 Nyakibale Community Health Plan, Uganda

Established in 1998, the Nyakibale Community Health Plan was set up to give the poor in Rujumbura county (with a radius of 40 kms) access to quality health care services, especially maternity care. It offers insured members discounted prices on delivery and various medical treatments. A Health Plan member only pays Ushs. 4,000 (US$ 2.42) for a normal delivery at the Nyakibale Hospital compared to Ushs. 10,000 at a government hospital. The plan covers free treatment for babies for three months after birth. In conjunction with the hospital, it also provides health care training to pregnant women and new mothers.

In order to be eligible for membership, families must belong to an existing group and at least 60 per cent of the group's members must join the scheme. The annual family premium for up to four people is Ushs. 11,000 (US$ 6.67). An additional family member pays an extra Ushs. 3,000 annually.

There is no waiting period for members to qualify for the health care services covered under the plan.

3.2 Asia

There are altogether 9 Asian community-based health-financing schemes described in this report. Only 3 out of 9 schemes are health care provider-based schemes. This is in strong contrast to the African schemes, the majority of which are health care provider-based.

Two of the reviewed schemes are in Bangladesh, two in India, one in Nepal and four in the Philippines. Out of these countries, the Philippines is the one with the most examples of community-based health-financing schemes.

With the exception of Vijaya Youth Club Credit Union, all other Asian community-based health-financing schemes described in this section provide coverage for normal deliveries, deliveries with complications or prenatal care. Six of them also provide postnatal care. None of the Asian community-based health-financing schemes provide coverage for transportation costs.

3.2.1 Gonoshasthaya Kendra Health Care System's Community Insurance Scheme, Bangladesh

Gonoshasthaya Kendra (GK) is one of the biggest non-governmental organizations (NGOs) in Bangladesh offering affordable health care services and medicines to the local population living in ten rural areas[27] and one urban area (Dhaka). It started offering a number of health care services in 1972 and set up a Community Insurance Scheme in 1975. In 2001, GK had a membership of 116,054, 55,586 of which (47.9 per cent) were women members. The scheme covers domiciliary level of primary and secondary health care.

[27] Savar, Bhatsala, Sreepur, Saturia, Serajgonj, Shibgonj, Sonagazi, Kashinathpur, Cox's Bazar and Charfesson.

The organization works for the development of women's status in Bangladesh. By insuring and offering maternity care, the organization aims to ensure better health for mothers and children, reducing maternal morbidity and mortality as well as infant mortality. GK considers the insurance package and the services offered as demand driven.

Since 1972, GK has been offering prenatal care to poor women. When the Community Insurance Scheme was established, prenatal care, together with delivery care and postnatal care were covered by the insurance as maternity benefits. These benefits are either free-of-charge or involve co-payments on a sliding scale, depending on the socio-economic status of the families. The following describes the range of maternity benefits insured by the scheme, which are serviced by trained birth attendants, qualified midwives, paramedics, doctors and obstetricians:

- Prenatal care: routine prenatal check-ups; medicines; referral for pregnancy with danger symptoms and for pregnancy with major complications; education on nutrition; Tetanus vaccinations.
- Delivery care: qualified medical personnel as mentioned above; hospital care.
- Postnatal care: routine check-ups for mother and baby; education on nutrition including encouraging mothers to breast-feed; medicines; hospital care.

Any family from GK's catchment area can join the scheme. A special scheme is also offered to families living outside the catchment area. There is no waiting period for out-patient care.

The number of insured women who benefited from the maternity care grew from 6,899 in 1996 to 10,749 in 2000.

1996: 6,899
1997: 9,065
1998: 9,852
1999: 9,977
2000: 10,749
2001: 10,897 (Projected)
Total: 57,439

3.2.2 Rural Health Programme of Grameen Kalyan, Bangladesh

Grameen Kalyan, a not-for-profit company, is the health service arm of the much larger, internationally renowned Grameen family. The Grameen family launched the Rural Health Programme in 1993, and Grameen Kalyan took over the management of the programme in 1997.

