PRINT: ISSN 0971-8923 ONLINE: ISSN 2456-6756
J. Soc. Sci., 15(3): 219-228 (2007)
DOI: 10.31901/24566756.2007/15.03.04

# Can Women's Associations be an Effective Mechanism for Gaining Access to Health Care Services? A Study of a Rural Women's Mutual Health Association in Nigeria

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**KEYWORDS** Maternal; health care financing; gender equity; sustainability

**ABSTRACT** This case study aims to investigate a rural women's association that engages in the financing of maternal health care for the members, to what extent this has been effective, and the gender equity, sustainability and policy implications of the scheme. The study utilized a qualitative phenomenological approach with an overall case study genre. The study shows that women who take part in the scheme have been assisted to access health care through the scheme. The scheme focuses absolutely on access to pregnancy and pregnancy-related health care problems. However, while there may be elements of mutual aid in receiving maternal health care, women were frequently unable to receive enough money required for treatment; some women found it difficult to keep pace with making regular contributions, thus raising problems of financial sustainability; there was also the issue of gender equity because while some women were able to receive financial assistance from their male counterparts/ spouses to make their contributions, other women could not receive such assistance; and also management capability could prove problematic in the absence of personnel trained for such tasks. The conclusion argues that women's associations may be available and may serve as a platform for rural health insurance scheme, but it would be naïve to think that the scheme would succeed without sending more trained health personnel to the rural areas, and accompanying this with effective training of those who would manage the scheme.

## INTRODUCTION

This research seeks to explore through phenomenological approach the attempts by women in Eastern Nigeria to provide access to maternal health services for themselves through a rural women's association, and the meanings the women make of this social action, and the health and social policy implications this may have for Nigeria and other developing countries.

The apparent decay in the state-provided health facilities, worsening inefficiency in the management of human, financial and material resources, and degeneration of services rendered in the public health institutions in the developing countries, against the backdrop of debt crisis and worsening economy led to two major publications by the World Bank advocating a paradigm shift from the state to the market as the provider of social services, where the state would be concerned with policy provision of regulatory and conducive environment. The Bank also advocated that the developing countries should abandon policy of free health care (World Bank, 1987, World Bank, 1993). In the Sub-Saharan African context, and more specifically, in Nigeria, some measures of reforms in the health sector within the overarching framework of structural adjustment programmes (SAPs) culminated in the introduction of user charges for the utilisation of public health services (Hanmer, 1994a, b, Russell and Gilson, 1995, Oshi, 2001). The overall objectives of the introduction of user charges were to curb the inefficiency inherent in public health institutions, to remove provision of subsidies for rich and relatively well-off people who could afford to pay for health care and to plough back the money raised from the user charges in the provision of free services for the very poor who could not afford to pay for health care, and the maintenance of the health institutions. Arguments were put forward that getting the rich to pay fees for health care for which they have the ability and willingness to pay would ensure equity when the money raised through user fees are used to provide services for the poor (Shaw and Griffin, 1995). In addition, the cuts in Government spending on health which have been the case in most Sub-Saharan Africa since the 1980s (Ogbu and Gallagher, 1992) would necessitate the public health institutions to make efforts to source part of their finances through internally generated revenue by way of user charges. Yet, some proponents of raising money for health care through charging patients argue that such charges would logically increase

public confidence in government health facilities, and serve as an incentive for the public to utilize government-owned health facilities. It is also posited that the collection of fees for service utilization would enable the government '(i) to allocate scarce funds from curative services to preventive measures…and (ii) to reallocate resources to needed subsidies for the poorest segments of the population with the worst access to health facilities' (Shaw and Griffin, 1996: 2).

However, researches conducted in the Sub-Saharan African Countries, such as Nigeria, have shown that the very poor may and do indeed fail to avail health care because of the unintended effects of the user charges (Ekwempu, et al. 1990) since lack of political will and bureaucratic inefficiency impair the functioning of any safety nets such as exemption policies. Oshi (2001) demonstrates the ambiguity of exemption policy in Nigeria and how politicians trade on it to enhance their political chances during elections, to the detriment of poor women, particularly.

