WOMEN'S ECONOMIC EMPOWERMENT AND COMMUNITY-BASED HEALTH INSURANCE: LESSONS FROM ETHIOPIA

TECHNICAL BRIEF

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Community-based health insurance (CBHI) aims to promote equitable access to quality healthcare, increase financial protection for informal sector households in rural and urban areas, and thereby, facilitate social inclusion of the majority of Ethiopian families in the health sector. Through its consecutive projects over the last two decades, United States Agency for International Development (USAID) has been extending financial and technical assistance (TA) to the federal, regional, and woreda (district) governments to pilot, scale-up, and solidify the health reforms in Ethiopia, including the CBHI added in 2010. USAID's ongoing Health Financing Improvement Program and the Transform: Primary Health Care project serve as important TA sources to the nationwide rollout of CBHI. This technical brief provides insights from the USAID Transform: Primary Health Care project's gender analysis on how CBHI is contributing to women's economic empowerment in Ethiopia.

CBHI IN ETHIOPIA

In 2010, the Federal Ministry of Health piloted the CBHI in 13 *woredas* (districts) in Ethiopia's four agrarian regions: Amhara; Oromia; Southern Nations, Nationalities, and Peoples Region (SNNPR); and Tigray. The CBHI objectives were to promote equitable access to sustainable quality healthcare, increase financial protection, and enhance social inclusion for the majority of Ethiopian families via the health sector. In 2015, based on evaluation findings and recommendations,[i] the CBHI was scaled up to 161 *woredas* and tailored to each regional context.[ii]

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As of March 2018, more than 3.9 million households or nearly 18 million individuals (increased from over 144,000 households and 660,000 individuals in 2012/2013) were enrolled in the CBHI program in 512 *woredas*. In other words, 18 percent of the total population of Ethiopia had access to health services through the CBHI. [iii]

Participation is voluntary and at the household level; CBHI members are enrolled as self-paying households and pay the annual premium contribution out-of-pocket, while poor/indigent households are exempted. Regional governments and *woreda* administrations have a targeted subsidy that pays contributions for non-paying indigent households, prioritized in a 70:30 percent split (except in SNNPR where *woredas* pay 100 percent).[iv]

CBHI provides access to a package of free, basic, curative health services (no co-payment) at the time of service at public facilities. Private and community facilities, such as pharmacies, are sometimes engaged to provide services public facilities cannot (e.g., medications where there are drug stock-outs in public facilities). There is no limit to the amount of services, as long as they are on the list of services covered under the benefit package.[v]

CBHI is one mechanism of social protection that increases access to health services for vulnerable community members. The 2015 evaluation of the pilot CBHI showed that female-headed households were more likely to join the CBHI than male-headed ones.[vi] By addressing economic barriers to healthcare access, CBHI could provide both an entry point and pathway for women's economic empowerment.

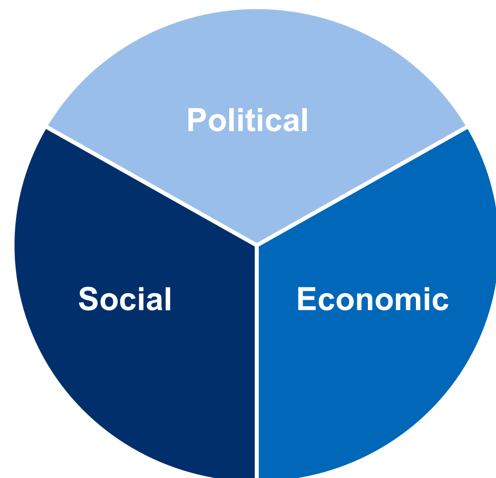
UNDERSTANDING WOMEN'S ECONOMIC EMPOWERMENT

Evidence over the years has demonstrated that women's economic empowerment is more than just "putting money in women's hands." In fact, doing so is insufficient and can have unintended consequences, such as intimate partner violence.[vii]

We know now that women's economic empowerment exists when women control and benefit from resources, assets, income, and their own time, as well as manage risk and improve their economic status and well-being while having the autonomy and self-belief to make changes in their life. This includes having the agency and power to organize and influence decision making, and enjoy equal rights to men and freedom from violence.[viii]

Development practitioners often focus solely on the economic sector as the entry point for women's economic empowerment, without recognizing the interconnectedness of political, economic, and social factors in women's lives—critical for sustained economic empowerment. *Exhibit 1* illustrates the relationship between these elements.[ix]

Exhibit 1: Women's Economic Empowerment Framework



In the exhibit above:

- **Political** represents capacity to analyze, organize, and mobilize to change policies, practices, and state institutions.
- **Economic** represents access to secure and sustainable incomes and livelihood.
- **Social** represents confidence, self-esteem, and action so women gain control to act on what is important for them, redefine rules and norms, and recreate cultural and symbolic practices.

This model illustrates the importance of identifying economic entry points together with political and social ones to promote linkages with other gender equality programming and action from governments, the private sector, and civil society that support women's empowerment.