The Rural Health Programme has been insuring and offering its members maternity care from its inception. The objectives are to increase pregnant women's access to health services in rural Bangladesh, to prevent and reduce maternal mortality in the vicinity of Grameen's health centres and to improve reproductive health in rural Bangladesh.

In 2001, 19,147 women benefited from the Rural Health Programme. Each year, thousands of women use the maternity care services covered under the programme:

1996: 2,933
1998: 4,080
2000: 5,103

The range of maternity care insured and offered by the programme, which often includes a small co-payment or is priced preferentially, is as follows:

- Prenatal care: free routine check-ups by health care worker; low cost medicines; laboratory tests by trained laboratory technicians at half the market price; referral for pregnancies showing danger symptoms and major complications.
- Delivery care: delivery by trained traditional birth attendants; who are supplied with birth kits; referral of delivery with complications - 10 per cent of the hospital costs is covered (approximately Tk 500-1,000).
- Postnatal care: free routine check-ups for mother and baby; education on nutrition including breast-feeding; vaccinations for babies; low cost medicines.

Female health assistants provide door-to-door basic health services, while qualified doctors and female paramedics provide prenatal and postnatal check-ups. Enlisted and trained traditional birth attendants handle deliveries.

Local people, who are covered by eleven Grameen Health Centres, are entitled to join the programme. Other rural villages not covered by Grameen Health Centres but are within a radius of 8 kms are also eligible.

The government of Bangladesh provides treatment for pregnancies with complications. These cases are referred to specific Maternity Hospital with Emergency Obstetric Care (EOC). However these services are provided at the Thana level (district level) and are not always accessible to the rural population. The Rural Health Programme has an important role to play as a quality health care provider with qualified personnel, working in remote rural areas.

3.2.3 Action for Community Organization, Rehabilitation and Development (ACCORD), India

ACCORD is an NGO working with the tribal communities at Gudalur, implementing development programmes as well as advocating tribal people's land rights. The tribal communities' population only accounts for 10 per cent of the total local population. However, poverty and their low social status mean that they experience great difficulties in obtaining adequate health care from the often poorly equipped and poorly staffed government hospital at Gudalur.

ACCORD has access to 8 health centres at Gudalur, as well as the Gudalur Adivasi Hospital, which was opened in 1990. The hospital is owned by Adivasi Munnetra Sangam (AMS), a federative body for the development of tribal people. In 1992, ACCORD initiated a 'Composite Social Insurance Package', which covers health, damage to huts and belongings, death and permanent disability of the head of the family. However, since the second half of 1997, child birth is covered under the package. This is in addition to five pre-natal health check-ups at clinics run by ACCORD, which have been covered under the insurance package since 1992.

There are altogether 15 health animators serving the tribal communities at Gudalur. Thirteen of them are women, reflecting the fact that it is easier for women health animators to sensitise and work with women members. Tribal women play a vital role in maintaining the health of their families and their communities. Health animators are trained for three to four years at ACCORD's hospital before serving the communities. Apart from detecting various illnesses, giving health care information and registering pregnant members, they also perform the duties of a midwife. Pregnant women members are advised to seek five pre-natal check-ups.

These check-ups include weight monitoring, immunisations, blood pressure measurement, iron tablets and information on nutrition.

The insurance package covers only the first and second deliveries. Most women members are daily wage earners and a hospital delivery incurs a loss of daily wages. Therefore, they prefer to deliver in their own villages assisted by a health animator. ACCORD also promotes home delivery, as it is less costly. However, pregnancy with complications and women with prior miscarriages are delivered at Gudalur Adivasi Hospital.

After the delivery, the baby is provided with a health card and is entitled to growth monitoring, vaccinations, and occasionally, nutritional supplements up to the age of five. The government hospitals provide the vaccinations, which are administered by nurses from the government hospitals.

