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Grassroots Women and Peer Learning: Home-Based Caregiver Networks and Health Mutual Funds

Pamela Ransom¹

Abstract

Universal access and financial risk protection are identified as health targets in global negotiations for post 2015 development goals although these represent difficult challenges for countries burdened by overstretched budgets and growing populations with increasingly complex health care needs. In many parts of Africa health financing is characterized by weak, under-resourced systems, high out of pocket contributions and lack of donor will. The paper gains insight from small scale, creative financing strategies for health emerging among the very poor through innovations of grassroots women's networks. We explore the influence of peer learning and information exchange in women's home-based caregiver networks that emerged in response to the HIV/AIDS epidemic in various parts of Africa. This examination of an Africa/ Asia peer exchange focuses on results of information sharing, particularly replication of the shared "best practice" of a health mutual fund model among caregiver groups from Kenya, Uganda and Nigeria. In all three countries semi-structured interviews of peer exchange participants report rapid launch of a fund (within one to two years in all three countries) after participants returned. Additional replications in the form of spin off funds are the result of women's engagement in follow up education and training. The paper examines characteristics of the replicated health mutual funds uncovering potential for new partnerships with governments in years to come.

Keywords: Health Mutual Funds, Peer Exchanges, Home-based Caregivers, Grassroots Women

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Access to affordable health care and financing are recognized as important global objectives in UN General Assembly resolutions encouraging governments and civil society to move towards these development goals (UN General Assembly, 2012). Protections from financial risks due to health are essential components in the fight against poverty and countries have been

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called to “urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services” (para.22). The Director General of the World Health Organization remarked in a high level meeting on the post 2015 development agenda that she “regard(s) universal health coverage as the single most powerful concept that public health has to offer” with a Task Team on Health synthesizing input from global thematic consultations reinforcing support (WHO, 2012, Tran, 2012, Task Team on Health, 2013). By spring 2015 universal coverage and financial risk protection remain proposed targets for the UN post 2015 sustainable development health goal of “ensuring healthy lives and promoting well-being for all ages” (BUSC, 2015; UNECOSOC, 2015).

These ambitions pose challenges for countries burdened by overstretched budgets and growing populations with complex health care needs. In many parts of Africa for example, health financing lies in the context of weak, under-resourced health systems, high out-of-pocket contributions and lack of donor will to finance broad-based programs. Thus calls for alternative resources and strategies for empowerment of communities to meet current needs continue to be renewed (WHO Africa Region, 2012, Nepad, 2007-15).

It is useful to gain insight from creative strategies for health financing emerging among the poor through innovations in grassroots women’s networks. We address the question of how women’s groups have learned to make adaptations to meet health-financing needs. We focus on one voluntary model, a health mutual fund. Our case examines transfer and expansion of health mutual funds in various parts of Africa among home based caregivers. We explore phases of inception, transmittal and replication through study of the influence of peer learning and information exchange. This lies in the context of broader issues of movement-based empowerment as grassroots women come together to meet collective needs.

Health Mutual Funds

In the developing world we find various ways groups and associations organize members to be proactive in ensuring adequate resources for health. Mutual health funds are one type of prepaid health financing strategy involving individuals coming together through networks and participatory structures to “finance or co-finance costs associated with health services” (Mtei, Mulligan, 2007; Carrin, 2003). This form of community financing also offers opportunities for engagement attractive for those involved. Atim (1998) identified “health mutual organizations” in a number of countries in west and central Africa as voluntary, nonprofit insurance schemes built “on the basis of mutual aid, solidarity and collective pooling of health risks in which members participate effectively in its management and functioning”.

Communal pooling of resources for health takes various forms including community health funds and micro-insurance serving similar goals (Carrin, Welkein & Criel, 2005). These structures are useful for trade associations or others who build on strengths of solidary, participation and shared management to meet health risks (ILO, 2001; Atim, 1998). The ILO (2001) found examples within informal associations of microenterprises. These funds offer a range of useful health services including reimbursing medical expenses, paying for accidents, negotiating prices for members and launching health campaigns. Characteristic principles include solidarity between members, democracy and participation of members in decision-making, autonomy and freedom (from government authorities etc.), strengthening personal development (respect for dignity and sense of responsibility) and nonprofit objectives (p. 21).