It is in these contexts that it becomes more useful to introduce methods of prepayments for health to alleviate the problems of user fees and at the same time make allowance for revenue generation from health care utilization (NHIS, a,b: no date). Many modalities of these have been tried in the context of Sub-Saharan Africa, some being localized church-sponsored hospital- and urban-based, exemplified by the Ndo Nwanne Health Scheme in Nigeria (Kömm, 2003) while others are community-based such as the Tanzania's Community Health Fund (Shaw, 2002). But could women's associations be an effective mechanism for operating pooling/ prepayment schemes for health care? How do the women perceive their participation in an existing scheme of such nature? What are the social and health policy implications of such schemes based on women's associations?

## STUDY LOCATION AND METHODOLOGICAL ISSUES

The study site, Elum Autonomous Community in Enugu State, Eastern Nigeria, is a typical rural area. It is largely a subsistent food crop farming community. Farming is seasonal, and in the absence of irrigation, it follows the rainy and dry seasons obtained in southeastern Nigeria. Land preparation starts in late March/ April as rainy season starts, and effective crop planting starts in May for yams, cassava, cocoyams and okra while rice cultivation takes off in June/ July. Okra harvest starts in June and constitutes the first farm-based source of finance for many women and their households. Part of the money generated from okra harvest is used for social activities such as group-based contributions, and also to prosecute the tedious and capital-intensive rice cultivation, and so many women look eagerly forwards to the okra harvest. Okra harvest is also the first real break from the dearth period of the annual agricultural cycle during which the folks experience both financial and food scarcity, and most household projects such as going to the hospitals for treatment of non-acute illnesses, house-building, and so on are frozen.

The initial entry point into the selection of participants was by going through the traditional ruler (the Igwe) of the village. The traditional ruler helped us in making initial contact with the leadership of four women's organisations. It was from the four women's organisations that the *Otu Chinyere* Women's Association was selected. It was selected on the basis of its relatively more defined focus on the financing of health care for its members, being more stable compared to the rest which were to a greater or lesser extent fluid in composition and functions. This is not, however, to deny the jural, political, social, and economic contributions of such associations to their members (see March and Taqqu, 1986). Rather, as stated above, our choice was predicated on the need to achieve the objectives of this study in the context of collective pooling of money for the purposes of payment of health expenditure by the members of the selected association. Next, there was the selection of individual participants for the study, which was by the purposive sampling technique. Through this process 24 members of the association were selected to take part in the study. The sample selection technique and the number of participants were intended to facilitate the elucidation and understanding in greater details the experiences and perceptions of a group of women rather than in being able to generalise these experiences to a larger population. Sample size is also in keeping with phenomenological studies.

In-depth interviews were conducted with the participants. Each participating woman was interviewed three times to get as much phenomenological details as possible. The initial

interviews were focused on the women's life history. This was to provide the context for understanding the woman's experiences and perceptions. Open-ended questions based on interview guide approach were used focusing on the participant's social and cultural history, as well as the reproductive experiences before participating in the women's organization. The next set of interviews was focused on the concrete details of the present perceptions and experiences regarding user fees, their membership of the women's organization, the collective financing of user fees for maternal health services, the benefits and problems as perceived by them. They were then asked to describe their lives and the impact financing user fees through participating in women's organisation's collective funding has had on their lives. The interviews were conducted for each woman over several days to weeks, thus allowing time for building of rapport and for them to reflect on their experiences. Key informant interviews were also conducted with the leaders of the Association, the traditional ruler (Igwe) of the Community and the medical doctor in charge of the cottage hospital serving the community. Six focus group discussions were facilitated, each composed of six members and lasting two hours. Issues such as life experiences before their membership of the association, and after they have joined the association, financial access to maternal health services before and after joining the association, membership criteria of the association, methods of payments of association's fees/ contributions, modes of disbursement of the funds to needy members, repayment of loans, types of maternal health services covered by the contributions, social control within the association and sustainability of the association were discussed. The confidentiality of the participants has been provided through carefully maintained anonymity. All names used in this study are therefore pseudonyms.