The annual premium is Rs. 17 per person. It is collected annually between January and March, either in cash or in kind. Even though pregnant tribal women are entitled to free delivery at government hospitals, many of them have chosen to subscribe to the insurance package, as they believe the quality of care at the local government hospital is unsatisfactory. In addition, the local government hospital is often short of medicines.

The delivery cost at Gudalur Adivasi Hospital is between Rs. 500 to Rs. 700. After each delivery, the hospital sends a bill to ACCORD, which in turn claims reimbursement from the insurance company. The maximum reimbursement for hospitalisation is Rs. 1,500. Compared to private hospitals, which charge Rs. 3,000 to Rs. 4,000 for each delivery, delivery costs at Gudalur Adivasi Hospital are relatively modest. An ambulance is also available at a cost of Rs.200 but is not covered by the insurance package.

ACCORD has detected changing health problems within the tribal communities. At the beginning of the programme, diarrhoea and malaria were the most common illnesses. These are being replaced by smoking and alcohol related problems.

In future, ACCORD plans to attract more people from other tribal villages at Gudalur to join the insurance scheme. It also plans to set up an insurance package that covers an entire tribal village with only one subscription. It hopes the insurance company could contribute partially to the cost of providing health care education in the villages on the premise that more and better health education will reduce health risks and that this will also directly benefit the insurance company.

3.2.4 Integrated Social Security Scheme of Self-Employed Women Association (SEWA), India

The Integrated Social Security Scheme of Self-Employed Women Association (SEWA) offers its women-only trade union members a range of insurance coverage (life, disability, asset, health and maternity) in partnership with two professional insurance companies.

SEWA members can only benefit from the insurance if they pay an annual fee or deposit a lump-sum payment with SEWA Bank.

A member can choose to pay an annual subscription fee of Rs. 85, Rs. 200, or Rs. 400 (to cover both herself and her husband) to be entitled to all the benefits mentioned above, except maternity benefits, at different amounts.

She is only entitled to maternity insurance and lifetime insurance coverage if she deposits a lump-sum payment of Rs. 700, Rs. 1,800, or Rs. 3,600.

The design of the maternity insurance allows SEWA to provide additional free coverage to women members aiming at encouraging them to opt for lifetime insurance membership. When a lifetime insurance member becomes pregnant, she is entitled to a cash benefit. which can be claimed three months before or three months after the delivery. The cost of a normal delivery at a government hospital was in 2001 around Rs. 500-Rs. 700. Although the cash payment does not cover the total cost of delivery, it is still a useful contribution to the total costs related to childbirth. In addition, woman members can seek free prenatal and postnatal consultations with an in-house general practitioner.

3.2.5 Maternity benefit scheme of Vijaya Youth Club Credit Union, Nepal

Women members of the maternity benefit scheme of the Vijaya Youth Club Credit Union (VYCCU) are very poor. The cost of a delivery at government hospital is between Rs. 1,000 and Rs. 3,000, depending on whether it is a normal delivery or delivery with complications. The cost of delivery at a private hospital is even higher. Consequently, delivery at a hospital is, therefore, out of reach for many poor women in Nepal.

The Vijaya Development Resource Centre (VDRC) in Newalparasi district, a local NGO, was very concerned by the high rate of maternal death in Nepal. It decided to set up a maternity benefits scheme in 1997 through the VYCCU, an organization under the umbrella of the VDRC, to provide a fixed Rs. 300 maternity benefit to all the female members of its Savings and Credit Programme.

When the Savings and Credit Programme was set up in 1991, all 28 members were men. Today, there are 3,000 women members in the programme, who account for around 40 per cent of the total membership. All women members are automatically covered by the maternity benefit scheme.

The cost of maternity benefit is financed solely through income generated from the various savings funds of the Savings and Credit Programme. When a woman member gives birth at a hospital, her relative submits a claim to the VYCCU. A supervisory committee verifies the claim and, within a day Rs. 300 is paid to the member's family.

Since 70 per cent of the members of the programme are considered very poor, this additional bonus of Rs. 300 is useful for the women members and constitutes an incentive for a woman to become a member of the programme.