Similar mutual and community health funds have been integrated into financing initiatives funded by the World Bank. In Senegal women's associations formed "health mutual societies" with support from the Urban Women's Programme Network through Profemu and Oxfam. These provide a form of micro-insurance with small regular member contributions pooled to meet health expenses (Shiner, 2003, Africa Step Team, n.d.)

Atim's (1999) research in Ghana and Cameroon focused on influence of social movements on non-profit, voluntary health insurance strategies. The analysis builds on Develtere's (1993) definition of a social movement as any "spontaneous collective attempt" to reach common goals or interests through collective practices or organizations which help attain the vision (Atim, p. 882). Atim (1999) identified inclusive mutual health associations or movements as one of five types of social movement based schemes. While these grow from professional associations, enterprise or trade unions, traditional solidarity networks arise from ethnicity or clan. Simple/ low participation community financing does not involve participants in management, in contrast to complex high participation models where involvement of members is key, often in partnership with health providers. Mutual aid societies finally are larger and include professional staff.

Health mutual funds sometimes provide extra support for those in need, although questions remain about their effectiveness in reaching the very poor (Ekman, 2004). One Tanzania study tracks a community health fund started in 1996 involving voluntary prepayment through use of a card. The fund successfully offset health care cost risks for the poor, expanding by 2003 to cover many districts (Mtei & Mulligan, 2007). Evidence from Burkina Faso shows their potential to protect household assets in rural areas and in the Democratic Republic of Congo, researchers found participation in a similar fund linked to more intensive use of health services (Parmar, Reinhold, Soares, Savadogo, & Sauerborn, 2012; Kutzin and Barnun, 2012). Creese and Bennet (1997) caution that most voluntary, non-profit insurance schemes are limited in coverage, scope or ability to reach the poor. Literature reviews cite large gaps in research on voluntary health financing in Africa, with inadequate understanding of these schemes inception, initial development or relationship to issues such as gender and empowerment (Spaan, Mathijssen, Tromp et al., 2012). We seek to further explore these themes through a look at health mutual funds expansion among grassroots women's home based caregiver networks.

Peer Exchanges and the Home Based Care Alliance

One social movement focused on health is the Home Based Care Alliance that emerged in recent years from broader global networks formed to empower grassroots women. In many countries throughout Africa the tasks of providing care for the sick, frail and elderly became particularly dire in the face of the escalating HIV/AIDS epidemic throughout the 1990's. As the numbers of individuals, particularly women, taking on tasks of care and support grew, a space emerged for formation of a supportive network for those in the care giving role. The Home Based Care Alliance (HBC Alliance) formed in 2005 with support of Groots International and the Huairou Commission, powerful global networks formed by the former head of UN Habitat at the Fourth World Conference on Women in Beijing. Their aim was to ensure grassroots women's connections at both the global and local level to facilitate self-empowerment and support (Ransom & Asaki, 2013). Over time, the HBC Alliance has grown into a 30,000 member federation of locally based groups across twelve African countries with leadership structured through local, regional and district hierarchies and NGO's providing supportive national coordination.

Social networks such as these sometimes influence the learning process. Networks help facilitate not only the way people seek out and transmit information, but also awareness, assessment and how participants “value” what they come to know (Borgatti & Cross, 2003). Structured learning through peers is one example of this influence on knowledge acquisition. Although specific mechanisms are not well understood, shared interests, values and ideas about change may play an important role (Gabriele & Montecinos, 2001, Jeanetta, 2007 p.2). In global women’s networks that nurtured creation of the HBC Alliance, peer exchanges emerged over time as a popular learning form. These are distinguished from ordinary training programs as a unique “exchange of ideas and experiences” between those with similar capacities and needs (Jeanetta, 2007 p.2). Peer exchanges between groups of grassroots women have been organized by networks in the Huairou Commission/ Groots International on an array of diverse themes. Through this exciting framework women come together over several days to simultaneously teach and learn through sharing proven best practices. The ultimate goal is stimulating empowerment through replication of innovations when participants take information home. A successful peer exchange involves various steps including participatory planning, identification of stakeholders (including allies, partners and funders), following guidelines for event documentation and hosting as well as careful post exchange follow up and evaluation (ibid p.4).

