VIABILITY OF ACCESSING HEALTH INSURANCE FOR THE URBAN POOR THROUGH COMMUNITY BASED ORGANISATIONS: THE CASE OF KIBERA SLUMS

BY: MUTHONI MWAURA WA

A RESEARCH PROJECT PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION

UNIVERSITY OF NAIROBI SCHOOL OF BUSINESS

OCTOBER 2009

DECLARATION

This research project is my original work and has not been submitted for examination to any other university.

Signature..... Date.....12/11/2009.....

NAME: MWAURA WA MUTHONI

This project has been submitted for examination with my approval as University supervisor

Signature..... Date.....12/11/2009.....

NAME: CAREN ANGIMA

DEDICATION

I dedicate this publication to the millions of disadvantaged Kenyans who when faced with the risk of illness turn to divine intervention as they cannot afford the minimum necessities needed to sustain human life.

ACKNOWLEDGEMENT

I am very grateful to my Supervisors for the valued academic and professional guidance and the entire University fraternity for according me a conducive learning environment and lastly to all my colleagues for their moral support.

Special thanks to my family and workmates for their patience, support and encouragement during the entire period of my study which was quite demanding.

May Good Spirits shine your ways eternally.

ABSTRACT

The aim of this research study was to determine the capacity of Community Based Organisations (CBO) in provision of health insurance to the urban poor. This was a descriptive survey. It focused on identifying the presence of factors that influence the success of Community Based Health Insurance (CBHI) in the CBOs studied. The study was conducted within the sprawling Kibera slums of Nairobi and was based on 91 CBOs as registered by the Kibera Division Community Development Assistant (2007). The respondents were drawn from 31 CBOs sampled from the 91 CBOs out of whom only one CBO failed to return the questionnaire delivered to them by the researcher. A structured questionnaire was used to collect the relevant data which was used to summarize the findings and draw conclusions. The rate of response was impressive and data collected was used to draw meaningful conclusions and recommendations.

The study concluded that the CBOs within Kibera Slums posses the factors that influence the success of CBHI. Members of some of the CBOs were found to have health insurance cover mostly through micro finance organisations such as savings and credit societies where individual CBOs join as corporate members to enhance the saving capacity and accessibility to credit facilities. All individual CBO studied, however, faced the problem of lack of adequate volume of exposure and acknowledged financial constrains and poverty as the major impediments to their growth. The level of members contributions for at least two third of the CBOs was adequate to sustain CBHI.

The study recommends that the CBOs cooperate with each other by coming together to form larger CBOs that would have adequate volumes or join the conglomeration of CBOs that are already offering CBHI besides other activities. Deliberate measures also have to be taken to assist the CBOs alleviate poverty among other risk control measures while the government and other agents should put more effort in improving the health facilities in the slums and partner with CBOs in health financing.

TABLE OF CONTENTS

ABBREVIATIONS

AKI	-	Association of Kenya Insurers
CBHI	-	Community Based Health Insurance
CBOs	-	Community-Based Organizations
CDI	-	Centre de Development Integral
GOK	-	Government of Kenya
HEFU	-	Health Economic and Financial Unit
IRDA	-	Insurance Regulatory and Development Authority of India
MFI	-	Micro- Finance Institutions
MOH	-	Ministry of Health
NHIF	-	National Hospital Insurance Fund
NHS	-	National Health Services
NSHI	-	National Social Health Insurance
NSHIF	-	National Social Health Insurance Fund
NHSSP II	-	2nd National Health Sector Strategic Plan
PHI	-	Private Health Insurance
SEWA	-	Self Employed Women's Association
SHI	-	Social Health Insurance
UHC	-	Universal Health Coverage
UMASIDA	-	Umoja Wa Matibabu Sekta Isiyo Rasmi Dar-Es-Salaam

CHAPTER ONE: INTRODUCTION

1.1 Background

Urban poverty is associated with various deprivations which make working, living and social environments of the poor extremely insecure. Urban poverty is viewed from five perspectives i.e. money poverty, relative poverty, hardcore poverty, poverty of access and poverty of power. The urban poor lack sufficient resources to afford minimum acceptable quality of shelter and other services They have incomes below a certain level while a majority live in absolute poverty whereby they cannot afford the minimum necessities needed to sustain human life. This income is globally estimated at one United States Of America Dollar (1 US $) per day. The urban poor are also faced with relative poverty as they cannot meet the minimum social, political and economic goods needed to maintain an acceptable way of life in their society and are extremely poor, a state referred to as hardcore poverty. Poverty of access is prevalent among the urban poor as they are unable to access basic infrastructure and services. Finally the urban poor are victims of poverty of power which entails vulnerability as a result of their very low levels of asset ownership while they are also unable to influence decisions and lack information to advance their case (Odhiambo, 2003).

On the other hand Community Based Organizations (CBOs) sometimes known as Community Organizations are civil societies and non-profit organizations that operate within a single local community. They are run on a voluntary basis and are self funding. In developing countries they often focus on community strengthening, including HIV/AIDS awareness, health clinics, orphan children support and economic issues (Wikipedia the free encyclopaedia). CBOs are grassroots groups formed to serve the interests of families or stakeholders in communities. CBOs usually emerge through schools, churches, neighbourhoods, ethic groups, sports or cultural activities (www.osi.ha/partnership/glossary.htm).

Of all risks facing poor households, health risks probably pose the greatest threat to lives and source of revenue because health shocks thrust health expenditure on poor households at a time when such shocks are hard to contain. Moreover, the uncertainty of the timing of illness and unpredictability of its cost makes financial provision for illness difficult for households receiving

low and irregular income (Jutling, 2003). Action to improve health and facilitate access to health care is important for individual well-being and national economic performance. However, paying for health care is problematic. Equally, vital elements of well-being such as food are paid through out-of pocket payments but that approach does not work well for health care. Unlike food, health care is needed unpredictably and can be very expensive (Dror, 2002)

The world over, countries are awake to this reality and are striving to achieve Universal Health Coverage (UHC). Carin, (2004), define UHC as access to adequate healthcare for all at an affordable price, while Majeed, (2003), defines UHC as access to health services by all groups in the population UHC is therefore a status in the health system of a country where there is a readily available, affordable and accessible medical care for all citizens. Attainment of UHC is a long-term process. For instance, of the 27 countries that have succeeded in attaining this status through Social Health Insurance (SHI) it took Costa Rica 20 years, Korea 26 years, Japan 36, Luxemburg 72 years, Austria 79 years, Israel 84 years, Belgium 118 years and Germany 127 years (Carin, 2004).

Governments the world over have employed two approaches to attain UHC for their citizens. Some use the National Health Service (NHS), which involves financing of health services through general tax revenue. Others use Social Health Insurance (SHI). SHI involves pooling of risks of ill health by individuals or households before an illness occurs and the direct financial consequences of illness of any member of the pool are met by the resources pooled by all participants of the SHI group (PHR Plus, 2004). At the same time Private Health Insurance (PHI) schemes may be in place while many other individuals voluntarily or otherwise are not insured and rely on their resources or charity to meet the financial consequences of any illness.

The transition to UHC is the number of years between the first law relating to health insurance and final law related to implementation of UHC (Carin, 2004). Among the countries that have attained UHC is Germany where 92% of the residents receive health care through statutory health insurance. By 1992 Germany's statutory health insurance relied on about 1,200 non-profit sickness funds that collected premiums from their members and paid health care providers according to negotiated agreements. Those not insured through these funds have alternative

insurance and some belong to the 0.3% who do not need it or the very poor who receive health care through social assistance (Carin, 2004).

In pre-colonial Africa, there existed a traditional system of medical care that was based on traditional beliefs and medical practices which were readily available, affordable and accessible to whomever needed it (Aregbeyen, 1983). On the onset of colonial administration, government and church owned hospitals that were funded by taxes and donations were introduced. On the advent of independence, there was a reduction in the number of patients and donors compelling hospitals to finance their budgets primarily by charging for their services. (Gakombe, 2002). In Kenya, a co-payment of Kshs.1.50 per user was in force in all public health facilities between 1963 and 1965. (Sessional Paper on National Social Health Insurance in Kenya, 2003). Kenya's immediate post independence economic development blue print, the "Sessional paper No.10 of 1965 (African Socialism and its Applications to Planning in Kenya)", laid down development policies aimed at eradicating poverty, ignorance and disease. Between 1965 and 1989 the government used revenue from general taxation to finance health services in line with its policy of free medical care as stated in Sessional paper No.10 of 1965. (Sessional Paper on National Social Health Insurance in Kenya 2003). The Government of Kenya (GOK) then was providing free out patient health services and hospitalization for all children and the unemployed in public health facilities. (Owino, 1998).

On 12th July 1966, a law that introduced social health insurance in Kenya, the National Health Insurance Fund Act was enacted creating the National Health Insurance Fund (Daily Nation, 2006, Nov. 29). Efforts by GOK to attain UHC through NHIS were rocked by the social economic crises of the late 1970s. Meanwhile corruption and poor leadership rendered National Health Insurance Fund (NHIF) ineffective. (Sessional Paper on National Social Health Insurance in Kenya, 2003). Due to severe budgetary constraints and declining support from donors the government was forced to introduce user charges for health services in 1989 leading to cost-sharing programs in the 1984 / 1988 development plans which were implemented in December 1989 (Owino, 1998).

The health financing system of cost sharing currently being practiced in Kenya is not affordable as over 50% of the Kenyan population living below poverty line. Other factors that render cost

sharing untenable is the fact that 7.7% of poor households are faced with catastrophic health expenditure i.e. out of pocket payment exceeding 40% of disposable household income (Mathauer, 2008).

In 2004 the government attempted to replace the current social health insurance scheme of National Health Insurance Fund (NHIF) by introducing the National Social Health Insurance Fund (NSHIF) whose plan was to achieve UHC within 12 years. The government's intention was that Kenyans, through the community spirit of solidarity, would pay small regular contributions to the NSHIF as cover for illness thus enhancing risk sharing among income groups. (Sessional Paper on National Social Health Insurance in Kenya, 2003). The NSHIF, however, never materialized. However, in 2006 the NHIF introduced comprehensive medical cover and rolled out to enroll members from outside the formal sector in large numbers but the impact of these changes are yet to be documented (Siringi, 2006).

Over the years, the search for an appropriate health financing system in Kenya has paid little or no attention to the ability of poor Kenyans to insure themselves because the strategies applied have been based on the belief that the poor are too poor to be able to save and contribute towards meeting their health care needs. Yet there is a growing realization that even the poor can make small, periodic contributions that can go towards meeting their health care needs. (Jutling, 2003). Little or no attention has been paid to social capital, a vital resource that societies possess in the form of persons, social relations, co-operation, norms, values, trust, network and institutions, which can be utilized for the development and improvement of the socio-economic welfare of society. Khayesi, (2002), defines social capital as the ability of communities to cooperate for mutual benefit and the norms and networks that enable people to act collectively.

In response to inadequacies of alternative systems for protecting the poor against health care expenditures, Community Based Health Insurance (CBHI) schemes have developed. CBHI is a general term for voluntary health insurance schemes organized at the community level. Run on a non-profit basis and applying the basic principle of risk-sharing, these schemes have arisen within community-based organizations (CBOs) which have strong links with poor communities and are therefore well structured to offer CBHI (Tara, 2007). CBHIs are recommended by The World Health Organization as a useful method for protecting the poor against health risks (World

Health Organization, 2002). Recent studies of community savings, loans and financing schemes show that the poor can insure themselves against unexpected events. Community-level health insurance programs improve access to essential drugs, primary care and basic hospital care. (Dror, 2002)

Legal recognition of CBHI will mark the attainment of UHC in a country as has been demonstrated by the legislations that guaranteed UHC in Germany and Japan. In Ghana, the 2003 National Health Bill recognized mutual health organizations and created provisions for licensing and provision of subsidies for licensed mutual health insurance schemes. The aim was to put in place a mechanism that would enable residents, through mutual and private health insurance schemes, to obtain basic health care without having to pay any money at the point of service delivery. (Kwavu, 2003).

Attainment of UHC remains a top priority for the GOK which is attested by the Vision of the 2nd National Health Sector Strategic Plan (NHSSP II) 2005-2010 - "*An efficient, high quality health care system that is accessible, equitable and affordable for every Kenyan household*" ("Second National", 2006). Though NHSSP II aims at strengthening community-based care through village health committees and community owned resource persons, it fails to recognize the potential of CBOs as a source of funding and limits itself to the GOK, cost sharing, the National Social Health Insurance Fund (NSHIF), development partners and other unspecified sources of funding. The Harambee spirit, of collective action by citizens or pulling together as it is literally referred to, which has been used to overcome various development hurdles, should be used to tackle the risk of ill health through CBHI as it will lead to the attainment of UHC in Kenya.

1.2 Kibera Slums

Kibera slums of Nairobi with its estimated human population of 500,000 to 750,000 have the highest concentration of urban poor in Kenya. A majority of the residence of Kibera slums lack sufficient resources to afford the minimum acceptable quality of shelter and other services as a majority of the Kibera slum dwellers live below poverty line. Kibera is Kenya's largest slum and covers an area of 256 hectares (630 acres) in the middle of Nairobi. It is an informal settlement

in Nairobi Kenya located some five Kilometres from the city centre and lacks the most basic amenities such as toilets, clean water and health facilities.

Kibera is densely populated; Salmon (2002) states that Kenya's 1999 census revealed that as many as 82,000 people were living within an area of less than one kilometre square. The scale of deprivation in Kibera is so huge that non-governmental interventions have managed only marginally to improve access to basic services such as schools, health facilities and water points. (Waran, 2007). Basic services are seriously wanting in this slum and due to the poor sanitation, every body is at the risk of epidemic diseases (Munyakho, 1992). Morgan (2000), states that the health care system in Kibera is one of the weakest worldwide.

1.3 Statement of the problem

With 56% of Kenyans living below the poverty line i.e. their levels of income are below the income deemed necessary to achieve an adequate standard of living in Kenya (Wikipedia the free encyclopaedia) and 40% of them living in absolute poverty, financing of healthcare for a majority of Kenyans is a real challenge. On the other hand, the existing healthcare system is designed on the basis of citizens who are capable of paying for medical care at the time and point of treatment. (Sessional Paper on National Social Health Insurance in Kenya, 2003). Meanwhile, Government efforts to offer health insurance through the NHIF have not catered for the economically deprived Kenyans as, despite its inadequacies, it caters for the less than 10% of Kenyans who are formally employed. The alternative to NHIF is private health insurance, which is almost negligible in a country where the penetration of personal insurance products is at 0.64%, (SBO, 2003). There is thus a need to search for an alternative mechanism of health financing that will cater for the majority of Kenyans. Studies carried out in the past have concentrated on the viability of NSHIF (Sessional Paper on National Social Health Insurance in Kenya, 2003), problems arising from the current cost-sharing scheme in the health sector (Owino 1998) and strategic choices adopted by private hospitals (Gakombe 2002) but no study has been carried on the capability of the urban poor to independently finance their health needs. This study sought to close this gap.

1.4 Objective of the Study

To determine the capacity of community based organizations to provide health insurance for the poor.

1.5 Importance of the Study

To the Scholars/Researchers the study will contribute to a body of knowledge from which others can learn.

To the CBOs that will adopt the recommendations of the study, they will unleash their potential in provision of health insurance to their members for betterment of the health of their members and the wellbeing of the CBOs at large. Further, CBOs that will adopt the recommendations in respect of amalgamation of CBOs to achieve adequate volume of exposure will in all their operations reap the benefits of economies of scale that come along with larger groups thus enhancing their performance in all their endeavours.

To the Policy Makers the study will provide an alternative mode of health financing in their endeavour to provide adequate health care for the urban poor whereby through the spirit of Harambee (pulling together) which is the country's national motto, the economically deprived Kenyans can take collective action against the risk of ill health outside the traditional National Health Services (NHS), cost sharing, NSHIF, development partners and the unspecified others. The study will help the policy makers to come up with better policies that will enhance the viability of CBOs and other likeminded organizations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Concept of Risk

The existence of risk is the fundamental rationale for insurance (Criel, 1997). If there is one thing about which we can be certain in this world, it is that uncertainty surrounds all that we do. This uncertainty is at the heart of risk and risk is at the very core of insurance. Risk would be defined as the probability of a cause of an event with negative outcome occurring. The cost of risk can be looked at in at lenst three different perspective i.e. frequency of risk, monetary cost or financial severity and human cost in terms of pain and suffering (Dickson, 2002). In view of the adverse effects of risks there is a need for risks to be managed.

2.2 Risks and Risk Management

Risk management is defined as the identification, analysis and economic control of those risks which can threaten the assets or earning capacity of an enterprise (Dickson, 2002). The primary objective of risk management is to preserve the operating effectiveness of the enterprise to make sure that it is not prevented from attaining its other goals by pure risk or the losses arising from those risks. There are two broad approaches to dealing with risk i.e. risk control and risk financing. Risk control focuses on minimising the risk to which the entity is exposed and includes the techniques of avoidance and reduction while risk financing concentrated on arranging the availability of funds to meet losses arising from risks that remain after application of the risk control techniques and include retention and transfer (Vaughan,1989). The mechanisms of risk transfer include Insurance among others.