The data analysis started early in the research with generation of provisional codes. Following the generation of provisional codes was the derivation of appropriate indicators, with which we embarked on construction of typologies. The emerging typologies did necessitate the modification and adaptation of our initial research design. For example, we had at the outset not predetermined to interview the medical doctor and the traditional ruler but it had become clear as we simultaneously carried out data collection and analysis that it was necessary to interview the both. In the main, our analytical approach, rather than being a linear one conducted post-data collection, was somewhat of an iterative process in which the cross-case analysis was carried out after the individual cases. Cross-case analysis was followed by memo-writing (Layder, 1998).

## RESULTS

***Socio-Demographic Profile of Participants:*** The women organisation under study is made up of 109 members. The average age of the participants is 29 years, and the age range is between 22 and 47 years. Among the initially selected participants, eight women were married, eight were widowed while eight belonged to the divorced/ single category. Classifying educational status simply as literate (ability to read and write simple sentences) or non-literate (lack of such ability) (see Gyapong, at al, 1992, cited in Agyepong, et al. 1995), 12 literate and 12 non-literate women were selected. These socio-demographic characteristics were in conformity with the purposive sampling frame used for the study in which it was aimed to achieve a balance between the various demographic and social groups so as to reveal salient differences or uniformity in the phenomena being explored. However, during the course of the research, one widow and three divorced women dropped out for reasons of constraints of time. This leaves 20 women respondents whose sociodemographic characteristics are presented in the Table 1.

***Organisational Profile/ Membership Contributions:*** The *Otu Chinyere* Women's Association was formed in 1996, starting with only 23 members; it has grown to its present population of 109 members. It is semi-open in membership, in which any women of childbearing age can join irrespective of social status. Therefore, the membership cuts across occupation, and social and economic backgrounds (including marital/ civil status). It is an independent association, and does not have any institutional linkages with churches, men's organisations, non-governmental organisations or government agencies.

The average monthly contribution has been changing since its inception. Currently, it stands at N100 per month (1 Dollar exchanges at

**Table 1: Sociodemographic characteristics of respondents**

| | *N* | % |
|---|---|---|
| *Marital Status* | | |
| Married | 8 | 40.0 |
| Widowed | 7 | 35.0 |
| Divorced/ Single | 5 | 25.0 |
| Total | 20 | 100.0 |
| *Literacy Status* | | |
| Literate | 11 | 55.0 |
| Non-literate | 9 | 45.0 |
| Total | 20 | 100.0 |
| *Primary Occupation* | | |
| Farmer | 7 | 35.0 |
| Teacher | 5 | 25.0 |
| Midwife/ Nurse | 2 | 10.0 |
| Trader | 4 | 20.0 |
| Total | 20 | 100.0 |

approximately 120 Naira), with seasonal variations in the payment of the contributions. During the planting season, around April to June, when there is general dearth of food, foodstuff and money, their payments come to any amount that they can afford, and some pay as low as N20, but during the wet season when okra is harvested, and early dry season when rice is harvested, the members with outstanding amounts make them up, by paying much higher amounts per month. Association's records show that some members have paid as high as N200 hundred per month during harvest times by way of making up the shortfalls of the amounts they contributed during the dearth period. The quotations below from two respondents (the first quotation was taken from an indepth interview while the second statement was made by the secretary of the association during a focus group discussion) highlight the constraints the women face in making their contributions during the period of financial dearth and how they get round the difficulties; the period of financial dearth corresponds to the planting season in the annual agricultural cycle, and is marked by both monetary and food scarcity.

'Last year, during the dearth season, things were exceptionally difficult for me. The association allowed me to spread out each contribution. I was allowed to reduce my monthly contributions to mere N20. I did not even finish up the contributions until the harvests, when I was able to clear up the backlog of the contributions'.