It also helps us consider how women's economic empowerment can be achieved through other sectors, such as health.

GENDER ANALYSIS FINDINGS ON CBHI

The USAID Transform: Primary Health Care project collaborates with other relevant USAID activities and health system partners, including the Ethiopian Ministry of Health, to enhance the system's functionality and ensure gaps are addressed. This also includes support for healthcare financing, such as CBHI. Since the USAID Transform: Primary Health Care project began in 2017, it has provided CBHI training to 6,882 (4,237 men, 2,645 women) health extension workers, *kebele* leaders, and health sector staff in its intervention areas. The project provides targeted technical support for low and moderately well-performing health facilities in selected *woredas,* including implementation of CBHI.

In 2017, the project conducted a gender analysis in 16 *woredas* in the four regions where it works: Amhara, Oromia, SNNPR, and Tigray. The analysis team collected qualitative data. Data collectors conducted interviews with 91 male and female health providers, health facility managers, health extension workers, and government representatives from *woreda* and zonal health offices, and the office of Women and Children's Affairs. The team also conducted 96 participatory group discussions with married and unmarried men and women aged 15 to 45 (in separate groups by marital status, sex, and ages 15 to 24 and 25 to 45).

The role of CBHI was an area of specific focus during group discussions to understand community perceptions of the scheme and its role in increasing access to healthcare. All group discussion participants across the four regions (except married women ages 25–45 from Amhara) overwhelmingly mentioned financial constraints as barriers to accessing reproductive, maternal, newborn, child, and adolescent health and nutrition services. The gender analysis data also showed that the CBHI scheme in Ethiopia facilitated women's economic empowerment and increased access to healthcare.[x]

Married and unmarried men and women who used or were expected to use CBHI recognized that having the insurance had removed, or would have reduced financial constraints or considerations while seeking or using health services. This same group also reported that CBHI motivated health seeking for themselves and their families, and without it, people would delay seeking services, which would have a negative impact on health outcomes.

> "BOTH MEN AND WOMEN ARE USERS OF HEALTH INSURANCE. BEFORE THIS TIME, WOMEN COULDN'T GO QUICKLY AND GET THE TREATMENT… BECAUSE THEY THOUGHT THAT THEY WOULD BE ASKED A HIGHER AMOUNT OF MONEY; THEY JUST STAYED IN THEIR HOUSES… BUT NOW, EVEN THOUGH THERE IS NO MONEY BUT HEALTH INSURANCE, THEY WOULDN'T STAY WITHIN HOUSE MOST OF THE TIME. THEY WOULD GO QUICKLY AND GET THE TREATMENT."
>
> — MARRIED WOMAN, AGE 15–24, AMHARA

Unmarried and married women reported that CBHI improved their ability to take themselves or their children to health centers without requesting financial support from a male head of household, positioning them to be better able to address theirs and their families' healthcare needs.

> "UNFORTUNATELY MAJORITY OF US, WOMEN, DON'T HAVE INCOME OF OUR OWN. WE RELY ON OUR HUSBAND'S MONEY IN ORDER TO PAY FOR THE MEDICAL BILL. BUT IF WE HAVE THIS CARD, WE DON'T HAVE TO ASK OUR HUSBANDS FOR MONEY WHENEVER WE ARE SICK. IN ADDITION, OUR HUSBANDS MAY NOT BE AT HOME WHEN WE GET SICK. HENCE, HAVING THIS CARD WILL ALLOW US TO GO TO THE HEALTH CENTER WITHOUT WAITING ON OUR HUSBANDS."
>
> — MARRIED WOMAN, AGE 24–45, TIGRAY

Men, women, and government representatives mentioned that, as a result of CBHI membership, women and other family members gained some decision-making power and freedom to make decisions about their health.

The Midterm Evaluation of the Health Sector Financing Reform Project—a 5-year USAID-

supported health financing activity that occurred prior to the current Health Financing Improvement Program—also documented successes and ways forward for CBHI and other health financing reforms in Ethiopia. This evaluation similarly found that CBHI facilitated wider and immediate women's healthcare-seeking behaviors without having to ask for money from their husbands, as well as greater health protection of the poor without catastrophic and impoverishing out-of-pocket payments.[xi]

Despite evidence of the CBHI's contribution to women's economic empowerment and access to healthcare, data showed that certain aspects of the scheme were disempowering for some men and women. For example, there were men who reported they felt that they received poor quality of services under CBHI because the services were free or subsidized. In addition, not all women benefitted from the program because enrollment required husbands to register or sufficient finances. Female heads of households, who were second wives in polygamous areas, were often omitted from the program if their husband registered the household with his first wife and children.[xii] Without their husband's sponsorship, second wives did not have the financial means to pay the annual membership fee, whose cost and coverage vary by region.