2.3 The Insurance Device

The primary function of insurance is to act as a risk transfer mechanism. Insurance involves transferring or shifting risk from one individual to a group and sharing losses, on some equitable basis by all member of the group (Vaughan, 1989). Insurance has two fundamental characteristics namely transferring or shifting risks from an individual to a group and sharing

losses on some equitable basis by all member of the group (Dickson, 2002). Insurance rests upon the principal of risk-sharing between many people. It relies on the law of large numbers whereby what is unpredictable for an individual is highly predictable for a large number of individuals (Criel, 1997).

Insurance primarily concerns itself with risks which have financially measurable outcomes and whose outcome can only be unfavourable or leave enterprises in the same position as they were before occurrence of an event. Insurance deals with fortuitous or accidental losses which must not be catastrophic i.e. wide spread in nature.

To counter the tendency of the persons whose exposure to loss is higher than average to purchase or continue insuring to a greater extent than those whose exposure is less than average, which is referred to as avoidance of adverse selection, there must be randomness in the risks covered. That is there must be a proportion of good and bad risks in the insured group equal to the proportion of good and bad risk of the group on which the prediction is made. Finally the cost of insuring the risk must not be high in relation to the possible loss i.e. insurance must be economically feasible.

The major activities of all insurers include rate-making, production, underwriting, loss adjustment and investment. Rate making is the process of determining the price per unit of insurance which like any other price is a function of the cost of production. The rates must be adequate, not excessive and not unfairly discriminatory. The premium income of the insurer must be sufficient to cover losses and expenses. Production involves supervision of the sales efforts which is carried by the agents or salaried representatives of the Insurer while underwriting on the other hand is the process of selecting and classifying exposures. If an insurer does not select from among her applicants, the result will be adverse to them.

The main responsibility of the underwriter is to guard against adverse selection. While attempting to avoid adverse selection through rejection of undesirable risks, the underwriter must secure an adequate volume of exposures in each class. In addition they must guard against congestion or concentration of exposure that might result in a catastrophe. Finally loss adjusting is the loss settlement process which provides for the indemnification of those members of the group who suffer losses. It is obviously important that the insurer pay claims fairly and promptly

but it is equally important that insurers resist unjust claims and avoid overpayment of them. (Vaughan, 1989).

As a result of their operations, insurers accumulate large amounts of money for the payment of claims in the future which are added to the funds of the insurers themselves. It would be a costly waste to permit these funds to remain idle and it is the responsibility of the insurers finance department to see that they are properly invested.

2.4 Self Insurance

As an alternative to purchasing insurance in the market, or as an adjunct to it where the first layer or proportion of a claim is not insured in the commercial market some entities set aside funds to meet insurable losses. Enterprises make decisions to self-insure because they feel they have the financial capacity to carry such losses and because the cost to them by way of transfers to the fund is lower than commercial premium levels since they are not paying the insurers administrative costs and profit. The risks mostly covered under this arrangement are the high frequency and low severity risks that the enterprise considers predictable (Dickson, 2002). Such risks include shop lifting whereby the culprits usually pocket small items from the shop whose cost the enterprise can easily absorb.

2.5 Social Insurance

Insurance is not always practised in this ideal commercial situation as described above as there are some people in society who face risks that they cannot afford to deal with themselves and require a social approach to insurance. Social insurance (SI) is defined as a device for pooling of risks and their transfer to an organisation usually governmental that is required by law to provide pecuniary or service benefits to or on behalf of covered persons upon the occurrence of certain pre-designated losses (Vaughan, 1989).

In SI individual equity is secondary in importance to the social adequacy of the benefits (Carin, 2004). Benefits are weighed in favour of certain groups so that all persons will be provided a minimum flow of protection. SI does not exclude anyone who belongs to a group that qualifies

for coverage nor does it charge risk related premiums. SI includes Social Health Insurance (SHI), which deals with the risk of ill health. Health Insurance as a source of financing for health care is a system in which potential customers of health care make an advance payment to an insurance scheme, which in the event of future health service utilization will pay the provider of care some or all the direct expenses incurred (Criel, 1997).

The International Labour Organisation (ILO) provides a guideline for an initial minimum package for social health insurance (SHI) which includes general practitioners care such as home visits, hospitalization where necessary, specialists care in hospitals, essential pharmaceutical supplies and prenatal, maternity and postnatal care by medical practitioners or qualified midwives. (ILO, 1952). SHI is guided by the basic assumption that health is a basic human right and insurance is a tool to advance its implementation whereas Private Health Insurance (PHI) on the other hand views health as a cluster of risks, insurance of which is a profitable economic activity. (UN, 1948 & 1997, WHO 1978). This brings forth the argument that society should provide at least basic health care to all citizens. However, attainment of this status is usually gradual and has to be within a set legal frame work as is illustrated in the examples provided below.

For instance in Belgium during 1851 a special law officially acknowledging the sickness funds (referred to as mutual health funds) was enacted. Sickness funds were based on occupational groups and were rather small-scale. During 1894 registration provided the legal foundation of these funds with a broader scope of activities, while they could henceforth benefit from government subsidies. Subsequently mutual health funds from the same political or ideological background combined into national alliances or unions. Until early 1940's membership to mutual health funds had been voluntary. In 1944 a decree was adopted to make health insurance compulsory for all salaried workers.

In Israel the first health insurance fund, the KUPAT HOLIM CLALIT (General Sickness Fund), was founded in 1911 by agricultural workers in collective settlements (Kibbutz) which during 1920 was taken over by the HISTANDRUT (General Federation of Labour) and became one of its political power bases. In 1920 three other health insurance funds were established and by 1948 when Israel gained statehood, 53% of the population was covered 80% being members of

general sickness funds. By 1995 when National Health Insurance Law was voted 96% of the population was covered. Now it is the duty of every resident to register as a member in one of the existing funds.

Meanwhile the origin of SHI in Japan is the development of voluntary community health insurance scheme in the nineteenth century. In 1935 a community health insurance scheme (having rice as a pre-paid contribution and basic care as the main benefit) was established in the Fukuoka Prefecture. In the 1930's government encouraged the replication of community health insurance on a National Citizens Health Insurance law based on community financing principle but with cash-based contribution was proclaimed and implemented. The law was designed to meet the needs of poor in underserved rural villages, the farmers and self employed workers in rural communities and small companies. It was initially run on voluntary basis. In 1922 a law was voted establishing compulsory insurance for selected groups of workers and by 1945 employee health insurance together with National Citizen's Health Insurance covered 60% of the population. Legislation establishing compulsory insurance for all was finally adopted during 1958 and was implemented in 1961. (Carin, 2004)

2.6 Community Based Health Insurance Schemes

Community Based Health Insurance Schemes (CBHI) is a general term for voluntary health insurance schemes organized at community level that are alternatively known as mutual health organizations (Criel, 2004). A form of insurance based on the concept of mutual aid and social solidarity, CBHI finds ways for communities to meet their health financing needs through pooled revenue collection and resource allocation. CBHI may develop around geographical entities (Village or district), trade unions, agricultural co-operatives or health care facilities and are typically designed by and for the people in the informal and rural sector who are unable to get adequate public, private or employer-sponsored health insurance. They usually depend upon members to help manage and run the scheme (PHR Plus, 2004).

The current Social Health Insurance systems in Germany, Belgium, Israel, and Japan among other countries have grown out of small-scale community based schemes that would meet the definition of CBHI. SHI in these countries can trace its roots back to mutual aid societies that

existed centuries ago, although these are what are now referred to as Community Based Health Insurance (CBHI) because they were not organized on a national scale. One of the first countries to institute social health insurance nationally was Germany in 1883. Like many other European countries Germany already had small funds often serving a particular employment group. A national structure was created from these funds and compulsory membership for almost all Germans was gradually phased in.

Many non-profit mutual community based health insurance scheme have recently emerged in developing countries. These schemes are characterized by mutual aid, solidarity and collective pooling of health risks. With the realization that even the poor can make small periodic contributions that can go towards meeting their health care needs, health insurance is increasingly being recognized as a tool for financing health care provision in low-income countries (Jutling, 2003).

The last two decades have seen a boom in CBHI in the sub-Sahara Africa .The current wave of promotion of CBHI in Africa is propelled by the need to access quality health care and the success of the Western European experience social health insurance initiated through CBHI schemes at the end of the 19th and beginning of the 20th century (Criel 2004). Whitehead (2001) states that a vast majority of the poor trapped in grinding poverty are perfectly capable of working their way out of it and do not need handouts which create dependence and kills initiative. Case studies of CBHI schemes and Micro Finance Institutions (MFI) sponsored health insurance schemes in Africa and Asia demonstrate that the poor are indeed perfectly capable of overcoming the various barriers that inhibit low-income earners from accessing health care.

In Tanzania Umoja Wa Matibabu Sekta Isiyo Rasmi Dar-es-salaam (UMASIDA) has a Health Insurance Scheme for the informal economy operators, 81% of whom live below the poverty line and who are considered too poor to pay for insurance. The contribution of UMASIDA towards health insurance show that informal economy operators can not only contribute towards their health insurance but they are able to insure themselves provided they participate fully in these arrangements and an appropriate method is adopted.(Kiwara, 2007). UMASIDA brings together mutual cells consisting of ten families each of which pays a monthly premium of Tshs.1,500.00 (US$1.3). These premiums, which are paid either directly or through a common group, cover

outpatient care, specified laboratory test and generic prescription for a member, spouse and four children below the age of 18 at dispensaries or health centers owned by UMASIDA. Cost is controlled by insisting on generic prescription and restricting all referrals to public hospitals. However, a deductible or co-payment of Tshs.500.00 (US$ 0.5) is payable per episode. The mutual cells make it easy for beneficiaries to encourage each other to pay premiums and through training workshops on the benefits of the scheme, measures are established to counter adverse selection. Because the instalments are small other daily or monthly needs are not compromised and so the scheme becomes viable and sustainable (Kiwara, 2007). The UMASIDA group premium approach could apply in the Kenyan informal sector where most practitioners also reside in informal settlements such as the Kibera Slums of Nairobi where mutual cells could be established as a basis of CBHI.

Criel, (1997) demonstrates that health insurance for the poor may also be hospital based as is the case with The Bwamanda Scheme, a voluntary health insurance scheme launched in 1986 in the Bwamanda District of the Democratic Republic of Congo. Members pay an annual subscription computed on community rating basis i.e. equal premiums for all. The annual subscription which is paid in cash is payable at a time coinciding with the purchase of Coffee and Soya beans crops and is equivalent to the price of 2kgs of Soya beans yet this enables the members to access 23 health centers and a 138-bed referral hospital. The members are also required to pay a co-payment at 20% of the rate charged to non-members. Starting with 32,600 people in 1986, the scheme had a positive financial balance after the first year of operation and even reported a small surplus of approximately US$1,300. Moreover, the district management team received substantial support from Centre de Developpement Integror (CDI) a non-profit organization that agreed at the start of the scheme to act as financial guarantors and committed itself to cover financial deficit, which could jeopardize the credibility of the insurance scheme. The scheme, which attracted 60,000 members, was launched in a setting where people trusted the management of the scheme, where subscription premium for participating households was subsidized, where the quality of health care supplied was of relatively high standard and where the district medical team had the freedom, willingness and skill to test change (Criel, 1997). The experience of the Bwamanda scheme could apply in the Kenyan system where the setup of health services is similar and might similarly gain acceptance if mission hospitals, in collaboration with Non-governmental organizations take up the initiative.

In Kenya a credit society christened Jamii Bora Trust which was established during 1999 with an initial membership of 50 street beggars has for the past ten years been engaged in a mission of making a difference in the lives of some of the most marginalized members of society. By December 2007 the Trust had 200,000 registered members. Jamii Bora Trust encourages street urchins and slum dwellers to turn to small trusts to save and get credit plus insurance services that would otherwise be unaffordable (Wanjibu Vol. 16. No.2, 2001). Members pay a registration fee of Kshs.50.00, a Kshs.50.00 contribution towards a disaster fund and are then required to deposit at least Kshs.50.00 saving with the trust on a weekly basis in addition to paying a weekly premium of Kshs.30.00 towards Jamii Bora Health Program. Premiums for Jamii Bora Health Program are also payable in a lump sum annual payment of Kshs.1,200.00 or in twelve instalments of Kshs.120.00 per month. The medical cover provided by Jamii Bora Health Program is in respect of one adult and four children below the age of eighteen while every additional child is covered at an extra premium of Kshs.240.00 per annum (Kenya Community Based Health Financing Association, 2007). Besides the health programme, Jamii Bora offers life insurance at the rate 1% of the loan amount for which upon death or permanent disability, the trust clears the outstanding loan while the family of the deceased is paid twice the amount of the deceased's savings with the trust. The medical benefits commence immediately on payment of the lump sum annual premiums or the first instalments as there is no waiting period while their medical cover has no upper limit. The Trust has contracted with 45 hospitals country wide which offer in-patient services to Trust members and invoice the trust on a monthly basis. Cover extends to include maternity cases and HIV Aids related illness. Meanwhile Jamii Bora Trust has hired professional staff who maintain records on all transactions related to the health program (Wanjibu Vol. 16. No.2, 2001)

In India, a self-help group has managed to overcome major hurdles and offers its own insurance. The Self-Employed Women's Association (SEWA), a trade union for female informal sector workers that was established by Ela Bhatt and registered at Ahmedabad in India during 1972 is an organization whose membership is drawn primarily from both urban and rural women working in the informal economy. SEWA's main goals are to organize women workers for full employment so that they can obtain income, food and social security. Besides forming a union, SEWA has created a bank, childcare co-operative, a health programme and has developed an insurance scheme known as Vimosewa to provide Insurance benefits (Garand, 2005). Vimosewa

began during 1992 as a Trust operated by SEWA Union. The Insurance plan started as a means of social solidarity without which traditional approaches such as borrowing from savings group/bank savings, moneylenders, aid of relatives, pawning and selling of assets to meet expenses are used. Vimosewa explains insurance as "*All contribute to a common pot: those who have faced the prescribed risk can take from the pot as per the rules and regulations decided by all*" Beginning with a membership of 50,000 in 1992, Vimosewa has weathered many storms and progressed well in achieving its mission to provide social protection for SEWA members through an insurance organization which they themselves are the users, owners and managers of. Vimosewa's efforts have been recognized by the GTZ who, in 1998, offered funding to develop greater management and insurance capacity for the group (SEWA Insurance, 2009).

Stalper (2000) states that governments too are recognizing the important role CBHI can play in dealing with the risk of illness. In Nepal, the Ministry of Health (MOH) set up a Health Economic and Financial Unit (HEFU) whose mandate was, through capacity building, training, research and studies, to develop an efficient, equitable and sustainable health care system that can contribute to the reduction of poverty by preventing diseases and providing a healthy work force in Nepal. HEFU set up special committee that regrouped the main actors and support organizations interested in the promotion of health in the micro-insurance schemes to share information and experience and prepare training materials. In India, the government, through the Insurance Regulatory and Developmental Authority (IRDA) requires that the formal insurance industry serve the low-income market (Ahuja 2000). These companies hence cooperate with organizations providing micro-insurance to meet the statutory minimum premiums that must be collected from the low-income members of the society. Therefore, in India micro-insurance provider either offer self-insurance, also termed full service provider, or partner with an insurance company (Stalper, 2000).

2.7 Factors Influencing the Success of CBHI

The success of Social Insurance Schemes depends on different factors but mainly on the degree of group cohesion, the administrative capacity to collect contributions and streamlining procedures for claiming and paying benefits. (Maes, 2003).

Carrin (2003), identifies six factors to include affordability of contributions, unit of enrolment e g. households or even cooperatives or mutual benefit societies vis-avis individual membership that is prone to adverse selection, distance of the household's home from the nearest health facility, timing of collecting such that contribution is supposed to match with income pattern, quality of care offered by the CBHI and the trust the group facilitating the establishment of CBHI has won from the population. The mechanism of risk-pooling applied such as reinsurance, establishing large pools, partnership with local and/or central government, progressive scaling up of CBHI and eventual merging also contribute to the success of CBHI.

A study carried out by Churchill and Wohlner (2004) on Improving Risk Management for the poor shows that for community based micro-insurance to effectively function where partnership approach is operational, there has to be real integral partnership within the "people's" organizations. The products have to be agreed on by partner organizations, in a transparent manner, as it is important that the products meet the genuine needs of clients. A real and integral partnership implies that the partners are open with and trust each other. The Products should be kept as simple as possible given the coverage needs. There has to be group insurance for insurance by its very nature is a collective enterprise where a large pool of similar lives, objects, or eventualities is being insured so that the "law of large numbers", spread of risk and avoidance of "anti-selection" can come into play. Marketing costs have to be minimal and therefore commissions have to be avoided. Costs can be further minimised by emphasising on risk only coverage. Automatic linking of insurance to other activities does contribute to the success of micro-insurance e.g. taking a loan in a micro-finance institution often leads automatically, and without additional cost, to group life insurance coverage.