(Obidiya, 38 years, widow, non-literate, farmer)

'We must make allowances for the dearth season. For us, it's really a dearth season in every sense of it. We experience financial scarcity and scarcity of other resources. So, we adjust by allowing reduction of the amount any member wishes to pay; secondly, we allow reduction in the frequency of making contributions; and thirdly, we give more flexibility to the mode of payment. We see ourselves primarily as friends and members of same family, and our primary objective is to help ourselves and each other. We are all sisters'.

(Chinwe, 40 years, married, literate, teacher, Association's Secretary)

The mode of contribution is mainly by monetary (cash) contribution, however, in some instances, a member could make her contribution in kind such as her crop, which would then be sold. The organisation, however, currently discourages this since the member could as well sell the crop herself to make monetary contri-bution. Another problem with contribution in crops is the unpredictability associated with the sale of such produce; the price could be higher or lower. Therefore, although the Association used to condone this mode of payment, the practice is being gradually phased out. A member narrated her experience of contributing in crops during a dearth period a few years back.

'Three years ago we had to make parts of our contributions as cassava tubers since it was very hard to come by cash. Selling each woman's cassava would not make sense as it would generate less money than if we brought the raw cassava together and process into garri; so the Association organized so that we brought the raw cassava tubers at the same time. Then we had to process the cassava into garri. Garri sells well here, but would be difficult for one woman to process so we cooperated and processed the garri, I mean, the four of us who made the contributions in cassava. So we sold the garri and got our money which we handed to the Association. We used to make such adjustments as occasion demanded'.

(Patricia, 29 years, divorced, non-literate, farmer)

Given the social and economic contexts of the study location, we had to explore the issue of whether members of this association got any assistance from family members or kin or friends to enable them to make their contributions, and how they felt about the assistance they received

in terms of easing off the financial burden. It was found from the focus groups that assistance from outsiders to individual members of the group towards making their contributions was minimal, for those who did not have spouses. Married women did get assistance from spouses. Individual indepth interviews reveal more clearly the differences in receipt of assistance among respondents. Five out of 8 married women interviewed reported receiving help occasionally from their husbands to make their contributions. They said that the financial help they got from their husbands from time to time made it easier for them to pay up their own contributions. By contrast, there was no help from relations of widows and divorcees and so they had to make their contributions themselves.

***Disbursement of Funds and Payment for Maternal Health Services: Contradictions between Ensuring Financial Sustainability, Social Control, Health Access and Economic Well-being of Members:*** Every member is eligible for and entitled to financial help to enable her to pay for maternal health care in any medical facility that provides obstetric services, including elective obstetric services and emergency obstetric care. The financial help comes in the form of soft loan. Members do not have to provide collateral in order to obtain financial help and there is no interest attached. The absence of collateral enhances the speed with which the member can receive money. The financial help is 'revolving' in the context that the members are required to pay back the money received so as to ensure sustainability of the fund. The repayment is made flexible and the member repays instalmentally to avoid placing too heavy burden on her since she still has to continue with her usual contributions. Paying back the money is also a type of social control to help check moral hazard, which, in this case, is a situation whereby members would resort to borrowing for flimsy reasons; or adverse selection in which women who think they will develop problems in current pregnancy (because they had problems in the previous pregnancy) or women who have already developed problems in their current pregnancy would rush to join the Association. Another measure to check adverse selection is that new members have to wait a minimum of 3 months during which time they must continue to make their contributions.

'If a member remembers that she will be expected to pay back the money, then she will have to ask for it only when she is sure she really needs it. This is because we do not usually refuse to give out money to members once we know she will use it for her pregnancy care. Women will also not rush to become members just because they have developed serious problems in their pregnancy, as they are told they must wait for 3 months before they can qualify for assistance'.