3.2.6 Bukidnon Health Insurance Programme (BHIP), the Philippines

In 1994, the Philippine Medical Care Commission, together with the Local Government Unit, set up the Bukidnon Health Insurance Programme (BHIP) which is one of the very first community-based health micro-insurance schemes. It insures members for out-patient care, in-patient care, laboratory services and dental services.

The BHIP charges an annual premium of P. 720 per person. The benefits, which are available after a variable waiting period ranging from two to five months, depending on the month a member registers, include:

In 2001, the BHIP had a total 28,000 members and 45 per cent were women. Maternity care covered under BHIP are as follows:

- Prenatal care: BHIP provides referral to doctors or hospitals for pregnancies that show danger symptoms or pregnancies with major complications (government hospitals provide free regular prenatal check-ups).
- Delivery care: up to P. 5,000 for the first normal or first complicated delivery at a hospital. This benefit is classified under in-patient care and there is a waiting period of 10 months. At government hospitals, normal delivery only costs between P. 1,000 and P. 2,000. Hence the reimbursement level for delivery under the BHIP is deemed satisfactory.
- Postnatal care: out-patient or in-patient benefits, depending on the type of medical care. A member is obliged to bring her newborn baby for free vaccinations at a government hospital before the baby is classed a dependant under the BHIP.

During the four years between 1997 and 2000, 43 members benefited from maternity care covered by the BHIP. It is envisaged that women members will have access to more comprehensive maternity care if all the BHIP members join PhilHealth's National Health Insurance.

3.2.7 Bustos LGU – PhilHealth Project (Medicare Para sa Masa), the Philippines

The Mayor launched an initiative in 2000 to set up a partnership between Bustos Local Government Unit (LGU) and PhilHealth with the objective of offering the local population affordable health micro-insurance with a comprehensive benefits package. The main aim is to make health care services more easily available and accessible to the very poor and thus improve their quality of life.

Maternity benefits offered by the insurance are as follows:

- Prenatal care: free to the local population at the Rural Health Unit and Barangay Health Station with or without health insurance.
- Delivery care: normal deliveries at the Rural Health Unit and the Barangay health station are fully covered. Deliveries with complications are covered under PhilHealth's National Health Insurance, which means that only 40 per cent of the cost is reimbursed.
- Postnatal care: routine check-ups for mother and baby; education on nutrition; nutritional supplements for mother and baby and designated medicines.

To date, 1,210 families have subscribed to this scheme. The number of women beneficiaries amounts to more than 1,200. In the 18 months since the insurance scheme was launched, more than 80 women beneficiaries have availed themselves of the maternity benefits.

The project considers the coverage for maternal and child health very important since children's health can only be strengthened if the mothers' health is adequately covered. The ultimate plan of the project is to provide universal health care coverage to the local population.

3.2.8 Novaliches Development Cooperative, Inc. (NOVADECI), the Philippines

Founded in 1976, NOVADECI is one of the largest cooperatives in the Philippines offering a host of services such as credit, insurance, health care, training and education.

The NOVADECI Health Care Plan (NHCP) was set up in 1993 with the aim of providing quality health care services to its members at affordable prices. With a fixed deposit, a member just

needs to contribute a one-time payment of membership fee and an annual premium to obtain family insurance coverage ranging from free medical consultations, free annual medical check-ups, discounted laboratory examinations, dental and optical services, and a fixed reimbursement for hospitalisation and delivery. There are two doctors working full-time at the NOVADECI clinic to provide various health care services.

The maternity care offered by NHCP in 2001 was:

- Prenatal care: three free prenatal consultations at NOVADECI clinic.
- Delivery care: up to P.5,000 reimbursed for hospital delivery at any hospital or maternity clinic; the normal delivery costs at the government hospitals are around P.1,000 and P.2,000; at a maternity clinic they are around P.2,500 and P.3,000; at private hospital it costs between P.10,000 to P.15,000. Most NHCP members tend to go to government hospitals for delivery.