Costs are further reduced by making aggregated premium payments. The premium may be paid out of the organization's revenue or aggregated by a variety of methods e.g. by direct debit from member's accounts as a part of membership dues etc Churchill (2004). Administration could be streamlined by integrating into already existing systems of a people's organization. The people's organization can in many cases maintain all records and only send copies of particular information to the Insurers when a claim is made. The claim procedures and verification have to be simple and there has to be rapid delivery of benefit payments to maintain faith in the insurance scheme, in the Insurer and in the people's organization itself. People's organizations

settling claims themselves enables the most rapid delivery of benefits. Finally, a profit sharing mechanism would be a good way to strengthen the integral partnership as well as provide a way for the insurer to gain greater interest and co-operation from the people's organization.

Criel, (1997), in their study of Bwamanda Scheme identified organizational or managerial capacity of the insurance provider as one of the factors that determine the success or failure of the scheme. Equally important are economic factors that involve value-maintaining mechanism for the collected fund, as are social factors such as faith in the management team's ability and trustworthiness to manage the scheme.

2.8 The National Hospital Insurance Act

The transition to UHC in Kenya commenced in earnest with the National Hospital Insurance Act, which established the National Hospital Insurance Fund (NHIF) under the control and management of the Ministry of Health. The fund came into operation on 12th July 1966 with the intention of covering partial in-patient health care costs for members. Adult workers earning a salary exceeding Kshs.1,000.00 per month were required to make a monthly contribution of Kshs.20.00. Their employers, who qualified for registration with the fund if they had at least five employees, would affix a Kshs.20.00 stamp to the contributor's card every month. In 1972, the act was amended to accommodate voluntary members and during 1990, the act was repealed to allow contribution on a gradual scale of income. Later the fund was de linked from the Ministry by the NHIF Act of 1988 (Daily Nation Nov 29, 2006). The benefits entitled to members by the act were a daily allowance towards the cost of in-patient treatment for a period of 180 days in a financial year. Surplus funds were supposed to be invested as per the Trustee Act in ways determined by the Minister of Health with the approval of the Minister of Finance (NHIF, 2009).

Though the fund was started with very good intentions, it has not kept pace with rising medical costs. The "surplus" in the fund has been misappropriated or been inappropriately invested (MOH Sessional Paper on NSHI in Kenya August 2003).

To counter the shortfalls of NHIF the MOH Seasonal Paper on National Social Health Insurance in Kenya of July 2003 set out to replace the NHIF with NSHIF. NSHIF aimed to attain UHC in

twelve years. Under NSHIF, Kenyans would pay small regular premiums to act as insurance for in-patient and outpatient medical care. The government was to subsidize the poor by earmarking at least 11% of total expected revenue from consumption taxes to be paid into the NSHIF (Sessional Paper on National Social Health Insurance in Kenya, 2003). Despite opposition by various stakeholders to the proposed National Health Social Insurance Bill, in 2004 it sailed through parliament but failed to become law when the President failed to assent to it.

Since then the Minister of Health has been promising to reintroduce the Bill in parliament but that is yet to take place. Meanwhile, within the framework of the current law, during 2006 NHIF introduced a comprehensive in-patient cover. NHIF has contracted hospitals under three categories A, B, and C to provide in-patient medical cover and partial cover for surgical cases in some of those hospitals. In Category "A" hospitals, members are now able to enjoy full and comprehensive cover for maternity and medical diseases including surgery. They are not required to pay anything on admission provided they are fully paid up members. At Category "B" (private and mission) hospitals, members enjoy full and comprehensive cover but may be required to co-pay where surgery is required. Under category "C" (private hospitals), NHIF pays specified daily benefits. Under the comprehensive cover NHIF is providing an in-patient cover for up to Kshs.360,000.00 (US$4,500) per year each for the contributor, spouse and children below the age of 18. NHIF pays between Kshs.400 (US$5) to Kshs.2,400.00 (US$25) per day up to 180 days (NHIF, 2009). Since the introduction of the comprehensive cover, NHIF has also engaged in a rigorous expansion campaign with an aim of increasing voluntary members and is currently targeting the informal sector and, to attract retirees, the 65- year age limit for medical cover has been abolished. (Siringi, 2006).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Design

The research design employed in this study was a descriptive survey method that sought to establish the capacity of Community Based Organizations in provision of health insurance to the urban poor in Kibera Slum. The survey focused on the factors that facilitate the success of a Community Based Health Insurance and the extend to which these factors are prevalent in the CBOs studied. This method was preferred because it allows for generalization of the research findings. In addition, the method allows an in-depth research which is facilitated by the use of a structured questionnaire.

3.2 Target Population

The target population for this study was the residents of Kibera slums. It was a survey of Nairobi's Kibera slums covering 91 CBOs as registered by the Kibera Division Community Development Assistant (2007). According to this report, the 91 CBOs were confined into 10 locations within the Kibera Slum as summarised in the table below.

	Location/Stratum	Population (No. of CBOs)	Sample Size
1.	Gatwekera	2	1
2.	Kianda	4	1
3.	Kibera	19	6
4.	Lainisaba	19	6
5.	Linder	1	1
6.	Mackinaw	6	2
7.	Mugumoini	11	4
8.	Olympic	3	1
9.	Sarangombe	25	8
10.	Soweto	1	1
	Total	**91**	**31**

3.3 Sample Size and Sampling Techniques

The researcher used stratified random sampling techniques to draw a sample of 31 CBOs from the population. This was done by classifying all the CBOs into their respective locations. The strata were therefore the locations within the Kibera Slum. This technique was preferred because it eliminates any possible bias in selection of the samples. In addition, the technique draws a good representation of all the strata. The sample size was also justifiable since it represents 30% of the population as recommended by Mugenda and Mugenda (1999). The sample size from each stratum is as tabulated in the Table under paragraph 3.2.

3.4 Data Collection

The researcher used primary instruments to collect data. The data was collected by the use of a semi-structured questionnaire that were administered to senior managers in the sampled CBOs. Mail survey through drop and pick criteria was used to administer the questionnaires to the target respondents. Gall and Borg (1996) points out that, questionnaires are appropriate for studies since they collect information that is not directly observable as they inquire about feelings, motivations, attitudes, accomplishments as well as experiences of individuals. They further observe that questionnaires have the added advantage of being less costly and using less time as instruments of data collection. Also, according to Satyanarayana (1983), a questionnaire is useful in obtaining objective data. This is largely because the participants are not manipulated in any way by the researcher. The researcher also carried out personal interviews to clarify matters arising from the questioner.

3.5 Data Analysis

The data collected was both quantitative and qualitative in nature. Quantitative data was analyzed by the use of Statistical Package for Social Sciences (SPSS). Qualitative data was analyzed using the content analysis. The analyzed data has been presented by the use of bar graphs, pie charts and tables. Measures of central tendency like mean, frequency and standard deviation assisted the researcher to interpret the analytical output and thereby enhanced drawing

of a concrete conclusion. Descriptive statistics was used to analyse closed questions of the Likert Scale by use of mean and standard deviation.

The mode of analysis was Pattern-Matching. Attention was paid to the multiplicity of the contexts in which CBOs in Kibera slums operate. The research had a knack for factors favourable to development of CBHI in each CBO. The empirical pattern as derived from each CBO was compared with the predicted pattern as derived from the literature on factors influencing the success of CBHIs and the empirical examples of CBHI documented in the literature review.

4.0 DATA FINDINGS, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter discusses data findings, presentation, analysis and interpretation. Data was analyzed using the SPSS programme and presented using bar graphs and pie charts. The study was on the viability of accessing adequate health insurance for the urban poor through these community based organizations, this research concentrated on Kibera slums. The area of survey was Nairobi's Kibera slums covering 91 CBOs as registered by the Kibera Division Community Development Assistant (2007). According to this report, the 91 CBOs were confined into 10 locations. From the sample of 31 CBOs, 30 CBOs filled and returned the questionnaires correctly. The researchers therefore got a response rate of 97%.

4.2 General information of the respondents

4.2.1 Number of registered members

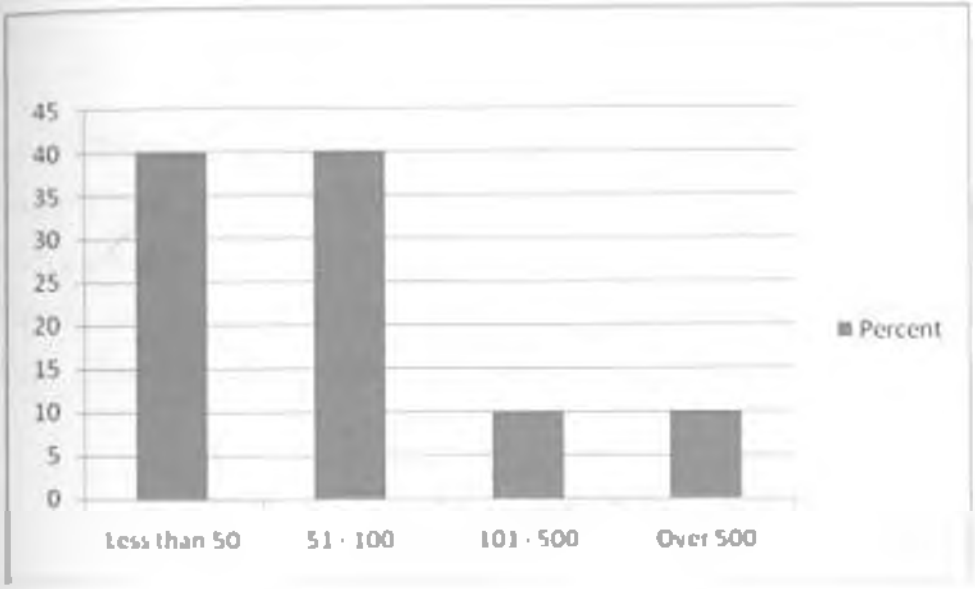
Table 4.1: Number of registered members in the studied CBOs

	Frequency	Percent
Less than 50	12	40
51 - 100	12	40
101 - 500	3	10
Over 500	3	10
Total	30	100

Table 4.1 Shows the number of registered members in the sampled community based organizations.

From the findings as tabulated in Table 4 1 majority of the community based organizations i e 40% had between 51 – 100 members or less than 50 members. Therefore 80% of the CBOs had 100 or less members. Very few (10%) of the groups had 101 – 500 members or above 500. At the upper end only 10% of the CBOs had a membership of over 500. This implies that no individual CBOs have the volume of exposure adequate to sustain a health insurance fund on its own. Thus to get an economically viable volume of exposure an umbrella organization under which the CBOs will set up a health insurance fund for their members has to be formed. Alternatively the CBOs would have to come up with other mechanisms of combining their efforts if a large enough viable health pool that can be relied on to deliver health insurance to their members is to be realized. The same information is put in form of a bar graph below.

Number of registered members



4 2 2 The period the organization has been in existence

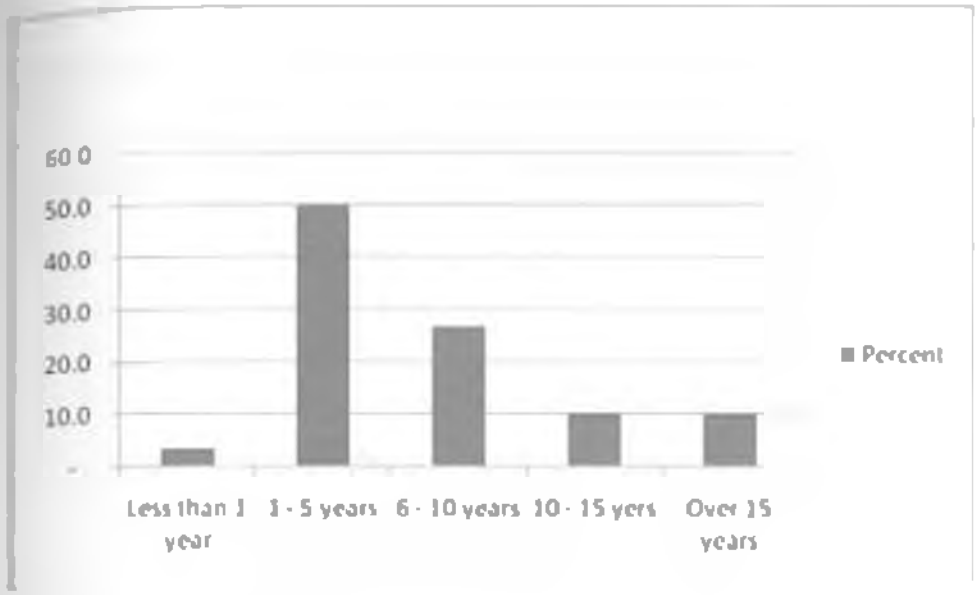
Table 4 2: The period the organization has been in existence

Period of existence	Frequency	Percent
Less than 1 year	1	3.3
1 - 5 years	15	50.0
6 - 10 years	8	26.7
10 - 15 years	3	10.0
Over 15 years	3	10.0
Total	30	100.0

Table 4.2 explains the period that the CBOs have been in operation.

Majority 50.0% of the CBOs had operated for a period between one and five years, with another 3.3% having been in operation for less than a year. This implies that at least 46.7% of the CBOs have survived over five years and thus can be relied on to deliver long term projects such as health insurance. This is further put in form of a bar graph below.

The period the organization has been in operation



4.2.3 Methods of maintaining records for the CBOs

Table 4.3: Whether the organization maintains formal records

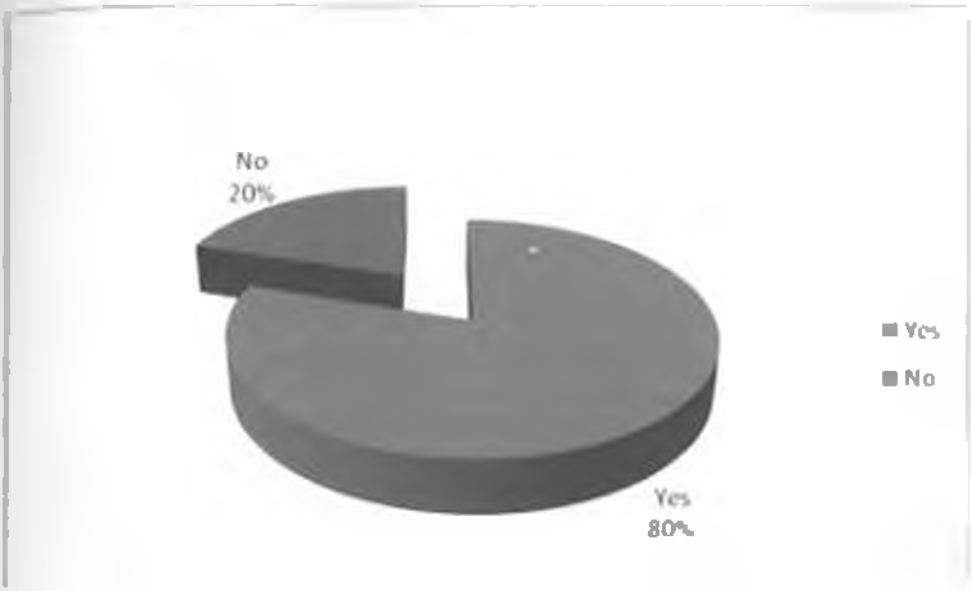
	Frequency	Percent
Yes	24	80
No	6	20
Total	30	100

Table 4.3 demonstrates that the level to which CBOs maintain formal records.