The India/Africa Peer Exchange

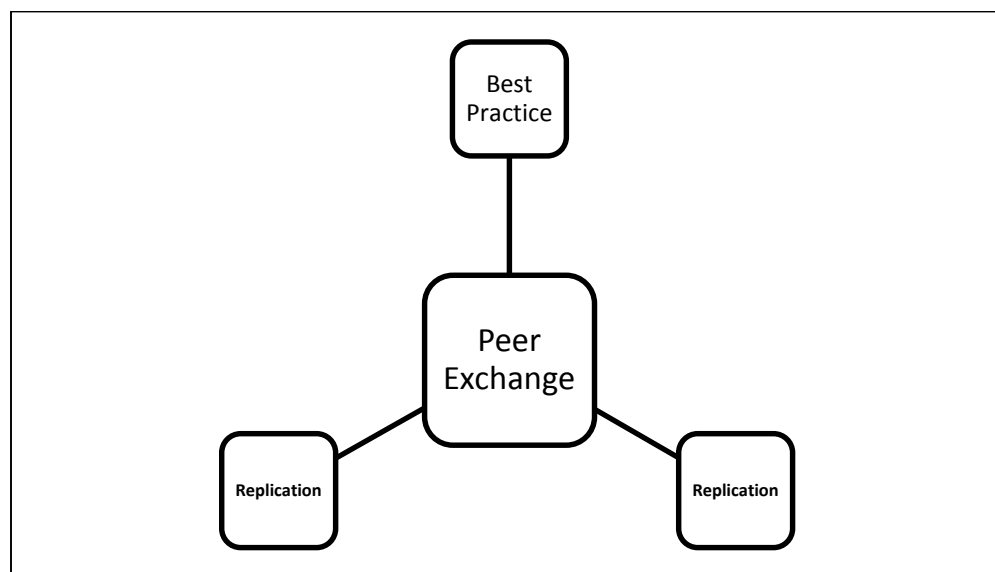
In 2009, a cross cultural peer learning exchange brought together representatives of the Home Based Care Alliance from four countries in Africa to learn from grassroots women’s federation members from India. The goal was to encourage “knowledge sharing and transfer of effective practices in health, community led HIV/AIDS initiatives, savings and credit groups and livelihoods” (Groots India-Africa Learning Exchange, p.2). The five-day event held in 2009 was organized by the Indian women’s group Swayam Shrikshan Prayog (SSP) and Groots International (Groots, 2009). Participants from the host country of India included 20 grassroots leaders from women’s federations in three states (Gujarat, Maharashtra and Tamil Nadu), while the African participants included four women’s grassroots groups from four countries who were national coordinators for Home Based Care Alliance groups. Kenya was represented by Groots Kenya, Uganda by the Uganda Community Based Organization for Child Welfare (UCOBAC), Nigerian participants were from the International Women’s Communication Center, while the Ntankah Village Women Common Initiative Group came from Cameroon. These were all linked through membership in the global Groots International/Huairou Commission women’s network.

In the peer exchange there was first an effort to learn about activities of the women’s grassroots federations in Maharashtra, Gujarat and Tamil Nadu in India, with presentations made on various innovative methods used to address regional needs (Groots, 2009). The second day focused on best practices in health, with participants sharing successful health initiatives, touring a primary health center in the Maharashtra host state and talking with community members about health services. The Indian host group, SSP, showcased their launch of a community health mutual fund started with involvement of the Oriental Insurance Company in 2006 (Groots A-I Exchange, 2009).

The mutual health funds goal was to strengthen the economic safety net for women federation members struggling with high interest loans taken to respond to family or personal health care needs (SSP, n.d). The fund is run and marketed by federation members and was introduced to women in the area through a participatory, door-to-door educational process. Self-

help groups collect contributions with a health mutual fund launched when a minimum of five hundred people became involved (Groots India-Africa Learning Exchange, n.d.) By 2009 the fund had grown to involve more than 13,000 policyholders with each member paying Rs. 100 annually. Members carry photo identification cards showing eligibility for reimbursements for 20% of the cost for public and up to 60% for private hospitals. Discounts on other medical services resulted from negotiations between the women’s federation, doctors and other health providers.

Fig.1.1 Grassroots Women’s Peer Exchange Learning Model



The African women who were HBC Alliance coordinating group members in the peer exchange responded with enthusiasm after learning about the health mutual fund concept. Following the presentations they talked over potential benefits and possibilities for replication of this strategy within their home countries.