NOVADECI's total membership was 6,200 in 2001, 72 per cent (4,464) of whom were women. Maternity care is identified as an important part of their health care needs.

Some 900 to 1,000 members have registered for the Health Care Plan, with women making up 80 per cent of the membership. It is not clear whether the high percentage of women members is due to the HCP's focus on women's health needs or because the plan simply reflects the health needs of its members.

There is a 12-month waiting period before a member can use the maternity care. There is no waiting period for other services. Costs covering hospital delivery or hospitalisation in general are reimbursed within two to three days.

3.2.9 ORT Health Plus Scheme (OHPS), the Philippines

ORT Health Plus Scheme (OHPS) is a non-profit community-based health micro-insurance programme set up and managed by ORT Community Multi-Purpose Cooperative at La Union since mid-1994. All members of the ORT cooperative, family members of children who attend ORT day care centres and the population living in barangays (municipalities) where ORT centres are located, are eligible to register for the Health Plus Scheme.

Most members of OHPS have registered for family membership. With a fixed payment, up to 6 family members are insured for a range of health care services. For those families with more than 6 members, the premium rises to P. 150 per month. Health care services covered under OHPS are:

- Out-patient care: free general and specialist consultations; vaccinations; laboratory tests; X-rays; prescribed essential medicines.
- In-patient care: up to 45 days extensive in-patient care at Ilocos Training and Regional Medical Centre (ITRMC).

In order to give insured members with modest incomes access to comprehensive health care services, OHPS also covers a wide range of maternity care for women members, as long as they have paid premiums for 12 months prior to availing themselves of the services. These maternity care are:

- Prenatal care: 6 obligatory prenatal check-ups; prescribed essential medicines; referrals for pregnancy with danger symptoms, sexually transmitted diseases or major complications.
- Delivery care: normal or caesarean delivery at ITRMC.

- Postnatal care: routine check-ups for mother and baby, education on nutrition, nutritional supplements for mother and baby and prescribed essential medicines.

The number of families who have subscribed to ORT Health Plus Scheme has steadily increased from 160 in 1994, 282 in 1995, 653 in 1999 and 800 in June 2001. Hospital deliveries covered by OHPS also increased between 1996 and 2000. During the past 5 years, OHPS has paid out insurance benefits for 27 hospital deliveries.

ORT Community Multi-Purpose Cooperative intends to maintain current level of maternity benefits covered by OHPS in the near future. While the government only provides free vaccinations and other preventive health care services, there is still a strong need from the local population for an affordable health insurance scheme that provides comprehensive health care benefits.

3.3 Latin America

There are two major reasons that give rise to only one community-based health-financing scheme from Latin America being described in this report. The first was a communication problem. Most Latin American schemes with e-mail addresses received the questionnaire, while questionnaires sent by fax only reached three schemes. Several attempts to contact the schemes that could not be reached by e-mail or fax were unsuccessful.

Altogether, only two replies were received from Latin America. One is described in this report, because the other reply arrived too late to be incorporated into the report.

More research needs to be undertaken on Latin American community-based health-financing schemes.

3.3.1 Asociación mutual S.M. LASPIUR, Argentina

Asociación mutual S.M. Laspiur was set up in 1990. It covers members for nursing care, vaccinations and hospital treatment. However it does not offer specific health care services for pregnant women. Only discounted prices are given for nursing care sought at a local establishment where S.M. LASPIUR has an agreement.

Insured members have the right to health care offered by the state. However, the public health care service provider is more than 50 kms away. The only health care provider in the area is privately owned and it does not receive state contributions to provide maternity care. This means that when a woman requires maternity care, she is obliged to go to the nearest public health centre, which does not always have all the necessary facilities for optimal care.

Women generally choose to join S.M. Laspiur because the cost is low. Nursing care is given at home and babies are given vaccinations. Insured members also can benefit from discounted prices when seeking health care in the private sector. It also provides credit to insured members to finance their health care needs. S.M. Laspiur would like to be in a position to provide prenatal and postnatal health care to both mother and child but lacks the necessary financial resources. Maternity care seems to be an area where there is little funding and heavy subsidies are necessary.