With 80% of these groups maintaining the formal records to include member's registers, minutes, banking records and files detailing all their activities CBOs would be relied on to deliver health insurance which is heavily dependent on formal records to include member's personal records, claim records etc. As no underwriter would succeed without accurate and detailed records of their insured the CBOs do meet one of the criteria of providing successful health insurance that is maintenance of data on members, activities and finances. Only 20% of

the respondents reported that the organization does not maintain formal records. The organizations that do not maintain formal records rely on their members memory of activities and events. The pie chart below explains the same

Whether the organization maintains formal records



4.2.4 The Interval between which members contribute funds to the CBOs

Table 4.4: The intervals between members contribution, in funding the organization

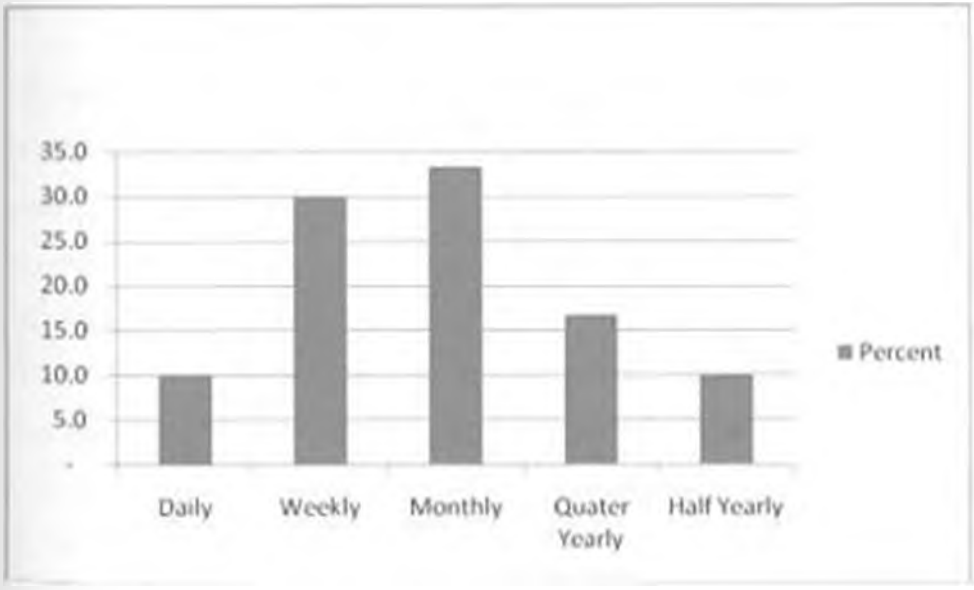
	Frequency	Percent
Daily	3.0	10.0
Weekly	9.0	30.0
Monthly	10.0	33.3
Quarter Yearly	5.0	16.7
Half Yearly	3.0	10.0
Total	30.0	100.0

Table 4.4 shows the intervals between members contribution. in funding the organization.

The result show that the most preferred interval of contribution by members is contribution on a monthly basis with 33.3% of the groups falling in this category. At least 73.3% of all the CBOs studied have their periods of contributing to their organizations ranging between daily to monthly which though very convenient to people of low income would have negative cost implication on any underwriter opting to collect premiums directly from individual members.

However, as demonstrated by CBOs elsewhere, where they have succeeded in providing health insurance to members, individual CBOs if left with the responsibility of collecting premiums from members and forwarding them as group contributions on a monthly, quarterly, half yearly or annual basis to the health pool this hurdle would be overcome. If the underwriter opts for group premiums the interval of premium collection by individual CBO for onward transmission to the underwriter would have a positive impact as it would attract more members as compared to the annual lump sums that would discourage many a member of the CBOs whose earnings are meager and have low level of asset ownership. The same information is put in form of bar graph as shown below.

The interval between members contribution to fund the organization



4.2.5 Existence of factors influencing the success of CBHI in the respondent CBOs

Table 4.5: The extent to which these factors assist in making the group successful

	N	Minimum	Maximum	Mean	Std. Dev
Group cohesion	30.0	1.0	5.0	4.2	1.1
Administration capacity to collect contributions	30.0	2.0	5.0	4.3	0.8
Affordability of contribution	30.0	2.0	5.0	3.7	1.1
Method of enrollment	30.0	2.0	5.0	4.0	0.7
Timing of collections to coincide with members earning patterns	30.0	1.0	5.0	3.5	1.2
Quality of services provided to members by the CBO	30.0	1.0	5.0	3.7	1.3
Assistance received from the government and other organizations	30.0	1.0	5.0	3.3	1.5
Quality of services provided to members by the CBO	30.0	2.0	5.0	3.5	1.2
Faith and trust the members have with the management	30.0	2.0	5.0	3.8	1.1

Table 4.5 shows the extent to which factors that influence the success of CBHI were considered by the respondents to have assisted in the success of their respective CBOs.

In the analysis one meant strongly disagree, two meant that the respondent disagrees, three meant the respondent neither agrees nor disagrees, four meant agreeing while five meant strongly agrees. The higher the mean the higher the number of respondent agreeing that a given factor does exist in their group or does influence the phenomenon under study. Any factor that had a mean score above three (3.0) was an indicator that the responds agreed on the existence or the influence of the factor in their organization. A standard deviation of one and below implied that the responds tended to be in agreement with the opinion as expressed by the mean score attained on the factor under scrutiny. On the other hand a standard deviation above one is an indicator that the respondents do not have a congruence of mind on an opinion. The respondents thus have diverging opinions on the existence or influence of the factor away from the mean score. Thus despite the mean score there is no general agreement on the existence or influence of the factor

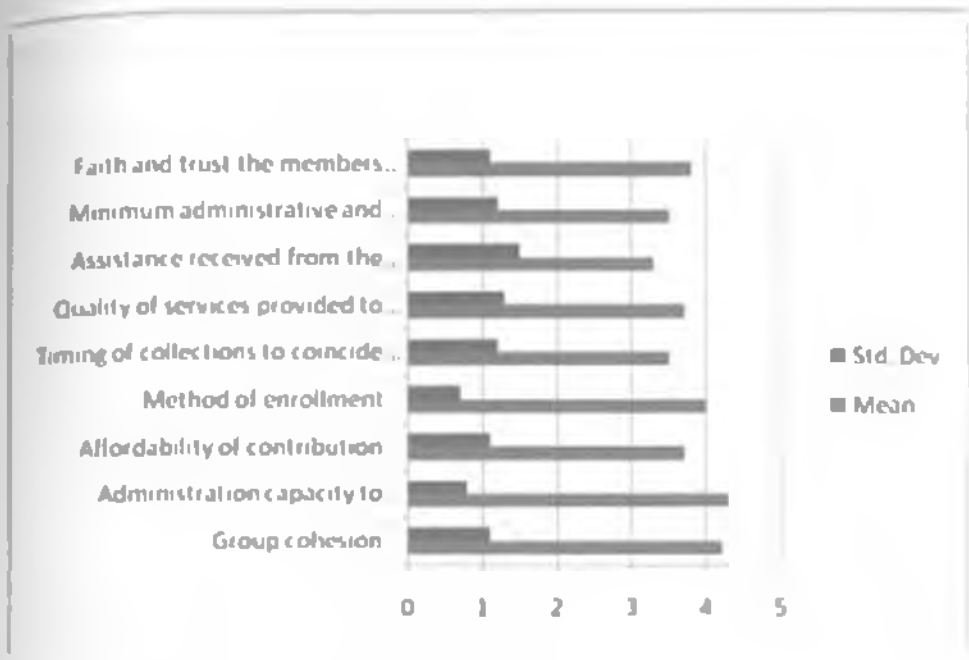
and the mean score cannot be relied on as a basis of generalizing the existence or influence of the factor.

From the findings the administration capacity to collect contributions was identified as the greatest positive contributor to the growth of CBOs with a mean of 4.3 and a standard deviation of 0.8. With a standard deviation of 0.8, administration capacity to collect contributions is prevalent in a majority of the CBOs studied as the dispersion of presence of this factor from the mean is minimal. The success of any insurance scheme is highly influenced by the administrations ability to collect premiums and as this appeared main strength of CBOs studied they would therefore he in a position to collect premiums without any difficulties. Group cohesion has also assisted significantly in the growth of the group with a mean of 4.2 and a std dev of 1.1. This indicates that social networks that would be relied on in the development and sustaining of CBHI are strong.

The method of enrolment which in 56.7% of the groups studied is through soliciting that is utilization of the existing social network to recruit new members is considered as one of the factors that influence the success of the CBOs. The method of enrollment had a high mean score of 4 and a small standard deviation of 0.7. With 90% of members of CBOs being people who interact freely social capital is present in the CBOs studied. The method of enrollment coupled with group cohesion not only influences their success but also enhances the social capital within the CBOs further boosting their ability to provide an avenue for health insurance for members.

The timing of collections to coincide with members earning patterns which as detailed above for 73.3% the CBOs ranged between daily to monthly is acknowledged as contributor to the success of the CBOs with a mean of 3.5 and a standard deviation of 1.2. The CBOs did consider external assistance received as a factor that influences their success. However, this scored the least in the factors that have contributed to the growth of the CBOs with a mean of 3.3 and a std dev of 1.5. Thus they can be relied on to develop CBHI without any external assistance if at all it is not forthcoming. The CBOs agreed or strongly agreed that they possessed all the factors that influence the success of CBHI and would thus be relied on as channels of delivery of health insurance to members and the urban poor at large. The same information is further illustrated in the bar graph below.

The extent to which these factors assist in making the group successful



4.2.6 Amounts contributed by individual members per month

Table 4.6: Individual's contribution per month

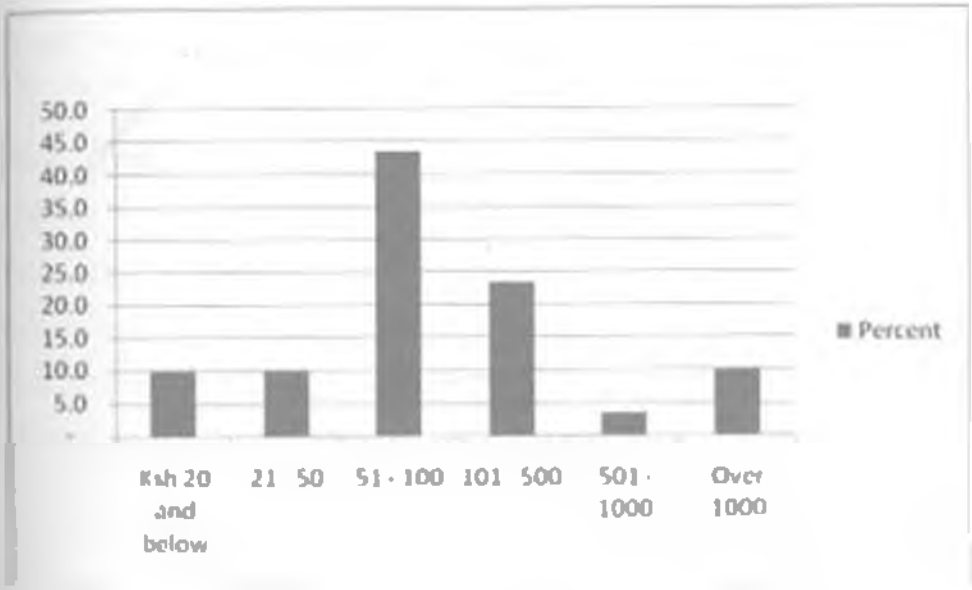
	Frequency	Percent
Kshs. 20 and below	3.0	10.0
21 - 50	3.0	10.0
51 - 100	13.0	43.3
101 - 500	7.0	23.3
501 - 1000	1.0	3.3
Over 1000	3.0	10.0
Total	30.0	100.0

Table 4.6 shows individual's contribution per month. Majority 43.3% contributing Kshs. 51 -100 per month, 23.3% contributing between Kshs.101 and 500, while only 13.3% were able to contribute over Kshs. 500 in a month. In the event that the CBOs adapt a monthly premium of

Kshs 100 as is the case with UMASIDA of Tanzania, Kshs.120 monthly premium charged by Jamii Bora of Kenya or Kshs.10 per day as charged by COMOCO SACCO all who run successful health insurance schemes monthly contributions will have to increase significantly.

With monthly contributions being inflated to between Kshs.101 and Kshs.500 by inclusion of the monthly premiums of at least Kshs120 per month 36.7% of the CBOs would afford to contribute to the health insurance pool. Having established that 40% of the CBOs have less than 50 members while another 40% have 51-100 members and only 20% have a membership of over 100 members rigorous recruitment campaigns require to be undertaken to attain adequate volume of exposure. CBOs also have to collaborate to achieve the required numbers for an economically viable health insurance fund or partner with already existing community based health insurance schemes. The same information is put in form of a bar graph.

Individual's contribution per month



4 2.7 Manner of keeping the funds collected

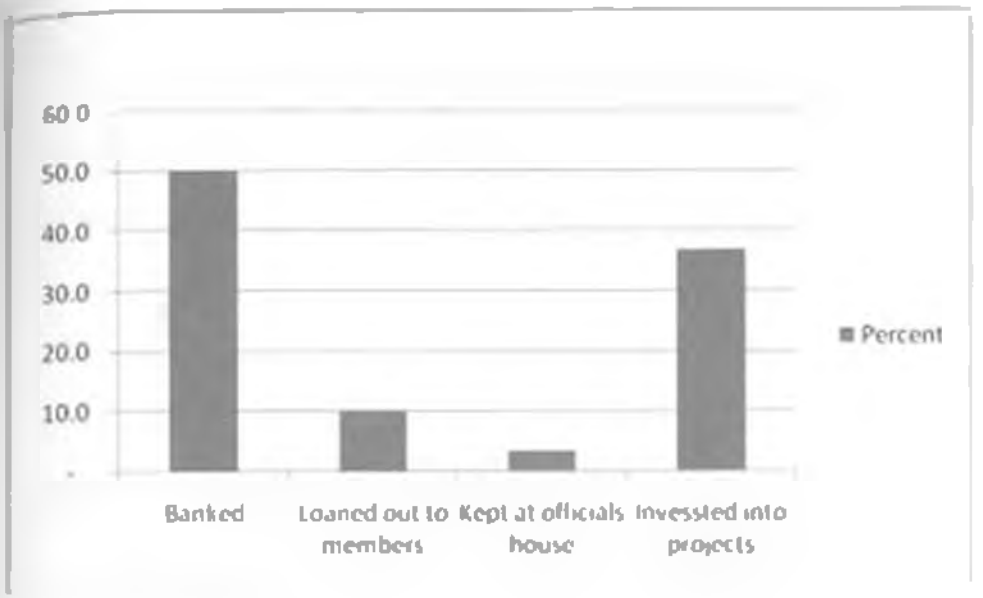
Table 4.7: How the collected funds are kept

	Frequency	Percent
Banked	15.0	50.0
Loaned out to members	3.0	10.0
Kept at officials house	1.0	3.3
Invested into projects	11.0	36.7
Total	30.0	100.0

Table 4.7 explains how the collected funds were kept.

Majority 50% of the groups banked the money, 10% loaned it to members, 36.7% invested it while only 3.3% kept the money in an official's house. This shows that the groups uphold proper accounting procedures and amounts accumulated for payments of claims in future would not be let to remain idle for they would be properly invested. The bar graph below explains the same information.

How the collected funds are kept



4.2.8 Methods of vetting new members

Table 4.8: The process of vetting and recruiting new members

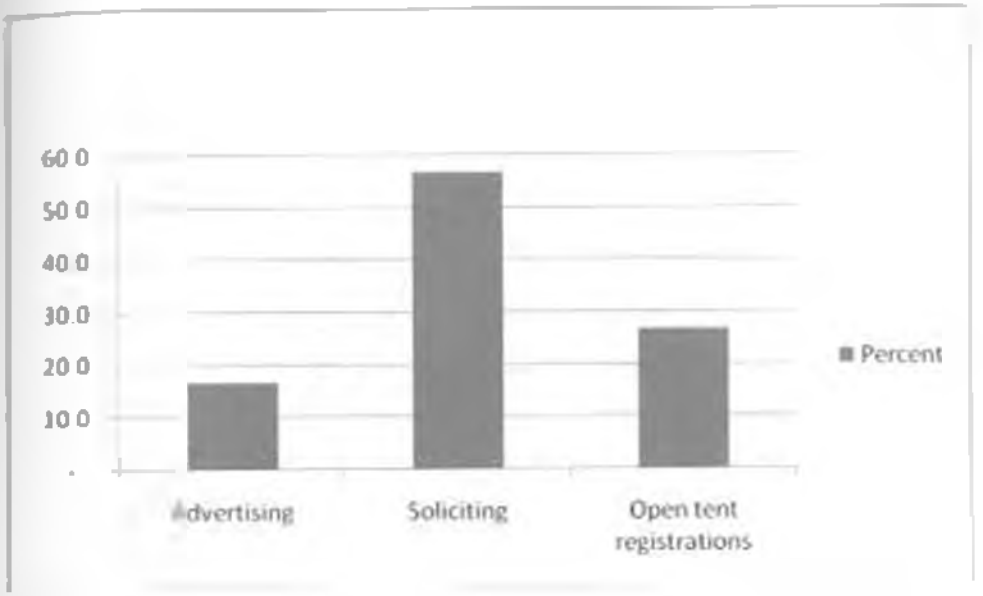
	Frequency	Percent
Advertising	5.0	16.7
Soliciting	17.0	56.7
Open tent registrations	8.0	26.7
Total	30.0	100.0

Table 4.8 explains the process of vetting and recruiting new members.

Most 56.7% of the groups were soliciting for new members, while only 16.7% were advertising for membership. Other modes of recruitment included application by interested members, enrolment during public awareness campaigns, picking on brilliant trainees after workshops and through community social networks. This implies that the members of the CBOs are derived

from a social network which is an indicator of the existence of social capital upon which the CBHI would be based. In such a situation members would encourage each other to pay premiums and enforce measures of countering adverse selection. This is further explained in the bar graph below.