To understand more about the role of women’s social networks in inception, and development of voluntary health financing, we focus on this case example of peer learning. We hope to understand more about how effective the peer exchange is as a strategy for influencing adaptation of the health mutual fund model among grassroots women’s groups. Change in practice is one clear method to determine successful learning outcomes. Examining the dynamics surrounding transfer of the health mutual fund concept after the peer exchange as participants returned to Africa helps assess not only the impact of learning from the exchange but also the extent of achievement of original peer exchange goals. The original aim was to transfer one best practice in health among network members. Three central questions will be addressed. How do women in a grassroots network describe the extent of follow-up in Africa regarding health mutual funds after the best practice was first introduced in the peer exchange? How do they describe subsequent efforts towards health mutual fund replication by the HBC Alliance? And finally, how do they assess future prospects and additional peer exchange needs regarding health mutual funds?

Our exploratory study draws information first from document reviews from the African/India peer exchange event. To assess outcomes from the event, semi-structured interviews took place with each of the African HBC Alliance national coordinating group participants who attended the Africa/India peer exchange event. Only one group in Cameroon did not respond to

the request for an interview, indicating only briefly in written form that they had started a health mutual fund. Results were coded around several themes including 1) HBC Alliance follow-up after the peer exchange 2) health mutual fund replication in Africa (management, participant satisfaction and challenges) and finally 3) future prospects and additional peer exchange needs regarding health mutual funds. We conclude by relating findings to identified principles of health mutual funds.

Results

Nigeria

At the Africa India Peer Exchange the HBC Alliance in Nigeria was represented by a participant based in the city of Ilorin in Kwara state. The interview revealed that after return from the peer exchange a debriefing meeting introduced Nigerian HBC Alliance members to the concept of a health mutual fund. Members already understood the idea of microcredit loans and quickly saw potential benefits of starting a health mutual fund. The respondent comments that, “we saw the wonderful work that was being done in India and within two months after attending the peer exchange started our own health fund.” The idea caught on because although many aspects of health care in Nigeria are free for those with HIV AIDS, caregivers and their families were often grappling with high costs of care.

The respondent noted that since the launch of the mutual fund in Kwara state the fund has grown to include 1600 HBC Alliance members (representing 32% of the 5000 HBC Alliance members nationally). These high levels are the result of the Alliance organizing 160 local coordinators who each recruited approximately ten paid members to the health mutual fund. It was further suggested that each of 16 Local Government Areas in Kwara state have a fund with meetings in each of the areas. Each area has a caregiver coordinator. Each participant (including Alliance home based caregivers, some of their family members and some families they care for) contributes approximately three dollars collected monthly from both. Funds are repaid without interest with no firm time is set for repayment, however the sooner funds are repaid the more quickly a new loan may be made. Participation also includes some outsiders, particularly from other grassroots women’s groups such as the market women’s association and women from garment and tailoring workers networks. Meetings take place the 26th of each month and there is a passbook in which people mark the amount paid. The various other groups and associations send a representative who state how much they are contributing as well as the numbers from their group that need support

All allocated funds go for various types of health related expenses such as paying for drugs or surgery. “The highest amount allocated for each household is approximately \$50”. At each meeting a list is drawn up of those scheduled to benefit in the next funding distribution although the numbers interested in receiving support were reported to be “increasing every day”. It was noted that, “at each meeting funds might be given to ten families but there are usually twenty or another forty who need support.” Management occurs through committee and members are reportedly “very satisfied” with the mutual fund. The primary challenge involves problems of the length of the waiting period for those needing support.

Health mutual fund members are identified through a pink card, which is distinct from a yellow card allocated for HBC Alliance members who contribute to another microcredit loan program. When members join the microcredit loan program they also get the health mutual fund card. These cards are used to obtain special discounts available to members from some hospitals

and clinics. We have established partnerships with some clinics and hospitals. These are the twelve government hospitals. We have established different types of arrangements with each in terms of the levels of discounts for those who present the cards. Starting in 2009 when we first set up the Health Mutual Fund we began to visit the hospitals and clinics to set up these special arrangements.