(Amaka, 45 years, married, literate, community health midwife, Association's Chairperson)

Every member of the organisation has at some time received financial help for maternal health care. The women who are yet to finish repaying their loan are still entitled to further help if necessary. They are not precluded from financial help merely because they are still indebted to the Association. This is, however, in principle. In practice, the association does not have any record of lending to a member who has not completed payment of a loan. There has not been any case of default of repayment, and it does seem that practically barring loan to those who are already indebted to the association (though denying so) may have contributed partly to the association's performance in loan recovery.

Indeed, the leaders of the association insisted that loan recovery has so far been 100 percent, an assertion that was corroborated by the members during the focus group discussions. In the opinion of the chairperson, the success in loan recovery stemmed from the trust and confidence they have in each other, but there is hardly any doubt that fear of social sanctions would play a role. Social sanctions in this community go beyond the confines of an association well into the wider society of the community. Should the association leak the information to the wider society that a member had cheated them, the types of social sanctions that would be meted out to the 'cheat' would include 'name-calling', composing stigmatizing songs for the offender, generalised refusal by the community members to buy from or sell to her. But as stated above, the leaders of this association would insist that social control and compliance with loan repayment were borne out of trust, confidence and friendship. Again, in the words of the chairperson:

'You see, the binding principle here is trust. The members of the association have absolute confidence in each other. We don't fear that any

of us will default. Nobody has defaulted since we started. We know each other; we trust each other; we are friends to each other. People can only join us on the recommendation of a member. Each new member has to make contributions for 3 months before being entitled to borrow. Trust is the secret of our successes'.

(Amaka, 45 years, married, literate, community health midwife, Association's Chairperson)

There is no fixed amount payable to a member in the case of obstetric emergency. The guiding principle is to enable their members to have access to maternal health services, especially emergency obstetric care. The money required for the medical expenses for a member is sometimes too high for the association to be able to pay the whole bill. In such cases, the association ensures that the initial deposit fee is paid so that emergency treatment could be started on their member. The organization further releases money according to their financial capacity at that time and according to the immediate need of their member. On benefits and coverage for maternal health services by the scheme, some emergency obstetric cases the organisation has financed for their members include spontaneous abortion, antepartum haemorrhage (vaginal bleeding in pregnancy before delivery), post-partum haemorrhage (severe vaginal bleeding within the first six weeks after child birth), prolonged labour, severe hypertension in pregnancy and removal of retained placenta. They have also been able to help their members to directly buy blood for transfusion, and antibiotics.

This organisation does not usually give out money to book for antenatal care (ANC) to its members, on the grounds that ANC booking can be planned for in advance by the pregnant woman, and the fee is also not a 'catastrophic health expenditure' (health expenditure that is unplanned, and is too high for the income of the affected person or household, and therefore may lead to dislocating the victim's source of livelihood by the sale of productive assets). The chairperson of the association, being a community health midwife, attempts to educate the members on the importance of booking early for ANC. However, a member who develops problems in her pregnancy before booking for antenatal care can receive money to take care of the emergency problems and thereafter, may request money to book for and receive antenatal care.

'I developed swelling of my legs and headache in my second pregnancy 3 years ago. The headache was becoming increasingly severe and so I had to visit the hospital. During my first visit I used my money because I had some money in the house and did not want to borrow from my Association. However, I did not know the extent of the problem. The doctor told me I needed to be admitted for bed rest otherwise I might have convulsion and lose the baby or my life. I was glad that I belonged to the Association because I got the sum of N5000 to take care of the costs. In addition, in the 7 days I stayed in the hospital, I had many members of my Association coming to visit me, bringing gifts with them, such as foods, fruits, etc That was 3 years ago, and I have been able to complete the repayments.'

(Nnenna, 31 years, divorced, literate, farmer, Association member)

***Life Experiences Before and After Organisational Membership:*** All the participants reported that their access to and utilisation of health services, specifically, antenatal care (ANC) services were low, as also was their social life activities. Six out of eight married women who participated in the study reported they did not go for ANC (maternity care) before they joined the association because they did not appreciate the importance of it, though they now know that they might have had enough money to afford the fees. All of the seven widows and three out of the five divorcees reported that apprehension over the costs of health care had adversely affected their health-seeking behaviour and their decision-making in failing to obtain maternal health services.