The process of vetting and recruiting new members



4.2.9 Disciplinary measures in the CBOs

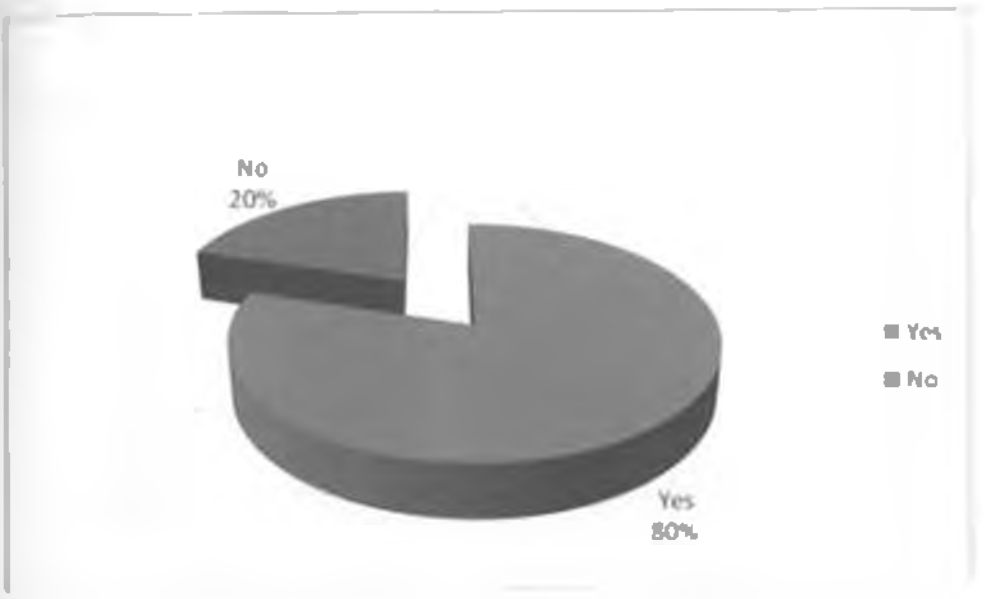
Table 4.9: Whether there have been situations where a member is forced to resign.

	Frequency	Percent
Yes	24	80
No	6	20
Total	30	100

Table 4.9 shows whether there have been situations where a member is forced to resign, or expelled from the organization. Most 80% of the groups had such a situation while only 20%had

not got to that extent. The reasons behind this action included members inactivity, misconduct, loan default, misuse of group funds and display of anti-social behaviors that would ruin the harmonious co-existence of members. This implies that the not only concerned about the harmonious co-existence of members but have also put in place disciplinary measures that enhance ease of administration. The pie chart below explains the same information

Whether there have been situations where a member is forced to resign.



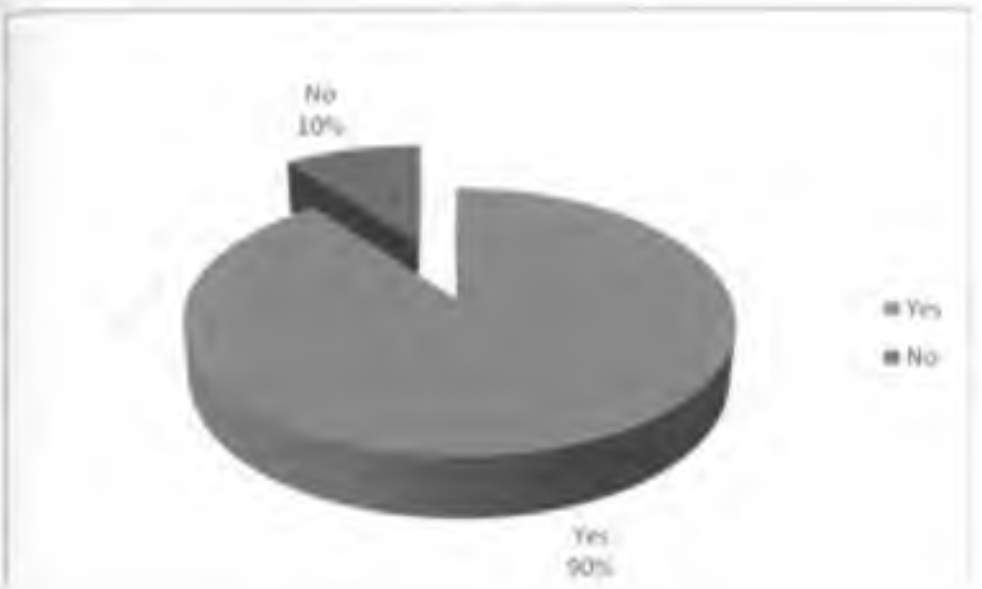
4.2.10 Level of interaction of members

Table 4.10: Whether the members interact freely

	Frequency	Percent
Yes	27	90
No	3	10
Total	30	100

Table 4.10 shows whether the members interacted freely. Majority 90% of the groups had members who interacted freely, while only 10% were not interacting freely. This implies that the CBOs possess vital resource of social capital in the form of persons, social relations, co-operation, norms, values, trust, network and institutions which can be utilized for the development and improvement of the social-economic welfare of society. Members had a friendly coexistence and hence were able to work towards common goals. No explanation was offered in all instances where it was indicated that members were not interacting freely. This information is represented in the pie chart below.

Whether the members interact freely



4.2.11 Factors influencing admission of a new member into the CBO

Table 4.11: The extent to which the factors contribute to a new member being admitted to the group

	N	Minimum	Maximum	Mean	Std. Dev
Being a friend to the officials	30.0	1.0	5.0	2.1	1.1
Being well known to the existing members	30.0	1.0	5.0	3.5	1.4
Living in particular neighborhood	30.0	1.0	5.0	3.4	1.7
Not being a member of particular tribe	30.0	1.0	5.0	2.7	1.8
Belonging to or not belonging to a particular religious community	30.0	1.0	4.0	1.5	0.8
Being an active member of other groups	30.0	1.0	5.0	2.3	1.4
Having skills that the group would require	30.0	1.0	5.0	2.9	1.7
By the virtue of their trade, profession and place of work.	30.0	1.0	4.0	2.4	1.4
Being imposed by the politicians or government agents	30.0	1.0	5.0	1.5	1.3
By possessing a particular physical or health condition	30.0	1.0	5.0	2.6	1.7

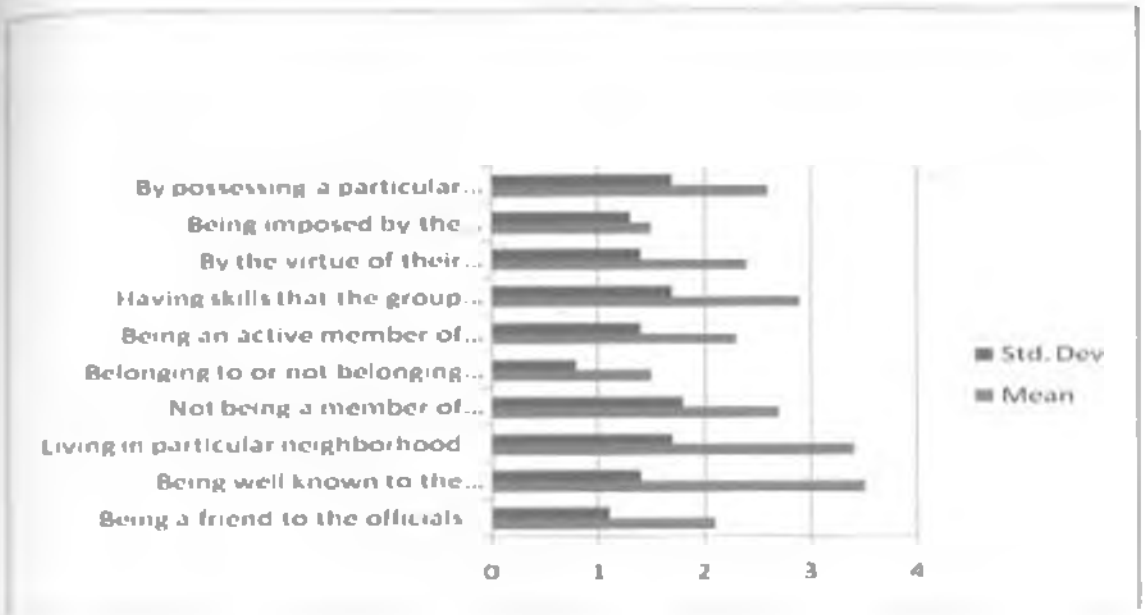
Table 4.11 demonstrates the extent to which the factors contribute to a new member being admitted to the group.

Being well known to existing members of the CBO and living in a particular neighborhood are the factors that influence recruitment of new members. Being well known to existing members had a mean scored of 3.5 with a standard deviation of 1.4. Thus though from the means score of 3.5 this factor would be viewed as being a contributory factor to new members being admitted to the CBOs there is no unanimity on the significance of this factor in influencing recruitment of a new member as it had high standard deviation of 1.4. Similarly living in a particular neighborhood did influence the recruitment of a new member since it had a mean of 3.4 but once again the factor had a high a standard deviation of 1.7 which showed deviation of opinions on the influence of this factor. The rest of the factors had a mean below 3 indicating that have no significant influence on a new member being admitted into the group. However, except for religious inclination that had a standard deviation of 0.8 implying that the CBOs did generally

agree that this factor was not significant the other factors had high standard deviations and thus their influence could not be ruled out. The responses received on factors contributing to a new member being admitted to a group, show that the CBOs possess factors that counter adverse selection and enhance social capital. As the CBHI scheme are run by members themselves these factors strengthens the administrative capacity of the CBHI schemes as members are known to each other and have good knowledge of new members.

Influence from politicians or government agents had the lowest mean of 1.5 though there was no unanimity on this factor as it had a standard deviation of 1.3 contrary to religious inclination which despite having a similar mean score had a low standard deviation of 0.8. However, at least 10% of the respondents did consider the tribal factor a major factor in their admitting new members. We noted that this was mainly influenced by the fact that during the post election violence of January 2008 property of their members were destroyed purely because the members were of a particular ethnic background and since then the tribes considered hostile have not ceased baying for their blood and would destroy their property at the slightest provocation. Properties seized from their members during the skirmishes are yet to be returned. This brought to the fore the issue of tribal and political hostility that has to be addressed if the CBOs quest for collaboration to achieve adequate volumes of exposure will be realized.
This is also put in form of a bar graph as shown below.

The extent to which the factors contribute to a new member being admitted to the group



4.2.12 Challenges facing the CBOS

Table 4.12: The extent to which the challenges have slowed down the pace of growth of the organization

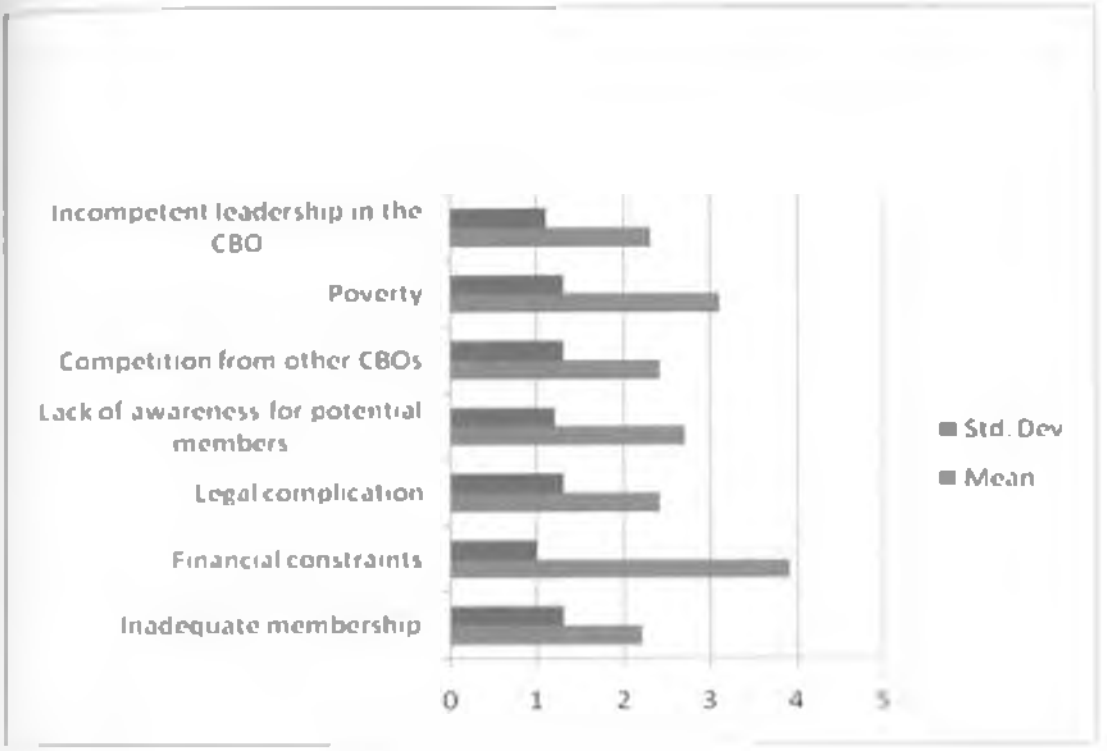
	N	Minimum	Maximum	Mean	Std. Dev
Inadequate membership	30.0	1.0	5.0	2.2	1.3
Financial constraints	30.0	2.0	5.0	3.9	1.0
Legal complication	30.0	1.0	5.0	2.4	1.3
Lack of awareness for potential members	30.0	1.0	5.0	2.7	1.2
Competition from other CBOs	30.0	1.0	5.0	2.4	1.3
Poverty	30.0	1.0	5.0	3.1	1.3
Incompetent leadership in the CBO	30.0	1.0	5.0	2.3	1.1

Table 4.12 shows the extent to which the challenges have slowed down the pace of growth of the organization.

From the findings majority of the respondents agreed that financial constraints is the biggest challenge to the growth of their CBOs with a mean of 3.9 and a standard deviation of 1.0, while poverty which has a direct relation with the aforementioned challenge of financial constraint ranks second with a mean of 3.1., though with a higher standard deviation of 1.3. With membership of CBOs being mainly below 100 members per group and assistance from the government or other organizations being largely absent these factors would pose major challenges to the establishment of CBHI for the urban poor.

However, with increased membership, collaboration between CBOs and seeking of external assistance as is the case with BAMWADA CBHI the capacity of CBOs to deliver health insurance to members and the urban poor would be enhanced. Factors like inadequate membership, lack of awareness for potential members and incompetent leadership turned out to be insignificant. Thus for the purpose the CBOs are currently constituted, they consider their membership adequate and similarly they should be able to get adequate membership for CBHI as they have done with the activities they are currently undertaking. The CBOs also appear to be popularizing themselves well in the areas they operate from, as potential members have no difficulties identifying them and they have competent leadership which is a boon for CBOs in their endeavors. The same information is expressed in form of bar graph.

The extent to which the challenges have slowed down the pace of growth of the organization



4.2.13 Level of collaboration within the various CBOs

Table 4.13: Whether the organization undertakes joint activities with other CBOs

	Frequency	Percent
Yes	19.0	63.3
No	11.0	36.7
Total	30.0	100.0

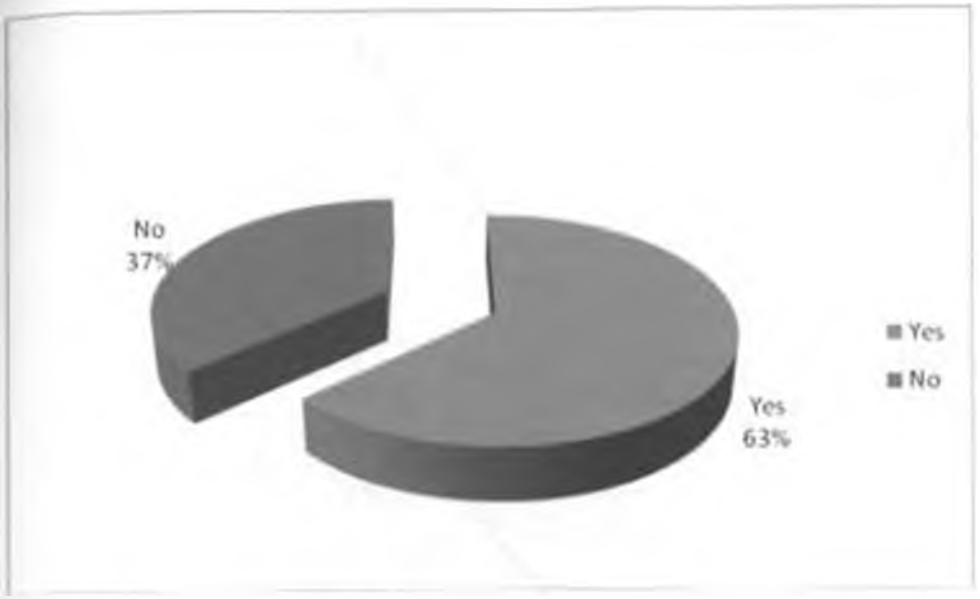
Table 4.13 explains whether the organization undertake joint activities with other CBOs. Most 63.3% of the groups do while only 36.7% do not. It also emerged that 10% of the CBOs are members of other organizations that bring together CBOs and individuals for saving and credit purposes among other activities. Respondents identified two such organizations namely Juhudi

Self Help Group and COMOCO is a Savings and Credit Society. Juhudi Self Help Group is a self help group that is strictly for corporate members and is involved in savings and credit activities through K-Rep Micro-Finance. It enrolls CBOs whose membership is restricted to 30 members to enhance their credit worthiness. COMOCO Savings and Credit Co-operative Society Limited on the other hand is a Savings and Credit Society registered in 1977 with the aim of affording employees of CMC Holding Limited and Simba Colts Motors Limited an opportunity to save and borrow. It recruits small and micro business people through their Micro Saver Project. CBOs independently registered with COMOCO which not only affords then savings and credit facilities but also offers health insurance to individual members of the CBOs. For only Kshs. 10.00 a day members of the CBOs registered with COMOCO enjoy a comprehensive family medical cover, personal accident cover of up to Kshs.100,000.00 and funeral expenses.