When asked about future goals for the fund there was an expressed desire to create a women's bank that merges the microcredit loans and health mutual fund. In addition, there is also a wish for more women from the HBC Alliance in Nigeria to return to India to have a chance to observe mutual fund operations firsthand. The representative comments that, "at the first India Africa peer exchange it was just me who got a chance to see their operations. It would be useful to take five other women to India to see the process."

Uganda

In Uganda, the following reflects responses from the HBC Alliance coordinating group representatives based in Bugiri District and Kampala. One attended the Africa India Peer exchange and the other sent a response as the person responsible for mutual fund operations. The Alliance in the country is now operating in 10 districts with a six-person board running the Alliance at the national level with each of ten districts in the country also having a board and its own HBC Alliance groups. The HBC Alliance reports 3745 caregiver members in the country in recent years.

The respondent who attended the Africa India Peer Exchange mentions the decision to launch a mutual fund as a result of a debriefing soon after the return. The comment was made that "we brought home based care alliance members together after the peer exchange and discussed some of the issues we learned from the training." It was pointed out that: From this discussion, we realized there was a gap because many members of the Alliance were facing health problems for which they had no funds available and we realized that we needed to start a process of savings in cases of sickness to help with problems such as allowing caregivers greater access to drugs and to get help with access to health providers.

The first health mutual fund was started one year later in Kampala in the area of Akawa. UCOBAC, the HBC Alliance coordination group, facilitated travel to several other communities in Uganda and the women comments that "we were able to train the home based caregivers in Busia and Jinja." Since then, ten communities across the country launched health mutual funds to support caregivers including Bugiri, Mbuya, Nakawa, Kawmpe, Lunguja, Masaka, Jinja, Kaongo, Busia and Lugaga.

The respondent notes that "in the various districts the name for the health mutual fund varies. Some districts may call it a hospital fund, others may call it a welfare fund." Regarding the rationale for starting, it was stated that although "we now have free medical services in our community it is not easy to access extra funds needed for costs related to health and these funds are used to help with various types of unexpected costs." In the district of Bugiri, for example where one respondent was based, there are now 200 caregivers in the HBC Alliance, of which just over one quarter, 55 (27.5%) are reported to be part of the health mutual fund. No exact numbers are reported for health mutual fund members nationwide.

Contributions are limited to Alliance members, caregivers, people who are HIV positive who become caregivers but do not include involvement of other outside community members including those caregivers take care of. They began by collecting 10,000 Uganda shillings, although collections have since doubled and funds are reportedly collected weekly. "Funds are used to cover either costs due to sickness or death including those related to transportation, drugs or money required for treatment." The health mutual fund primarily distributes collected resources

to those in need, and partnerships have been established with public hospitals, private doctors, and government and private health centers. While there is no formal card related to membership there is an effective referral system in place involving printed “forms and flyers as a referral system to hospitals”.

A treasurer collects funds and a management committee holds weekly meetings to make allocation decisions. The committee reviews forms where members explain their funding needs and sign a repayment guarantee identifying a second responsible person. Each approved applicant has one month to use and return the funds. “Each person is allocated to receive four or five dollars in a loan, four or five times what they put in for the month.” The level of satisfaction among caregivers with the fund varied with “some satisfied and some dissatisfied” which was linked by the respondent to whether or not a person had benefitted by receiving money. Of the 55 who contribute monthly about four (13.7%) receive benefits.

The main challenges relate to difficulties in demanding repayment from those who are sick, (currently about 1% of those who receive funding never repay). Other problems include a lack of funds for regular monitoring as well as a need for better bookkeeping and savings records. In addition more education needs to take place among caregivers and community members about the health mutual fund to increase participation. Need is reported to have increased because some projects previously helping to promote the fund have ended.

For the future respondents desire additional stakeholder involvement particularly among widows, orphans as well as community nurses and doctors. They also hope that there might be more formal government recognition and support, as well as expansion of membership to all HBC Alliance members. In response to questions about what they might like from the original Indian peer exchange hosts, they would “like to know more about how they started and have an update on where they are now and what future plans they have.” They would “also like to know more about how they collaborate with health staff in hospitals and health centers, whether they have community doctors and nurses in their areas and whether they have village health teams attached to health centers.”