Questionnaire on Maternity Care, for organisations with Health Micro-Insurance Schemes

I. Does your Health Micro-Insurance Scheme cover health care and other related services to insured pregnant women (maternity care)?

Yes ❐ (Please kindly answer questions 2 to 13) No ❐ (Please go directly to question 13)

II. Please list the health care and other related services that are covered specifically for insured pregnant women and for which the costs are covered by the Health Micro-Insurance Scheme *(please also state from which year to which year the relevant services have been covered by the insurance scheme)*

III. **Before delivery (prenatal care)**: e.g. routine prenatal check-ups by health care worker, nurse, midwife and/or medical practitioner ; medicines ; referral for danger symptoms of pregnancy ; referral of women with sexually transmitted diseases ; referral for major pregnancy complications etc.

____

____

IV. **Delivery care** : e.g. trained birth attendant, qualified midwife, doctor, surgeon, hospital care, medical supplies, pharmaceuticals, food.

____

____

V. **Transportation costs** between home and the clinic/ hospital for delivery

____

____

VI. **After delivery (postnatal care)** : e.g. routine check-up for mother and baby ; nutritional education, especially information and encouragement of breast feeding ; nutritional supplements for mother and baby ; and medicines, etc.

____

____

VII. Who is eligible to join the Health Micro-Insurance Scheme offered by your organisation?

____

VIII. After joining a Health Micro-Insurance Scheme, how many months does an insured woman have to wait before she can make an insurance claim for maternity care provided by your organisation? ______________ months

IX. Please state the type(s) of benefits that is/ are provided (please circle appropriate answer(s))

Cash benefits

A. *Specific lump-sum payment* (amount:)

B. *Other cash payments* (please specify:)

Medical benefits

A. *Provision of health care and other related services by (specifically appointed) health care provider(s) and other related service provider(s)*

(Please state condition(s) and limitations that are applied, if there is any)

____

B. Total or partial refund of the medical costs when presented with receipts

(up to amount :)

(How long does it take to get the refund ? __________weeks / ___________months)

X. Annual premium of the Health Micro-Insurance Scheme (Please also state the currency):

1996 ____________________________________

1997 ____________________________________

1998 ____________________________________

1999 ____________________________________

2000 ____________________________________

2001 ____________________________________

XI. Total number of **insured women** of the Health Micro-Insurance Scheme in 2001 is

women members ______________________________

wives of male members ______________________________

XII. Total number of insured women, who benefited from maternity care each year is

1996 ____________________________________

1997 ____________________________________

1998 ____________________________________

1999 ____________________________________

2000 ____________________________________

2001 ____________________________________

XIII. Why has the organisation chosen to provide maternity care?

____

____

XIV. How does the organisation decide which maternity care to cover by the insurance scheme?

____

____

XV. Who are the health care provider(s) and other related service provider(s)?

____

____

XVI. Does your organisation intend to continue or expand the types of maternity care covered through your insurance scheme? If so, how?

____

____

XVII. Are insured women of the Health Micro-Insurance Scheme of your organisation entitled to government provided maternity care? If so, what types of maternity care do they receive?

____

XVIII. Why do these women choose to be insured by your organisation's Health Micro-Insurance Scheme

The following question is only relevant to those organisations that do not offer maternity care as part of the Health Micro-Insurance Scheme.

XIX. Would your organisation consider providing maternity care? If yes, please give more details regarding the provision of the planned maternity care as part of the present benefits package offered. If no, please briefly explain the reasons.

Exchange rates (as of October 2002)

Currency	**To 1 US$**
Francs CFA (Mali, Sénégal, Togo, Burkina Faso)	670,3880
Tanzanian Shilling	977,4400
Uganda Shilling	1795,0000
Indian Rupee	48,2000
Nepalese Rupee	78,0000
Philippine Peso	52.4000
Taka (Bangladesh)	57,8600