This implies that the community based organizations are largely able to work together for the good of the community. Similarly they can collaborate within themselves and/or with other organizations to overcome the problem of lack of adequate volume of exposure at the individual CBO level together with financial constrains and come up with viable CBHI schemes.

Of the groups that do not undertake joint activities with others 71.4% are either restricted by the unique nature of the activities they undertake or have not had the opportunity to interact with other groups. However, 28.6% of the groups that had not undertaken joint activities with other groups had been influenced by tribal animosity whereby given a chance they would only work with groups constituted purely by their tribe mates. The violence that erupted in Kibera following the 2007 general elections had a major influence in the concerned groups disinterest in working with other groups. The pie chart below explains the same

Whether the organization undertakes joint activities with other CBOs



4.2.14 Extent of members involvement in decision making.

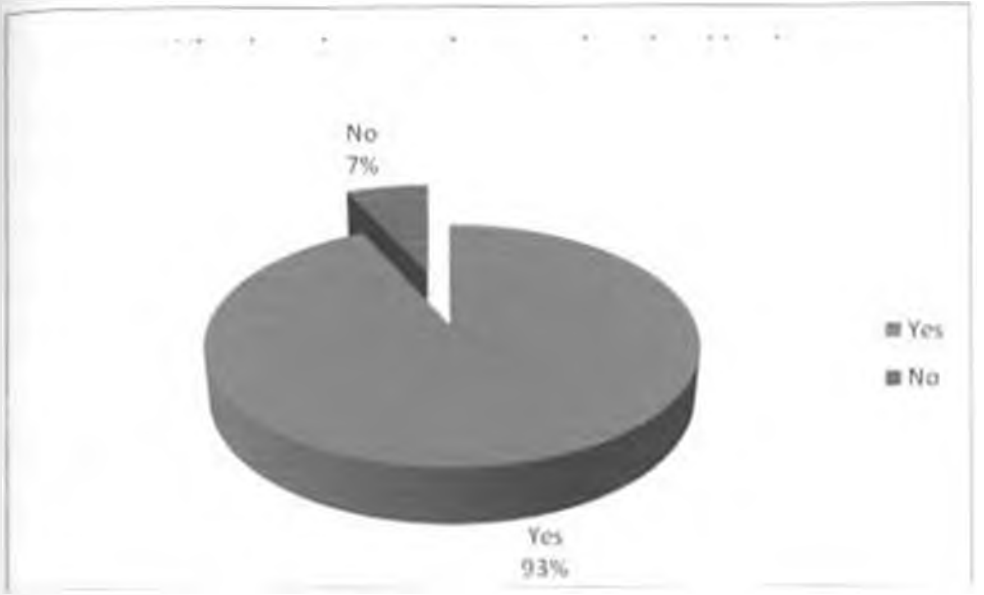
Table 4.14: Whether the members are involved in the organization's decision making

	Frequency	Percent
Yes	28.0	93.3
No	2.0	6.7
Total	30.0	100.0

Table 4.14 shows whether the members are involved in the organization's decision making. Most 93.3% of the groups involve the members in decision making while only 6.7% do not. This means that members have a sense of ownership of the organizations which would translate to useful support for CBHI if members opt to resort to them to address their health needs. As they are involved in decision making a decision to adopt CBHI or join an organization that provides health insurance would not only be in direct response to their needs but would also be owned by members. The 6.7% of the CBOs that do not involve their members in decision making did not

offer any reason as to why members are left out of the decision making process. This is also put in form of a pie chart as shown below.

Whether the members are involved in the organization's decisions making



4.2.15 Factors contributing to poor health of members of CBOs

Table 4.15: The extent to which the factors contribute to poor health of the members of the group

	N	Minimum	Maximum	Mean	Std Dev
Long distances from the hospitals	30	1.0	5.0	2.8	1.2
Lack of facilities and drugs at health centers/ hospitals	30	1.0	5.0	3.8	1.1
The expensive fees charged at health facilities	30	1.0	5.0	3.9	1.1
Lack of access to good diet by members due to poverty	30	2.0	5.0	4.0	0.9
Apathy of the members to modern medicine and medical facilities	30	1.0	5.0	3.0	1.5
Poor sanitation within the neighborhood	30	2.0	5.0	4.5	0.7
Ignorance of members of the available health facilities	30	1.0	5.0	2.5	1.4

Table 4.5 shows extent to which the factors contribute to poor health of the members of the group.

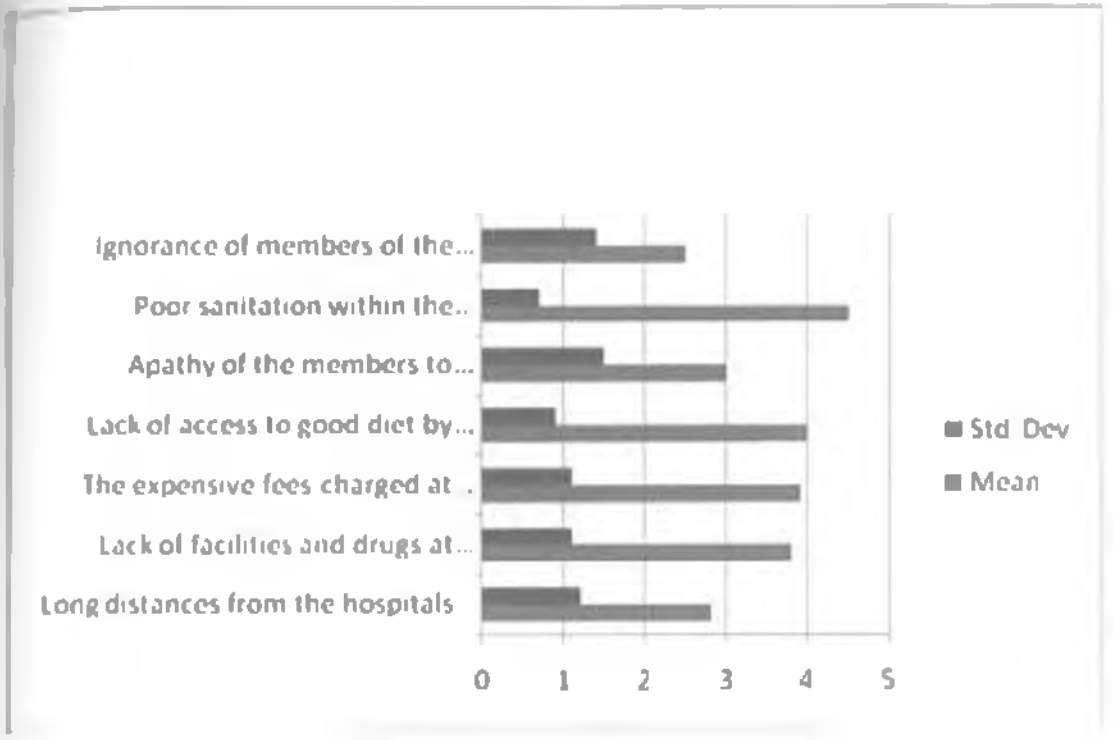
Poor sanitation within the neighborhood was reported as the main hazard of the risk of ill health that faces members of the CBOs studied. Poor sanitation had a mean 4.5 which indicates that on average most groups concurred on the negative impact poor sanitation had on members health while the standard deviation of 0.7 was a show that most opinions tended the gravitate towards the mean on this issue. The CBOs too agreed that lack of access to good diet by their members does contribute to members poor health as this factor had a mean of 4.0 and a standard deviation of 0.9. With a mean of 3.9 and a standard deviation of 1.1 the expensive fees charged at health facilities was also viewed as an active hazard to the risk of ill health for the urban poor.

The facilities and stock of drugs in the health centers/hospitals in Kibera were found wanting as indicated by the mean score of 3.8 and standard deviation of 1.1 for this factor. Thus any risk management measures undertaken by providers of health insurance to the urban poor must address the issues of poor sanitation, poor diet, medical charges and quality of services in the health facilities at the disposal of the urban poor. Though the health facilities have their inadequacies they were found to be within reach as the factor on the long distances from hospitals had a mean of 2.8 meaning that the available health facilities are within a short distance from where members reside. However, there was no unanimity as to the distance of the health

facilities as this factor had a standard deviation of 1.2 meaning that this factor has to be addressed as there are quite a number of instances where it is a contributor to the poor health of members. Though the respondents were undecided as to whether members have apathy to modern medicine and medical facilities most respondents felt that the providers of medical services give them a raw deal by not engaging qualified staff whom they felt were only available for patients in the up market. They also felt that researchers were using them as Guinea Pigs for medical researches that only benefit the developed countries where most researchers hail from and the affluent members of the Kenyan society.

The members of the CBOs studied have good knowledge of the health facilities available to them which means that CBOs would not have much difficulties marketing health insurance to the urban poor. Thus health facilities in Kibera have to be improved to enable CBOs attract membership for CBHI as no members will agree to pay premiums in the full knowledge that in the event of falling sick there are no facilities to address his plight. Risk management measures in the form of risk control by way of improving member's diet and the sanitation of the slum have to be undertaken to protect the health pool. The same information is put in form of a bar graph below

The extent to which the factors contribute to poor health of the members of the group



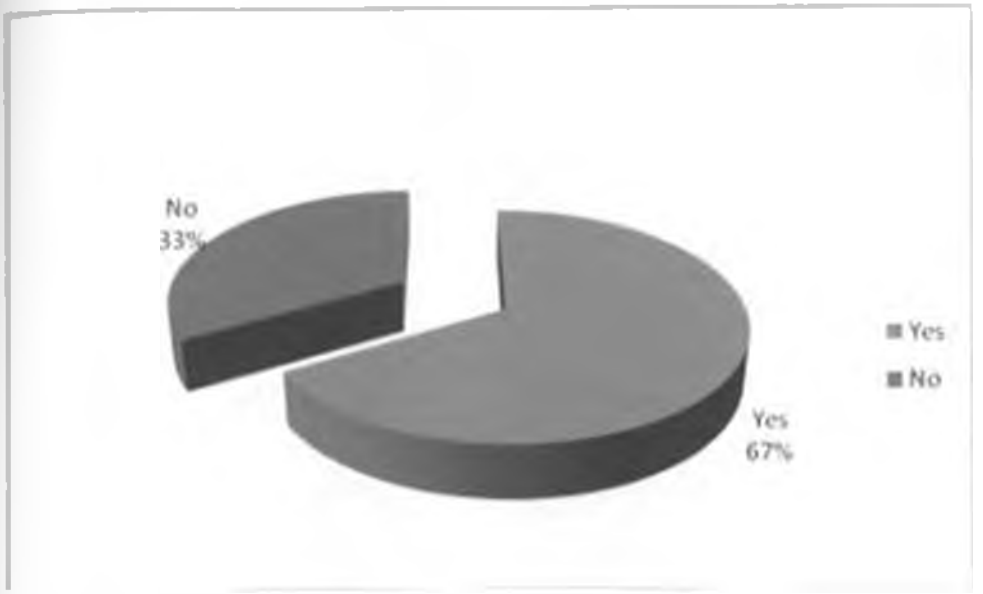
4.2.16 Intensity of the problem of lack of medical care for members of CBOs

Table 4.16: The instance at which the members die for lack of medical care

	Frequency	Percent
Yes	20.0	66.7
No	10.0	33.3
Total	30.0	100.0

Table 4.16 shows whether there has been instance when the members died due to lack of medical care. Majority 66.7% of the respondents agreed, while only 33.3% did not. This means that the urgent measures require to be undertaken to revert this trend. Thus there is a need for the risk of ill health facing the urban poor to be addressed urgently. The pie chart below gives the same illustration

The instances where members have died for lack of medical care



4.2.17 Level of health insurance cover for members of CBOs

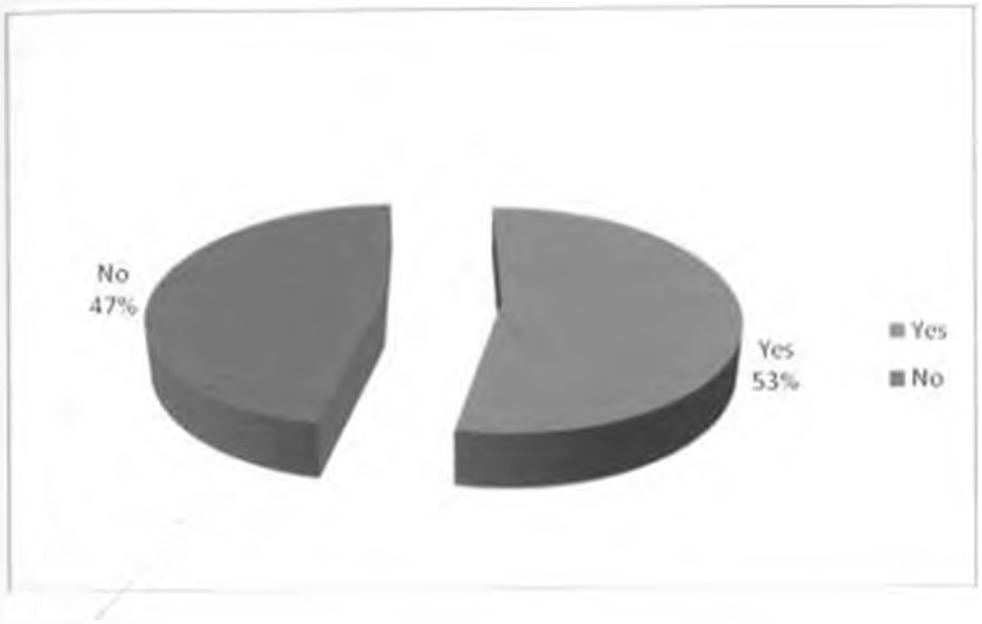
Table 4.17: Whether there are members of the group who belong to health insurance scheme

	Frequency	Percent
Yes	16.0	53.3
No	14.0	46.7
Total	30.0	100.0

Table 4.17 shows whether the CBOs have members who belong to health insurance schemes. Majority 53.3% of the CBOs have members who have health insurance cover while members of 46.7% of the CBOs did not have any health insurance cover. Respondents whose members have health insurance cover identified NHIF, Jamii Bora and COMOCO SACCO as the organizations providing health cover for their members. These organizations provide comprehensive in-patients medical cover for the concerned members. However, the percentage of members covered in the groups where members had health insurance cover was largely below 15%. This

implies that not withstanding other factors that hinder them from joining health insurance schemes introducing the concept of health insurance to members would not be difficult as this is not a new phenomenon

Whether there are members of the group who belong to a health insurance scheme



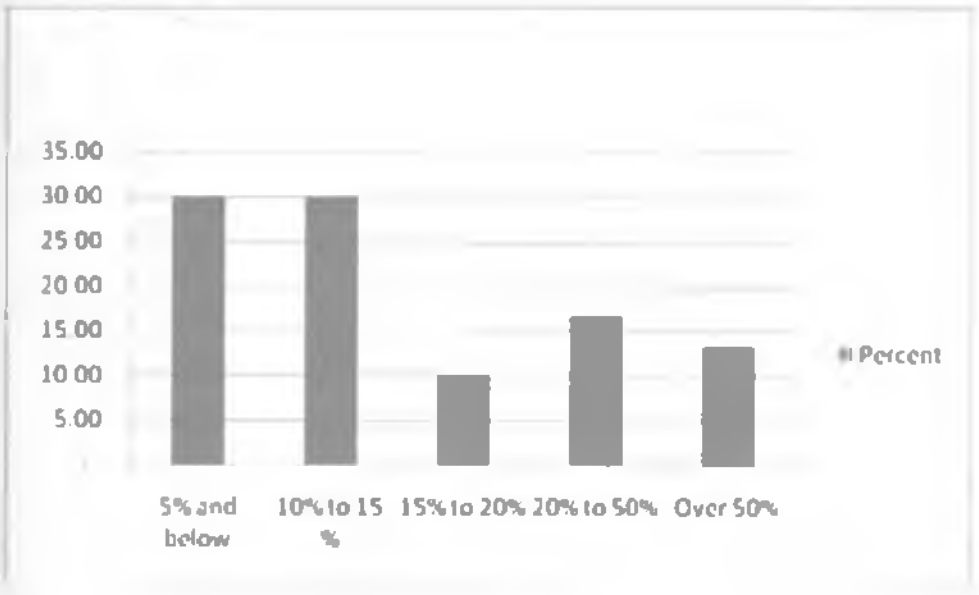
4.2.18 Level of health insurance coverage for members of CBOs