Kenya

In Kenya interviews reflect responses from representatives of the HBC Alliance in Kakamega and Laikipia County, both members of Groots Kenya, the network organization of grassroots women’s groups who serves as the HBC Alliance national coordinator. The HBC Alliance had close to 18,000 caregiver members in the country in 2012. The Laikipia County representative attending the Africa India Peer Exchange representative comments about the debriefing upon return from the Africa India exchange: In addition to initiating the health mutual fund in my area, I also went around Kenya to other communities affiliated with Groots Kenya and did trainings on the health mutual fund concept in either other regions in 2011. Of the eight areas where trainings took place, four have now started health mutual funds including Limuru, Kendu Bay, Kakamega and Gatundu.

In Laikipia, a health mutual fund was launched the same year as the Africa India exchange, although initially it involved only a small 50 person support group of “caregivers dealing with orphans and HIV/AIDS”. The rationale for starting the fund was because “many of the members needed money to buy medications so the idea of a health mutual fund was attractive”. Reasons for starting the fund also include the fact that: Where we live we have free healthcare available to those who need HIV/AIDS medications, but when it comes to other opportunistic medications, the

drugs available are not free. There are other types of baseline investigations and tests and if someone needs to change regimes it is very costly.

One year later, the health mutual fund initiative was expanded to other Alliance members in the area, with a current membership in the fund reported to be currently 500.

In Kakamega, the health mutual fund was launched in 2011, two years after the 2009 exchange. This is reported to be as a direct result of participation in the training referred to above. We started a health mutual fund because to get health services in my country is very expensive so many poor women cannot afford. The health mutual fund was a platform to make us save for our health and be able to have assurance that we can get treatment when we fall sick.”

The respondent also states that, “the Groots Kenya women who participated taught us how Indian women were saving money for health.” It was explained, “They have been able to have a big movement of women who are involved in savings that are helping them to improve their economy”. Alliance members were receptive since other types of women’s savings efforts had already been started in the area.

In Kakamega the mutual fund initially involved only home based caregivers and elderly grassroots women in the community. The fund now exists in two areas within the district including Lugala and Madioli, with contributions varying from \$1 to \$2 dollars per month. Contributions are accepted from caregivers, some of the people caregivers take care of (called “friends” in the Alliance), as well as family members of caregivers and elderly women caring for people with HIV/AIDS. In Laikipia of the 500 active fund members, approximately 350 (70%) are home based caregivers with no non-Alliance caregivers participating, although it was mentioned that in some cases caregivers make contributions on behalf of the persons that they care for. There are also now approximately 50 family members of caregivers contributing. A 50-shilling annual registration fee is required along with another 40 shillings collected monthly from each member. Contributions are voluntary with all contributions nonrefundable. If a person fails to contribute for one month they are allowed to contribute the next month to make up for the month skipped.

In Laikipia funds collected from members may cover a variety of specific health benefits and services that are laid out in mutual fund by-laws. If the money is not used, it goes into a revolving fund that is available for other income generating activities. There are some restrictions on what can be covered such as lifetime medications. In Kakamega funds may be used to pay for medical check-ups, treatment consultations, medicine and maternal health bills. Non-Alliance caregivers are able to become members, contributing and receiving allocations from the fund only if, “they are willing to pay into the fund and meet designated criteria for being a poor household.” Of the current 117 participants, 100 (85%) are now Alliance member caregivers, with approximately 10 (11.7%) people receiving allocations from the health mutual fund each month.

In both communities partnerships have been established with a wide range of health services. These include public and private hospitals, private doctors, (specifically army camp doctors who provide medication), government health centers and pharmacies in Laikipia and public hospitals, government health centers and clinics in Kakamega. In Laikipia mention was made of the fact that members receive a card, which can be presented to health entities with whom they have partnerships. Some services are provided free and others are discounted 50% for members.

Both communities have management committees for the funds, which include 12 members in Kakamega and 11 in Laikipia. Representatives include fund contributors, community based organizational leaders, who are caregivers and people designated as HIV positive. In Laikipia funds are collected monthly at Alliance meetings, with records of funds collected kept by both the

treasurer and secretary and recorded in member passbooks. The management committee decides funding allocations, with recipients not being required to pay back. Approximately five to ten people receive funding each month for various health care expenses.