CBHI CONTRIBUTIONS TO WOMEN'S ECONOMIC EMPOWERMENT

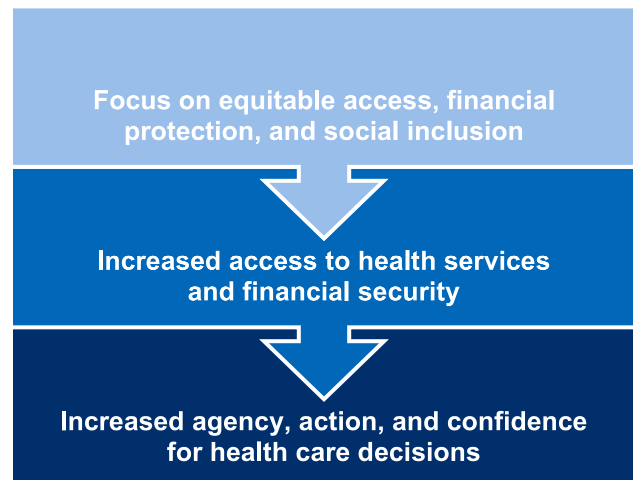
Findings from the USAID Transform: Primary Health Care project gender analysis show that the objectives of the CBHI scheme did help catalyze women's economic empowerment through the health sector. Namely, the establishment of the CBHI scheme (**political**), with its focus on equitable access, financial protection, and social inclusion, did create an entry point for women's empowerment in the **economic** element: Through removal of financial constraints, the CBHI scheme provided resources that increased women's access to seeking and using health services, and enhanced their security by imparting freedom from financial worry.

This, in turn, created entry points in the **social** element by increasing women's:

- Agency to go to health centers independently of a male head of household
- Action to address healthcare needs for themselves and their families
- Confidence to make decisions about their own health.

Exhibit 2 illustrates how the three elements have, together, contributed to women's economic empowerment, and improved health-seeking behavior and access to health services.

Exhibit 2: CBHI Entry Points for Women's Economic Empowerment



CONSIDERATIONS FOR PROGRAMMING AND FURTHER RESEARCH

In the context of the women's economic empowerment framework, findings from the USAID Transform: Primary Health Care project gender analysis demonstrate how the health sector in general, and health insurance schemes in particular, can serve as entry points. Following are considerations for the CBHI program and potential research to better understand this dynamic and its potential.

CBHI Program:

- Ensure that second wives have the same opportunity and access to the CBHI program as first wives, who are sponsored by their husbands.
- Expand to vulnerable groups who are not regular residents of the area or targeted by the CBHI, such as day labor migrants and housemaids.

- Sensitize families and communities on the benefits of the CBHI program

Possible Research Lines of Inquiry:

- As household health-seeking behavior increases, does women's care for the sick lessen?
- Does the CBHI increase preventive care and reduce emergency treatment, thus easing the burden on women to carry more household responsibilities?
- Does enhanced access to health care increase productivity due to quick access to treatment for all household members?
- Does the CBHI increase women's use of family planning services?

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ENDNOTES

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[iii] Ibid.

[iv] Ibid.

[v] Ibid.

[vi] Ethiopian Health Insurance Agency. 2015. *Evaluation of Community-Based Health Insurance Pilot Schemes in Ethiopia: Final Report. Addis Ababa, Ethiopia.* https://www.hfgproject.org/evaluation-cbhi-pilots-ethiopia-final-report/

[vii] Bolis, Mara and Christine Hughes. *Women's Economic Empowerment and Domestic Violence: Links and Lessons for Practitioners Working with Intersectional Approaches.* Oxfam America. https://www.oxfamamerica.org/static/media/files/Womens_Empowerment_and_Domestic_Violence_-_Boris__Hughes_hX7LscW.pdf

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[ix] Ibid.

[x] EnCompass LLC. 2018. *Transform: Primary Health Care Project Gender Analysis: Final Report.* Watertown, MA: USAID Transform: Primary Health Care Project. https://encompassworld.com/resources/transform-primary-health-care-project-gender-analysis

[xi] Ethiopia Performance Monitoring and Evaluation Service (#AID-663-C-16-000010-EPMES). 2017. *Final Evaluation Report: Mid-term Evaluation of Health Sector Financing Reform/Health Finance & Governance Activity*, Ethiopia.

[xii] Second wives can access the CBHI in three ways (except Tigray): (1) their husband sponsors 50 percent of the annual contribution, (2) they register as a female-headed household and pay the full amount, (3) the government pays the contribution if she is indigent.

The USAID Transform: Primary Health Care project is a 5-year activity funded by the United States Agency for International Development, which provides technical assistance to the Government of Ethiopia to support its implementation of the Health Sector Transformation Plan, with the ultimate goal of preventing child and maternal deaths. The project focuses primarily on the areas of reproductive, maternal, newborn, child, and adolescent health and nutrition within four regions of Ethiopia—Amhara; Oromia; Southern Nations, Nationalities, and Peoples Region; and Tigray.

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