Table 4.18: The percentage of the members that belong to the health insurance scheme

	Frequency	Percent
5% and below	9.00	30.00
10% to 15 %	9.00	30.00
15% to 20%	3.00	10.00
20% to 50%	5.00	16.67
Over 50%	4.00	13.33
Total	30.00	100.00

Table 4.18 shows the percentage of the members that belong to the health insurance schemes. 30% of the groups had 5% and below of their members covered by one or the other health insurance scheme and another 30% of the CBOs had between 10% - 15% of the member covered with health insurance cover. At least 26.67% of the CBOs had 15% to 50% of their members enjoying a health insurance cover while 13.33% of the CBOs had over 50% of the members covered by a health insurance provider. Of all the cases where health insurance was present members and their families were enjoying comprehensive in-patients health insurance covers from NHIF, Jamii Bora of COMOCO SACCO. This means that the concept of health insurance does exist in the CBOs serving the urban poor and if enhanced and the factors that would inhibit the spread of health insurance among the urban poor addressed CBOs could be utilized as channels of delivery of health insurance to the poor. The same information is represented in below bar graph

The percentage of the members who belong to a health insurance scheme



4.2.19 Effectiveness of CBOs meeting the various needs of their members

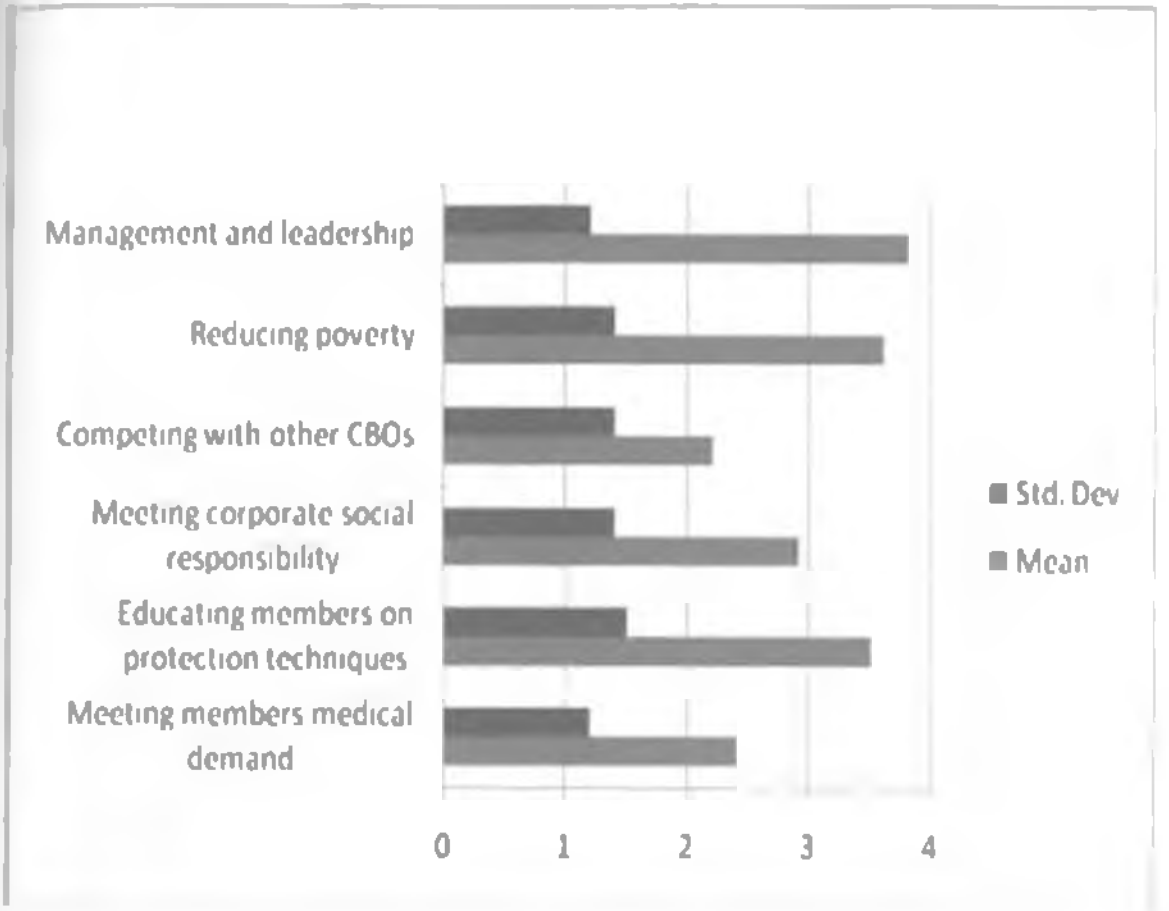
Table 4.19: The effectiveness of the organization in meeting the needs of the members

	N	Minimum	Maximum	Mean	Std. Dev
Meeting members medical demand	30.0	1.0	5.0	2.4	1.2
Educating members on protection techniques	30.0	1.0	5.0	3.5	1.5
Meeting corporate social responsibility	30.0	1.0	5.0	2.9	1.4
Competing with other CBOs	30.0	1.0	5.0	2.2	1.4
Reducing poverty	30.0	1.0	5.0	3.6	1.4
Management and leadership	30.0	1.0	5.0	3.8	1.2

Table 4.19 shows the effectiveness of the organization in meeting the needs of the members. The CBOs are effective in educating members as this factor had a mean score of 3.5 though the standard deviation of 1.5 shows that there were extreme opinions on how effective CBOs have been in educating their members. This high score is attributed to the fact that quite a sizable number of CBOs have education on prevention and care for AIDS/HIV as their main objective.

Similarly for the same reason effectiveness of CBOs in meeting the need of enhancing management /leadership of members faired well with a mean of 3.8 and a standard deviation of 1.2 as many organizations are formed to tackle leadership issues in their environment. The CBOs agreed that they are doing well in the process of eradication of poverty for their members as this factor had a mean score of 3.6 though there were divergent opinion on how effective the CBOs have been in eradicating poverty as this factor had a high standard deviation of 1.4 despite the fact that one of the main objective of all groups studied was tackling poverty. However, CBOs have not effectively meet the health needs of their members as this scored a mean of 2.4 and a standard deviation of 1.2 which shows lack of unison in the respondents observation on whether or not the CBOs have not been effective in meeting the medical demands of members. The bar graph below explains the same.

The effectiveness of the organization in meeting the needs of the member



CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the findings, conclusions and recommendations of the study based on the objectives of the study.

5.2 Summary of Findings

From the study it was found out that, the individual CBOs studied lack adequate exposure to sustain a health insurance fund. The study established that 80% of the CBOs have less than 100 members and thus there is no single CBO with sufficient membership to constitute an adequate volume of exposure. With 46.7% of the CBOs studied having been in existence for over five years and 10% of the CBOs having operated for at least 15 years the organizations were found to be stable. They would thus be relied on to undertake long term projects such as running health insurance funds. The study also found that 80% of the CBOs maintain formal records and would thus be able to maintain the various records required in the running of a health insurance pool. The study established that the intervals between members contribution in funding the organization in most organizations was monthly while 73.3% of the CBOs had their members contribute at intervals ranging from daily to monthly. This was an indicator that member's contributions to the CBOs are timed to fit into the earning patterns of members. In so doing members do not strain much to contribute and this minimizes the rate of default.

The factors that influenced the success of CBHI among them group cohesion, administration capacity to collect contributions, affordability of contributions, suitable methods of enrollment etc were present in all CBOs studied. According to the study, the amount per month contributed by at least 63.3% of the members of the CBOs studied was Kshs. 51-100 which is not adequate to run a health fund. However, if monthly contributions are increased to between Kshs.101 and Kshs.500 to include a monthly premium of at least Kshs120 for health insurance, 36.7% of the CBOs would afford to contribute to a health insurance pool. In most CBOs the funds collected

were banked. In most CBOs, the process of vetting and recruiting new members was through soliciting and most organizations had situations where a member had been forced to resign due to failure to comply with the organizations rules and regulations or due to having anti-social behaviours. The study also established that the members interacted freely. According to the study, the factors that influenced admission of new member into the majority of the CBOs were; being well known to the existing members and the living in a particular neighborhood.

The challenges that had slowed down the pace of growth of the majority of organizations were financial constraints and poverty. The study also found that most of the organizations undertook joint activities with other CBOs and in most CBOs, members were involved in organization's decision making. According to the study, the factors that contributed to poor health of the members were poor sanitation within the neighborhood, lack of facilities and drugs at health centers/ hospitals, the expensive fees charged at health facilities and lack of access to good diet by members. The study also found that there were some instances where members died for lack of medical care, however, majority of respondents reported that there were some members of the groups who belong to health insurance fund. At least 30% of the CBOs have 10% to 15% of members who belonged to a health insurance scheme while an other 30% of the CBOs having 5% and below with health insurance cover.

On the effectiveness of the organizations in meeting the needs of the members, the study established that the organizations performed well in educating members on protection techniques, reducing poverty and also good management and leadership.

5.3 Conclusion

The research concludes that if the community based organizations would cooperate with each other or partner with community based organizations such as COMOCO SACCO that are already providing health insurance to their members, they would build the capacity to provide health insurance. The interviews that were carried out show that the CBOs posses the factors that influence the success of CBHI schemes except for the lack of adequate volumes of exposure which can be overcome by CBOs collaborating or joining existing schemes.

Further interviews showed that these groups face different challenges due to financial constrains as a result of the high prevalence of poverty. The study also concluded that the CBOs posses social capital that can be utilized to overcome the obstacles that would otherwise hinder CBOs form becoming viable channels of delivering adequate healthcare for the urban poor.

5.4 Recommendations

The study recommends that the government and all the related stakeholders be on the fore front of educating and assisting the CBOs realize the potential they have in delivering health insurance to their members with little or no external financial assistance. This will enhance provision of quality health services for the urban poor.

The ministry of health and other not for profit organizations should come up with health facilities in areas inhabited by the poor that should be well equipped and adequately stocked with drugs following which they should partner with CBHI schemes that would utilize these facilities to deliver health care to their members. With time CBOs should also invest in health facilities that would not only serve their members but be a source of revenue for the groups.

The CBOs and other stake holders also have to work out risk control measures to include improvement of sanitations in the areas occupied by the urban poor, reduction of poverty, educating the urban poor on healthy living together with improving the feeding habits for the urban poor. These measures will go along way in controlling the risk of ill health. The risk that remains thereafter will have to be handled by the CBHI formed by the CBOs.

5.5 Limitations

The purpose of this research turned out to be a limitation to the study as it turned out that residents of Kibera are not very keen on issues that do not have immediate results on their welfare. Lack of enthusiasm on the part of respondents is suspected to have contributed to the researcher getting either inadequate information or responses or if otherwise the response given would have been totally different from what the researcher expected.

The small size of the sample (31) could have limited confidence in the results and this might limit generalizations to other situations.

Most of the respondents were busy throughout and had to continuously be reminded and even persuaded to provide the required information. The respondents had did not appear to accord the exercise the required time due to official duties which was a major concern.

5.6 Suggestion for Further Study

This study suggests that further study be done on the community based organization's challenges and solutions with a bias to provision of health insurance. This is relevant since this study has shown that the CBOs have a capacity to provide health insurance, but it identified that they face many challenges

The researcher also suggests that the same type of study be done in other poor urban areas. This will provide viable information to the government and other stake holders for the sake of planning for health financing for all Kenyans.

REFERENCES

Ahuja, R. (2000), *Micro Insurance in India* Retrieved April 10, 2009 from India Insurance Report Series

Aregbeyen, J. B.O. (1983), *Free health care delivery program in Bendel State in Nigeria, problems and prospects;* Doctoral dissertation, Howard University, Washington D.C, 1983

Carrin, G. & James, C. (2004), *Social Health Insurance key factors affecting the transition towards Universal Coverage* World Health Organization, Geneva. Retrieved October 31, 2005

Carrin, G. (2003), *Community based health insurance schemes in Developing Countries: facts, problems and perspectives*: Discussion Paper No.1-2003 World Health Retrieved August 29, 2007

Churchill, C. & Wohlner, E. (2004), *Improving Risk Management for the poor.* Retrieved from http://www.microfinance.lu/comas/media/microassurance-06-an-2005pdf June 1st, 2007.

Cooper, R. D., & Emory, C. W. (1995). *Business Research Methods*, 5th edition; Boston: Irwin.

Criel, B. & Kegels, G.(1997) *A health insurance scheme for hospital care in Bwamanda District Zaire. Lessons and questions after 10 years of functioning.* Tropical Medicine and international health 2 No.7, 654-672. Retrieved June 1st, 2007.

Criel, B., Chris, A., Robert, B., Pierre, B., & Maria, P. W. (2004) *Community health insurance (CHI) in Sub-Saharan Africa researching the context Tropical Medicine and International Health*, 9 No.10, 1041-1043.

Daily Nation, (2006, November 29 p.35); *Challenges of providing health insurance in Kenya International Social Security Association*

Dickson, G., & Stein, (2002), *Risk and Insurance*. London: The Chartered Insurance Institute

Dror, D. M., Preker, A. S. (2002) *Social Reinsurance: A New Approach to sustainable community health financing Washington DC*: The International Bank for Reconstruction and Development/The World Bank and The International Labour Organization

Gakombe, K.K. (2002). *Analysis of the Industry and the strategic choices adopted by private hospitals in Nairobi.* (MBA Project, University of Nairobi, 2002)

Gichuki G. R. M. (2005), *Environmental problems and human health in Urban Informal Settlements* A Case study of Mukuru Kwa Njenga, Nairobi. Master of Arts in environmental planning and management dissertation, Unpublished. University of Nairobi

Grund, D. (2005), *working group on micro insurance. good and bad practices.* VimoSewa India Case study No.16. CGAP Retrieved November 29, 2006,

International Labour Organisation, (ILO), *The Social Security (minimum standards) Convention*, 1952 (No.102)

Jutting, J. P. (2003) *Do community based health insurance schemes improve poor peoples access to health care?* Evidence from rural Senegal. OECD Development Centre France, World Development Volume 32, issue 2 February 2004 pp 273-288, Elsevier Limited. WHO 2002

Jutting, J. P. (2003) *Health Insurance for the poor? Determinants of Participating in Community Based Health Insurance Schemes in Rural Senegal* OECD Development Working Paper No.204

Kenya Community Based Health Financing Association (2007) *Jamii Bora Trust* Retrieved on January 27, 2009 from http://www.kcbhfa.org/jamiiboratrust.html

Khayesi,M., Kinyanjui,M.N. (2002). *Social capital in micro and small enterprises in Africa. Implications for poverty alleviation in East Africa*; ISBN: 1904855606 148pp.

Kiwara,A.D.(2007, April). Group premium in micro aid and emerging experience from Tanzania. *East African Journal of Public Health 4 (1)*

Kwavu,A. (2006, JUNE) National Health Bill Memorandum. Ministry of Health, Ghana.

Maes, A. (2003). *Social Security in Africa Informal Economic and Social Security in Sub-Saharan Africa International Social Security Review 56, 3-4.* Institute of Social Law, Catholic University of Laval, Belgium

Majeed, A. (2003) Universal Health Coverage In the United Kingdom. *Journal of Ambulatory Care Management 26 (4) 373-377.*

Mathauer, I., Schmidt, J. O., & Wenyaa, M. (2007). Extending social health insurance to the informal sector in Kenya an assessment of factors affecting demand. *International Journal of Health Planning and Management 2008 23:51-68: Willey Inter-science*

Mbaisi, J. (2004). Factors influencing husband wife communication on HIV/ AIDS in Kibera, Nairobi. *Master of Arts in environmental planning and management dissertation, Unpublished.* University of Nairobi

Ministry of Economic Planning, Kenya (1965) African Socialism and its application to planning in Kenya, *Sessional paper No.10*

Ministry of Health, Kenya (2005), *Second National Health Sector Strategic Plan 2005-2010*

Morgan, T. C. (2000). *Have we become too busy with death?* Christian Today.