They also said that their economic life was worse. They attributed this to the fact that they had no knowledge of the principles of making little savings from their meagre financial resources. Their pattern of income and expenditure followed the seasonality of the agricultural cycles, getting money during the harvest and spending it as it was got from sales of agricultural produce, and then experiencing financial scarcity during the planting season. The teachers, who reported that they were already used to receiving salaries irregularly, said they did not see any use for savings for health before joining the Associations. Two out of the four traders reported they were used to just juggling the marginal gains they got from the petty trading with feeding their family and not bothering about keeping any

money aside in any form for the purposes of health. This culture of not having any savings (for health) was cross-cutting, affecting all the farmers, teachers, and half of the traders; with only the nurse/ midwives being the exceptions. These findings from indepth interviews were confirmed during the focus group discussions. One string that kept running through this in all the focus groups was that they felt that there was no need to bother saving if one's money was very small, as theirs was. It was found during the focus groups that the non-challant attitude towards savings is pervasive among the rural dwellers, especially poor women. It was further probed whether there was no savings at all in groups in the community, such as rotating savings and credit associations. The respondents said that that might exist, but their purpose would usually not be saving for health, rather each contributor would get their own collective share and decide what to do with it. Other ad hoc groups could also be formed with the purpose of making little contributions towards sewing uniform wears for festivities such as Christmas.

However, from both indepth interviews and focus groups, respondents reported that since they became members of the association their decision making in seeking maternity care was faster since they were certain of obtaining money to pay the fees for the services. They also felt 'empowered' in this context, because they felt they could confidently go to the health facility when they got pregnant. Indeed, according to them, their new experience of saving for health by contributing to their association removes the necessity and problems of going to plead with moneylenders to give them loans. In addition, they could now take their decisions themselves, or alongside their spouses (for married respondents). For example, all the married women reported they could now take health-seeking decisions with their husbands, but, in addition, they have an increased bargaining power since they no longer depended solely on their husbands to obtain money for their maternal health expenses. Their participation in the organization has also enabled them to learn the importance of making small savings and investment in health from their meagre resources. They reported that they have developed self-confidence in handling health situations since they have the hope and assurance that they can always secure financial help for their maternal health needs.

'Keeping money aside for health matters was not an issue for me before I joined the Association. I never really gave it a serious thought. Since I did not keep money anywhere for the purposes of paying for health, I always felt that there was no way I could use the hospital services as I could not afford to pay for them. I never even bothered going to the health facility for the pregnancy and delivery of my first 2 babies. Things changed after I joined this Association. I became a member of this Association 7 years ago, and have had 3 children. You won't believe it, I went for 'antenatal' [antenatal care] for all the 3 babies.'

(Obiageli, 39 years, Association member, non-literate, farmer, married)

'Attending meetings has helped to make me more aware of my social environment. Can I say that I am more enterprising now? I think it's reasonably fair to say so. Belonging to the Association has made me learn to save. No doubt, it has its own challenges but the challenges contribute to making it interesting. Let me tell you, striving to raise your contributions gives you a sense of responsibility. If not for any other thing, though nobody prays for illness, I am reasonably immune to fear of seeking treatment, which used to be a constant and nagging fear before my membership of the Association'.

(Monica, 23 years, married, literate, teacher)

'Try to go and borrow money from the village moneylenders and hear what they will tell you: the collateral, the interest, guarantor, etc. The amazing thing is that some of them even require you to come with palm liquor, or they begin to make passes at you. How can someone in trouble, someone asking for a loan, have money for palm liquor? But that's the situation. So, you can understand what belonging to the Association means to us. We don't have to borrow from those heartless moneylenders; we can even do without bothering our relatives. Yes, we can.