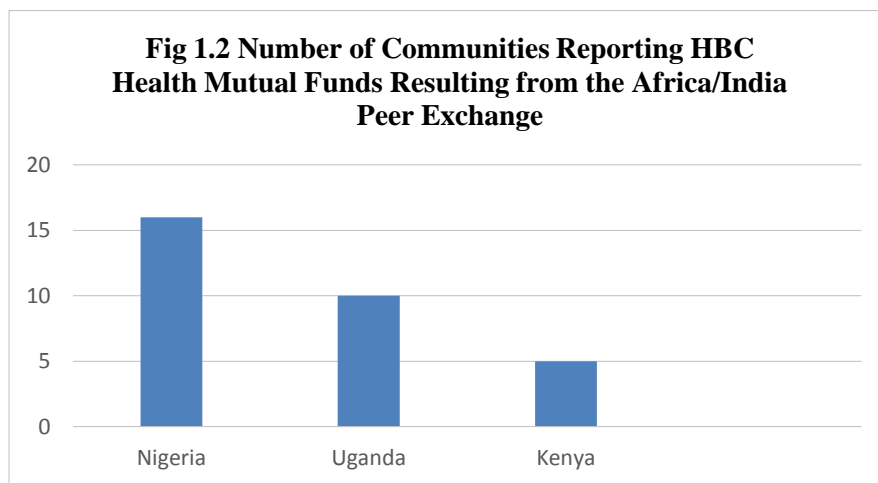
Respondents reported that in both communities caregivers were “somewhat satisfied” with the health mutual fund. The primary challenge identified in Kakamega was the fact that some members “may be very sick and require a lot of money to go to a high level hospital however the health mutual fund can only pay a maximum of 5000 Kenyan shillings.” In Laikipia a similar challenge was noted although it was stated that “some expect too much that we can’t provide, for example a diabetic who needs medication for a lifetime or on a daily basis”.

Future goals from the perspective of Kakamega was a desire to expand the initiative to a larger scale and have it become part of the health system “adopted by government as a pro poor health investment”, along with a contribution of government funds. There was also a desire for expansion of home-based caregiver involvement. In Laikipia, they would like to “find a way to cater for those admitted to the hospital and find ways the fund might be able to cater to long term hospitalizations and lifetime medication issues.”

In response to the question about needs for additional learning from Indian trainers, the Laikipia representative wished to learn more about how to cater for community members, methods for networking with clinics and private hospitals and more guidance about government involvement.

Discussion and Conclusion

Health care and support functions once dependent solely on the family have moved towards home based care providers who have formed powerful networks of grassroots women in countries across Africa. We have examined participatory knowledge transmission within these networks through study of one learning methodology, the peer exchange. We sought to understand learning and replication of a specific “best practice”, a health mutual fund. With respect to our question of the extent of learning, we find evidence of an exciting transformation towards greater control of health within this women’s social movement. We also see change from a sole focus on care giving as members garner resources, such as network strength in numbers and social bonds, to increase health access of caregivers through strengthening financial systems of support.



With respect to the question concerning peer exchange follow up, it is clear that HBC Alliance representatives from all countries in Africa responding (Nigeria, Uganda and Kenya) were both strategic and disciplined. They worked quickly after the peer exchange to conduct appropriate debriefings and trainings about the mutual health fund concept upon their return home.

With respect to our question about replication of the health mutual fund “best practice”, all three countries show rapid implementation of the model through launch of a fund (within the same year as the exchange in Nigeria and Kenya, and within one year in Uganda) after participants returned. There were also significant spin-offs, with funds started in more than one location in each of the three reporting countries (Fig. 1.2), although in the country reporting the most new communities involved, Nigeria the funds were all in one state. In Uganda and Kenya the numbers of communities with HBC groups launching health mutual funds ranged from five to ten within two to three years following the exchange. The dynamism of caregiver networks and district group structure clearly seems useful as a base for launch of health mutual funds to increase health support. While the time since inception of the mutual funds was short, there is also some evidence of sustainability (three to four years) of the mutual health funds thus far.