Muga, R. (2003) *Sessional Paper on National Social Health Insurance in Kenya.* Ministry of Health, Kenya

Munyakho, D. (1992) *Poverty and Ill health go hand in hand:* World Health 00438502, 45 (6)200.

National Health Insurance Fund (NHIF). (2009). Retrieved February 28, 2009, from http://www.nhif.or.ke/healthinsurance/aboutus

Odhiambo W., Manda D. K, (2003); *Urban poverty and labour force participation in Kenya.* Kenya Institute for Public Policy Research and Analysis.

Onyuncha, E. O., (2002), *Health seeking behaviour among residents of the informal settlements of Kibera, Nairobi*. Master of Arts in environmental planning and management dissertation, Unpublished. University of Nairobi.

Owino, W. Were, M. (1998) *Enhancing health care among the vulnerable groups, the question of waiver and exemptions Institute of Policy Analysis and Research*. Discussion Paper, Nairobi

Parasulaman, A. (1986), *Marketing Research, Canada, Addison-Wesley Publishing Co.*

PHR Plus (2004), 21 *Questions on Community Based Health Financing: Overview of Community-Based Health Financing*. Partners for Health Reformplus, 2004

Salmon, K. (2002), *Nairobi's "Flying Toilets"- Tip of an iceberg*; Retrieved July 15, 2008 from Terra Viva: IPS-Inter Press Service

SBO Research, (2003), *Insurance Industry Research Report Association of Kenya Insurers*

Second National Health Sector Strategic Plan 2005-2010 NHSSP II, (2006, March 29). *Supplement Daily Nation*

Sessional Paper on National Social Health Insurance in Kenya, (2003, July), *Ministry of Health, Kenya*

SEWA Insurance (VIMOSEWA). (2009), Retrieved from http://www.sewainsurance.org/vimosewa.htm

Sessional Paper on National Social Health Insurance in Kenya. (2003, August); *A bridged Version draft*

Siringi, S., & Nzioka, P., (2006, November 7). *Medical Cover gives Ngilu's Bill a lease of life* Daily Nation

Stalper, I. (2000). *In Napal Micro-Insurance Helps the Poor Cope with Health Needs, ILO's "Step Programme* (Strategies and Tools against Social Exclusion and Poverty).

Tara, S. Kent, M. R., Mirai, C. Mills, A. (2007) *Management initiatives in a community based health insurance scheme International Journal of Health Planning and Management:22, 289- 300*

The National Health Sector Strategic Plan: 1999-2004, (1999). *The strange culture of the slums*. Ministry of Health Reform Secretariat, Nairobi. (2007 June 5) Economist 383

Uma, S. (2003). Research Methods for business. John Wiley and Sons Inc.

Vaughan, E. J. (1989). *Fundamentals Risk of and Insurance:* New York-Chichester-Brisbane-Toronto-Singapore. John Wiley & Sons

Wajibu Journal of social and religious concern, Vol. 16 No.2 (2001), *Jamii Bora Trust A credit scheme with a difference*. Koinonia Media Centre. Retrieved from http://web.peacelink.it/wajibu/14_issue/p6.html

Waran, R. (2007 March / April). Life in Kibera. World Watch 08960615. 20 (2)

Whitehead, M. Dahlgren, G. Evans, T. (2001 September). *Equity and health sector reforms. can low income countries escape the medical poverty trap?* The Lancet. 358, 833-836

Wikepidia, the free encyclopaedia. *Community Organizations*. Retrieved from en.wikepedia.org/wiki/community-basedorganizations

APPENDICES

Appendix I: Questionnaire

Part A: Demographic Information

1) Name of your organization

.....

2) Organization Registration Number .....

3) Number of Registered Members

Less than 50 [ ]

51 – 100 [ ]

101 – 500 [ ]

Over 500 [ ]

4) For how long has your organization been in existence?

Less than 1 year [ ]

1-5 years [ ]

6-10year [ ]

10-15years [ ]

Over 15years [ ]

Part B: General Information

5) What are the main activities that your organization undertakes? (Kindly list them)

i. .....

ii. .....

iii. .....

iv. .....

6) Does your organization maintain formal records?

Yes [ ]

No [ ]

If no, how does the organization keep track of its activities and finances?

.....

.....

If yes what kind of records do you maintain?

.....

.....

7) If your organization is funded by members at what intervals do members contribute?

Daily	[ ]	Quarter yearly	[ ]
Weekly	[ ]	Half Yearly	[ ]
Monthly	[ ]	Yearly	[ ]

Other (Kindly indicate) .....

8) Using the below scale, state to what extent do you consider the following factors have assisted in the success of your group.

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

	1	2	3	4	5
Group Cohesion					
Administration capacity to collect contributions					
Affordability of contribution					
Method of enrolment					
Timing of collections to coincide with member earning patterns					
Quality of services provided by your group to members					
Assistance received from the Government and other organizations					
Minimum administrative and marketing costs the group incurs in its operations in comparison to amounts spend on the groups co-activities					
Faith & trust members have with the management					

9) How much is the individual member's contribution per month (amount in Kenya Shillings)?

Kshs. 20 and Below	[ ]	51 to 100	[ ]	501 to 1,000	[ ]
21 to 50	[ ]	101 to 500	[ ]	Over 1,000	[ ]

Others please specify .....

10) How are funds collected kept? (Kindly tick where appropriate)

Banked [ ]

Loaned out to members [ ]

Kept at officials house [ ]

Invested into income generating activities [ ]

Others please specify .....

11) How do you go about the process of vetting and recruiting new members?

Advertising [ ]

Soliciting [ ]

Open tent registrations [ ]

Any other (Kindly indicate) .....

12) Are there instances where you have been forced to request members to resign from the organization or actually expelled a member(s) from your organization?

Yes [ ]

No [ ]

If yes, what led to such a move?

.....

.....

13) Do members of your organization interact freely?

Yes [ ]

No [ ]

If no, kindly state the factors that lead to their not interacting freely

.....

.....

.....

14) Using the below scale, state to what extent what the following factors contribute to a new member being admitted into your group.

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

	1	2	3	4	5
By virtue of being a friend of officials of the group					
Being virtue of being well known to existing members					
By virtue of living in a particular neighbourhood					
By virtue of being or not being a member of a particular tribe					
By virtue of belonging to or not belonging to a religious community					
By virtue of being an active member of other groups in the neighbourhood					
By virtue of having skills or and resources that members feel would assist the group					
By virtue of their trade, profession or place of work					
Being imposed on the group by politicians and government agents					
By virtue of possessing a particular physical or health condition e.g. a given challenge or illness					

15) Using the below scale, state to what extent what the following challenges have slowed down the pace of growth of the organization and its attainment of the goals for which it was established.

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

	1	2	3	4	5
Inadequate membership					
Financial constraints					
Legal complication					
Lack of awareness for potential members					
Competition from other CBOs					
Poverty					
Incompetent Leadership in the CBO					

Any other kindly specify

.....

.....

.....

.....

.....

.....

16) Does your organization undertake joint activities with other Community Based Organizations within the locality where you are based and Kibera at large?

Yes [ ] No [ ]

If no, kindly state the factors that contribute to your not interacting with other like organizations.

.....

.....

.....

.....

17) Are members of your organization involved in the decision making of the organization?

Yes [ ] No [ ]

If no, kindly state how else members contribute in the running of the organization.

.....

.....

.....

.....

.....

.....

.....

18) Using the below scale, state to what extent the following factors contribute to the poor health of members of your group and their families.

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

	1	2	3	4	5
The long distance from the nearest health centre/hospital					
Lack of facilities and drugs at the heath centres/hospitals in Kibera					
The expensive fees charged at the health facilities in Kibera					
Lack of access to good diet by members due to poverty					
Apathy of members to modern medicine and medical facilities					
Poor sanitation within the neighbourhood					
Ignorance of members of the available health facilities					

Any other kindly specify .....

.....

.....

.....

.....

.....

19) How serious is the problem of member and their families not been unable to seek medical care as they could not afford kindly explain.....

.....

.....

.....

.....

.....

.....

20) Do you consider the number of instances when your members or members of their immediate family have died due to lack of medical care alarming

Yes [ ] No [ ]

If yes, kindly give a brief description of how serious this problem is.

.....

.....

.....

.....

.....

.....

.....

.....

.....

21) Are there members of your group who belong to a health insurance scheme?

Yes [ ] No [ ]

22) If yes what is percentage of members who belong to a health insurance scheme?

5% and Below	[ ]
5% to 10%	[ ]
10% to 15%	[ ]
15% to 20%	[ ]
20% to 50%	[ ]
Over 50%	[ ]

23) Using the below scale, How would you rate the effectiveness of your organization in meeting the needs of your members.

Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

	1	2	3	4	5
Meeting members medical demand					
Educating members on protection techniques					
Meeting corporate social responsibility					
Competing with other CBOs					
Reducing Poverty					
Management and leadership					

24) What do you suggest should be done to enhance the viability of CBOs especially in meeting the health needs of your members?

.....

.....

.....

.....

.....

.....

THANK YOU FOR YOUR ASSISTANCE

Appendix II: Community Based Organizations registered in Kibera

NAMES	LOCATION	CONTACT PERSONS	NUMBERS
1. Kibera Kiandu S.H.G	Sarangombe	Simon Njuguna	0721652311
2. Mwanzo Mpya Community org. Project	Lainisaba	Timothy Mutunga	0720915348
3. Jitegemee Youth Group	Kibera	Makori	0724984704
4. Sarangombe Kibera S.H.G	Sarangombe	George Ouma	0720416750
5. Kalisodan River Bank Association	Mugumoini	Joshua Mula	0734595303
6. St. Magdaline Women S.H.G	Lainisaba	Ann Njeri	
7. Kibera Kids Youth Project	Mugumoini	Robert Anzenze	0723128860
8 Toche Amo S.H.G	Mugumoini	Kennedy Oeta	0733455714
9. Starays Hope Community Centre	Sarangombe		0734518144
10. Bonde S.H.G	Kibera		0720574987
11. Mashimoni Gender Aids Fighters S.H.G	Lainisaba		0720711229
12. Pamoja Kianda Youth Organisation	Sarangombe		0720948911
13. Ndoto Syamuti Mwiu	Sarangombe	Seth. Muyambu	0733986558
14. Soweto Muslims W/G	Kibera	Yasmin	0724380025
15. H.O.Y.W.K. Programme	Sarangombe	Ngare	0735289349
16. Desert Street Youth Organisation	Sarangombe		
17. Langata S.H.G	Mugumoini	Crsphine	0721564334
18. Progressive S.H.G	Mugumoini		0721564334
19. Abeinjirandala S.H.G	Kibera		0721261886
20. Karina S.H.G	Sarangombe		0722255528
21. By Grace Support Group	Sarangombe	Rose Ithara	0725996837
22. Railway Line Community B. Org.	Lainisaba		0726600807
23. Ayany Women Group	Sarangombe		
24. Disabled Support Project of Kenya	Sarangombe		
25. Kibera Disabled S.H.G	Lainisaba	Joycaster Ndinda	0724591558
26. Mesocho S.H.G	Sarangombe	Nyamweya Matagaro	0733634699

27. Maono Education Centre	Mugumoini	William Machuka	0736750995
28. Community Dev. Program Kenya	Makina	Jane Wambui	0720438516
29. Mary Rice Day Care Centre	Mugumoini	Dennis Vaughan	020607449
30. Tulenge Juu Centre	Gatwekera / Sarangombe	Violet R. Gaya	0722997580
31. Umande Trust Welfare Association	Sarangombe	William M. Misati	0206751287
32. Ghetto Reporters	Lainisaba	Cosmos M. Nduva	0720412408
33. High Vision 2007 S.H.G	Lainisaba	Robert Ndegwa	0722635349
34. Dry-land S.H.G	Lainisaba	Johannes O. Juma	0720394246
35. Ogil Women Group	Lainisaba	Rachel Korir	0721482198
36. Peer Mothers Fighting Aids in Kibera	Kibera	Dorcas Atieno	0726998069
37. Jitegemee W/G	Kianda	Emily Nyaboke	0727573819
38. Sarangombe Women Conquers S.H.G	Kianda	Margaret W. Githue	0727602213
39.Ebenezer Sisters Group	Kibera	Joyce W. Gacheru	0722248631
40. Kyeni Kya Lindi W/G	Lindi	Felistus Mukende	0725546954
41. Bidii Kenya W/G	Makina	Khadija Dode Jadin	0736318619
42. Golden Girls Welfare Group	Mugumoini	Virginia Arina	0722716178
43. Adonai Women Group	Olympic/Sarangombe	Esther G. Matano	0724394841
44. Vision Mothers S.H.G	Soweto	Margaret M. Githinji	0721432035
45. Action Speaks, Windows & Orphan W/G	Sarangombe	Susan A. Odienyi	0724810810
46. Jikaze Two W/G	Kianda	Mary Wanjiku	0723715942
47. Ujuzi Youth Try Organisation	Makina	Milcah M. Kariuki	0721236712
48. Victoria Youth Group (V.Y.G.)	Sarangombe	Kenneth O. Ochuodho	0724315623
49. Toa Jasho Youth Dev. Group	Kibera	Abdinut Adan Malicha	0725576272
50. Youth Development Forum (YDF)	Lainisaba		

51. New Egesa Youth Self-help Group	Kibera	Nahashon Nyamwange	0734288249
52. Oasis Youth Community Development	Gatwekera	William O. Aimo	0726296797
53. Toi Market Youth Group	Makina	Samson A. Nyamwatta	0721711290
54. Mwanetu Youth S.H.G	Makina	Boniface K. Mwobe	0724760040
55. Jodabal Ali Youths S. H. G	Makina	Diab Asman	0736209652
56.Gatwekira Umoja Usafi no maendeleo youth - S.H.G	Sarangombe	Anthony Githinji	0721924700
57. Kibera Vision Youth Group	Kibera	Samuel Kinyati	0724744313
58. Wuu Vunja Ukimwi W/G	Lainisaba	Josphine Kamene	
59. Kisumu Ndogo Kwaho Sodis Women Group	Kibera	Margret Otieno	0723089951
60. Morning Star W/G	Kibera	Eunice Mulinge	0720793058
61. Nkiro Women S.H.G Programme	Sarangombe	Hawa Abdalla	0722775767
62. Karumaindo W/G	Lainisaba / Silanga	Judith A. Anest	0721603753
63. Jenga W/G	Mugumoini	Roselyne A. Anyona	0725682607
64.Keroka W/G	Kibera	Hellen Vugutsa	0726763578
65. Toi Upendo Ladies	Kibera	Rosemry A. Onguta	0723652377
66. Witelhoeni Group Kibera	Olympic	Sicily W. Wainaina	0722356028
67. Inua S.H.G	Sarangombe	Stephen Mwangi	0723308858
68. Kibera Test Post Club	Kibera	Florence Atieno	0725516198
69.Birogo Square S.H.G	Mugumoini	George Wamwere	0722884515
70. Katwekera Tosha S.H.G	Sarangombe	Roseline Omondi	0734283675
71. Lindi Silanga Usafi Group	Lainisaba	Mary Awino	0727509427
72. St. Charles Lwanga Community S.H.G	Mugumoini	Robert Anzenze	2728113

73. Good Samaritan Mashimoni Group	Lainisaba	Ronald W. Sunc	0721718952
74. Kibera HIV / AIDS Support Initiative Programme (KHASIP)	Sarangombe	Pamela A. Otieno	0725447708
75. Usima S.H.G	Sarangombe	George Akello	0721965118
76. Pamoja Tuinuane S.H.G	Kibera	Agustine O. Matoka	0724641972
77. St. Bakhita Group Kibera	Sarangombe	Edward Malelu	0727959801
78. Ukweli S.H.G	Lainisaba	Joseph Ndungu	0727782690
79. St. Florence Educational Centre	Sarangombe	Florence Munyao	0726836435
80. Rehema S.H.G	Lainisaba	Sammy M. Ngari	0722499642
81. African Christian in Development Org.	Kibera / Makina	Martin O. Ogweno	0722964033
82. Agape Upendo S.H.G	Kibera	Jane W. Gathige	0722458873
83. Namukambi S.H.G	Lainisaba	Alex B. Khura	375366
84. Couples of Light Association	Lainisaba	John Ndera	0720747707
85. New Sokoni S.H.G	Kibera	Bernard Awino	0735260481
86. Gatwekira Joint S.H.G	Sarangombe	Jared Odiawo	0721620019
87. Epuka Jaga Railwayline Saving Scheme	Lainisaba	Fredrick Mbithi	0721994634
88. Bidii Women & Men of Peace Group	Olympic	Anne Wanjiku	0722528925
89. Young People of Purpose Community Centre (YPPCC)	Sarangombe	Josiah Sallaga	0721873601
90. Ambassadors Christian & Development S.H.G	Kibera	Peris B.Otete	0722122830
91. Bidii Two S.H.G	Kianda / Sarangombe	Mary Thuku	0724516163