Ijeoma (44 years, Divorced, literate, dress-maker/ seamstress)

Besides access to maternal health and increasing knowledge of the importance of making savings, the study explored the respondents' experiences before and after they joined the Association from the perspective of the social interaction, and self-esteem – one's feelings and

thoughts about herself. Findings from the indepth interviews and focus groups showed that three out of the seven widows reported that their social interaction with other women was poor. The details given by one widow are worth noting, as other widows in the wider society may be experiencing 'much the same problems which, though may be perceptual, may still be significant. She said she had severe low self-esteem because she had continued to bear children after the death of her husband. She felt morally inferior to other women. It disturbed her even at night, often causing insomnia. She even had loss of appetite and once thought she was having real sickness. It got to the point that she could not freely attend her church activities, and going to the market was a very worrisome problem for her. She often felt that she was being stared at, gossiped about and mocked in her absence, though she admitted that she was not the only widow who bore babies after the death of her husband without being re-married. Probing revealed that these psychological symptoms did occur during pregnancy and postpartum period and so could as well be attributed to postpartum depression from the very pregnancy she had after her husband's death. She further revealed that she could not bring herself to telling anybody, not even her friends. These self-perceptions of (im)morality and their negative consequences on the respondent's social interactions before joining this Association contrast sharply with her current positive self-perceptions which she reported as being an outcome of her membership. This is not peculiar to her, as the participants reported that their 'self-esteem' have also significantly improved by reason of their membership of the organization. They attributed this to their close interaction with their fellow women members and the learning process they undergo by reason of their close social interactions with Association members.

'My life has changed since I became a member of this association. At the peak of my sadness, I never thought I could ever be happy again in my life. The level of friendship I have experienced here has made so much difference in my life. That is not to talk of what I have benefited in receiving assistance to pay for health. Look at my baby [showing us a baby she was carrying during the interview], I gave birth to her in the hospital. That was possible because I had become a member of this association. I have not even told you that I have learnt about family planning, just because I belong to my association. So, I can now stop having babies so that I will train these ones I have already got. I just cannot tell you enough of what I have benefited since I joined these women'.

(Mary, 39 years, widowed, non-literate, farmer)

***Perceptions of the Association by Key Community Members:*** In Elum, as in other places, the activities of women's associations (both the index association and others), do not go unnoticed. It was therefore pertinent to try to seek out the perceptions of people in the community. For this purpose, we conducted indepth interviews with the traditional ruler of the community, since he is supposed to be the chief 'welfare' custodian of his community. Indepth interview was also conducted with the medical doctor in charge of the cottage hospital that serves the community. The traditional ruler, while impressed with the activities of the Otu-Chinyere Association for which he called for encouragement of their activities, lamented about the attitude of other women's association by which they use their contributions to sew Christmas dresses, and he describes this as 'vanity'. Dr. Madueme, the Medical Doctor in the Cottage hospital, enumerated some medical conditions for which the association has helped its members to pay for in his hospital, and his described the Association as a success.

'If other women will organise themselves like the members of the Otu Chinyere Women's Association, they

will make significant impacts on the maternal health of the community. I am aware as the Chief of this community that they have helped their members to receive many and different types of treatment. The Otu Chinyere really needs encouragement. Unfortunately, though other women's associations exist they prefer to use their contributions to sew new uniforms during Christmas or do other things, largely ignoring health issues. That's vanity'.

(Chief Ekwe, Traditional Ruler of the Community)

'In our health facility, we co-operate with the members of Otu Chinyere Women's Association. Their members have received treatment here for a number of medical conditions, including prolonged labour, antepartum haemorrhage, and indeed, many of them have their normal deliveries here. I don't know exactly how they operate but

they often accompany their members to our health facility, and help their members with payment of their bills and purchase of medical consumables. I think their success derives from the fact their leader is a community health midwife'.

(Dr. Madueme, Medical Doctor in charge of the Cottage Hospital serving the community).