Fig. 1.3. HBC Alliance Health Mutual Fund Characteristics and Link to Fund Principles

Mutual Health Organization Principles**	Alliance Health Mutual Funds Characteristics Linked to Each Principle	Nigeria	Uganda	Kenya
Solidarity-Fixed Contributions	Regular member contributions	X monthly	X weekly	X monthly
Democracy and Participation	Participatory collections	X	X	X
	Management through committee	X	X	X
	Variability in mutual fund size and membership by location	1600 Kwara state	55 in Bugiri- + 9 other districts	617-500 Laikipia +117 Kakamega (2 districts)
	Voluntary membership Member ID	X card	X- No card	X card
Autonomy and Freedom	No gov't approval or involvement	Partnerships 12 gov't hospitals/clinics	Partnerships public hospitals, gov't and private health centers, private doctors	Partnerships public hospitals, gov't health centers, clinics
	No outside interference in management	X	X	X
Personal Development	Personal responsibility through membership/Respect for human dignity	Repayment of loans without interest—no time limit	Repayment required after 1 month	No repayment required
Non-profit objective	Goal to strengthen health safety net; Reductions health expenses	X	X	X

Responsibility	Solidarity and member responsibility	X	X	X
Social Movement	Builds on HBC women's networks Varying degrees of exclusivity marketing and enrollment	X 31.25% of fund HBC Alliance members; fund open to HBC friends, family, other women's associations	X 27.5% Bugari fund HBC members; also open to other caregivers	X 70% in Laikipia HBC members, 85% Kakamega Open to friends, family or other caregivers

****Source: ILO Mutual Health Organizations, 2001**

The HBC Alliance health mutual funds launched in Africa as a result of the peer exchange generally follow broad principles and characteristics of health mutual organizations (Fig. 1.3) previously discussed, although in some communities different labels for these funds are sometimes used (ILO, 2001). We see commitment to solidarity and member responsibility through general requirements for regular through small, fixed member contributions. Each newly launched fund demonstrates autonomy and freedom, with leadership remaining in Alliance hands. There is variability in participation if we look at fund size with participation highest in Nigeria and lowest in Uganda. These differences also reflect some limitations in clear reporting by respondents of community versus participant totals nationwide. Exclusivity of membership to the HBC Alliance appeared greatest in Kenya (70 to 85% of participants were Alliance members), in contrast to lower levels in Nigeria (31.5%) or Uganda (27.5) due to practices such as inviting participation by other grassroots women's associations. This may be compared to India, where enrollment is in the thousands and where more outreach and involvement of the broader community occurred.

Democratic principles are also reflected in fund structure, operations and management. We find consistency in management functions allocated to committees in all reporting countries, and decisions about recipients and withdrawals resting in collective hands. Reported monthly recipients were however relatively small, ranging from four per fund in Uganda, to approximately ten in each of the three other reporting locations. With respect to potential for reaching the very poor, consideration should be also given to the large grassroots base of the HBC Alliance. All of the funds suggest non-profit objectives although rules and criteria for withdrawal based on health need vary slightly. There is also some variation in rules for repayment, which is required in Nigeria and Uganda but not, for instance in some funds in Kenya. Respondents point to interesting diversity in patterns of partnerships that have been negotiated with range of health providers for member discounts and savings.

It is also noteworthy that none of the respondents report outright dissatisfaction of members. At the same time, only one of the three countries report complete participant satisfaction which was linked by some to range of management challenges faced by the funds including high caregiver expectations, longer waiting periods at times for members to receive support, and hurdles related to meeting needs of the very sick. Future research should involve more extensive surveys of a larger number of fund participants.

Finally, with respect to the question posed about future prospects for these funds we uncovered a desire for greater expansion and caregiver involvement, and new possibilities for creative institutional arrangements such as merging health mutual funds into a women's bank. There is also clear potential for increased government involvement, coordination and support. We see demand for additional peer exchanges and linkages with the groups in India. New programs should support continued peer coordination among health mutual funds through ongoing progress reports and updates, opportunities for new participant training and information about management issues including health system integration, partnerships, record-keeping and outreach, to name a few.

In conclusion, women's grassroots networks continue to be a source of empowerment and creativity for those coming together to meet common goals. Women reshape their lives through active social engagement and careful learning from best practices of peers. The collective health financing systems the caregivers have established are holistic, building emotional, educational and business skills. These complement and fill in gaps even in places where government health services play an important role. Although health mutual funds are limited in scope, we find women taking the initiative and moving from positions of weakness to new forms of strength. As countries move to embrace new global health targets for universal care, there are opportunities for governments and relevant health policy stakeholders to build on these initiatives rather than starting anew.

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