The Association may well be a success since the members have done what has not been done before in the community by way of increasing access of women to health care, but the composition and function dynamics of the Association are by no means without critical issues and problems that have important implications for social and health policy as well as scholarly debates.

## DISCUSSION

This study raises a number of important policy and academic issues. These include the debates on the introduction of user fees and their impacts on maternal health and maternal mortality in developing countries (Ekwempu et al., 1990; Kisekka, et al. 1992, Harrison, 1997, Oshi, 2001); community financing of maternal health services (McPake et al., 1993); gender and equity issues in user fees and access to health (Standing, 1999); and the place of social relations within women's associations in access to health. On user fees, the women who participated in this study have demonstrated that women, rural women, can actually grapple with the payment of user fees in a rather successful manner. The findings show positive maternal health, social and psychological outcomes for the respondents. The women were able to access maternal health services, when in need. They were free of the nagging fear of catastrophic health costs before receiving treatments. However, there are still issues that beg attention. A point at issue is that of social exclusion. The findings show that the membership of this association seems to be limited to a sub-group of women who can afford to make their contributions, and to repay any loans they may take. While the claim by the leadership of the association that membership is open (or semi-open) to any woman from any socio-cultural and economic background is not being disputed, it seems reasonable to posit that such a claim relates rather to non-discrimination in terms of marital status, educational level and primary occupation than to practical 'invisible' discrimination based on financial capacity. This is important, but there may actually be a covert self-selection inherent in the organization in the context of 'who is capable to pay belongs', and 'who is not capable to make contributions is not welcome'. Therefore, importance of financial capability as a selectivity (inclusion-exclusion) factor should not be overlooked.

Another issue regards the capability of other association to be able to embark on this kind of project. Preliminary findings showed that other women's associations exist in the community, but the issue of contributing for health is not an objective for them. This may not be unconnected with lack of knowledge of the importance of doing this or lack of interest to embark on such a scheme (since they are aware that an association does contribute for health payments). More importantly, the significance of having a health professional to lead the group cannot be ignored, and the presence or absence of a health professional may be the critical factor in establishing and managing a scheme like that. For example, the leader and brain behind the Otu Chinyere Association is a community health midwife. Therefore, would it be possible (and to what extent) for associations that have no health personnel in the rural communities to manage pooling schemes for health prepayments? This question is of paramount importance given the fact trained health personnel are hard to come by in the rural areas, and that the national rural health insurance - in which the community members would be charged with managing the scheme - would be introduced to the villages soon. The Nigerian Government and its agency in charge of extending the National Health Insurance to rural dwellers may well find a number of associations in the rural areas, which could be used as a platform for the scheme, but it would be naïve to think that the scheme would succeed without sending more trained health personnel to the rural areas, and accompanying this with effective training of those who would manage the scheme.

In the context of gender and community financing of health care (maternal and child health), married women received assistance from their spouses in the payment of their contributions, thereby arguably tilting the gender balance. It is not known whether their spouses also implicitly determine or influence their behaviour in the association. Even in the absence of explicit institutional linkage to external (male-dominated) bodies, the embeddedness of the

association within a patriarchiacal society raises some gender issues of which Elum is one. For example, like any other association, women's associations are the products of the society in which it is situated and actors in reproducing that society. So, because gender relations are inherently unequal in patriarchiacal societies such as the one in which the association studied was located, gender relations would also be inherent in the association, and indeed, in other women's organization in the community. Therefore, gender is an issue in such organisations because as Roche (1998: 176) puts it 'gender is an interesting vehicle for understanding the two-way relationship between an organisation and the society in which it is situated'. Equity (gender) also becomes problematic when married women got help from their spouses to make their contributions to the associations, and those who are widows and divorced could not avail such assistance. This is because women who do not receive any assistance will encounter an added burden in their attempts to keep pace with their contributions, as demonstrated by the findings. Despite assistance from spouses of married women, evidence from this study shows that they still find it difficult to make their contributions.

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