

Gender roles and perceptions about improved Community-Based Health Insurance

A case study in Babati, Tanzania

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ABSTRACT

People's access to safe health care is not as common as one might think. Today with new and different health insurances and improved health policies people should in theory have safe health care. Although numerous of health insurances exist, targeting large parts of populations, there are still many issues with them. The Behavioural Model of Health Services Use and Separate Spheres are the two theories that are used in this study. Where Separate Spheres describes men's and women's separate worlds, their responsibilities in them and how it effects them and the Behavioural Model of Health Services Use, which describes factors that either impede or enable people's access to health care utilization. This study's purpose is to see what different perceptions men and women have about the insurance and how these perceptions can affect families' choice to enroll to the insurance. The study uses a qualitative approach and is based on semi-structured interviews. Results in this study showed that men and women have very different perceptions about the insurance. Men want the insurance because they want to save money and decrease health expenses. While women wants the insurance for their children to always have access to health care. The roles between men and women in households are significant and their different responsibilities affect their priorities and perceptions.

Keywords: Gender differences, Decision-making, Health care, Behavioural Model of Health Services Use, Separate Spheres

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Evelina Flodkvist, Stockholm, 2017

ACRONYMS

CBI	- Community-Based Health Insurance
CHF	- Community Health Fund
iCBI	- Improved Community-Based Health Insurance
BMH	- Behavioural Model of Health Services Use
TASAF	- Tanzania Social Action Fund

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1. INTRODUCTION

The safety net when you get sick is not the same around the globe; safe health care is essential for people to not get caught in a poverty spiral. Whenever you get sick you need a safety net. Once you get caught it is hard to get out and the spiral continues to spin downwards. Insurance systems in many developing countries are not as successful as needed, where health care tends to cost a lot of money. People do not always have the amount of money that is needed to be able to get treatment. In many developing countries a large percent of the population is employed in the agricultural sector. The seasonal cultivation affects both people's economy and health, during the crops high season farmers have the least amount of money and during the rain season the diseases spread. Therefore money is essential all year round for farmers to have access to health care. With a health insurance the ability to get treatment is evenly spread throughout the year and is not affected in the same way by seasonal cultivation.

The issues which have been addressed in previous research regarding health insurances are concerning larger areas such as the unequal access to the services of the insurance between rich and poor, corruption, bad management and transparency etc. (Kamuzora & Gilson, 2007; Mtei et. Al., 2012). However, gender inequalities when it comes to access and use of health insurance have not been researched about to the same extent.

Previous research shows that gender differences acts like a barrier when it comes to health care utilization and since women are affected worse by diseases it is essential to address these gender issues (Vlassoff, 2007). The role between men and women in households has worked a barrier for women to access the same rights to the sphere outside the home as men. They do not have the same decision-making power, which results in women always struggling for equal livelihood and health as men. Men generally make the decisions about production and purchases in a household and in most cultures, reproductive and productive activities are valued differently. Income and earning brings greater decision-making power, respect in society and autonomy. Women spend more time than men in volunteer, reproductive and other unpaid labor,

while men spend more time in productive, remunerated work (Vlassoff, 2007). Women account for more than 40 percent of the labor force worldwide, still women earn less than men and the reasons are varied. To work as unpaid family laborer or in the informal sector is more likely for women than men to do (Revenga & Shetty, 2011). Men are also more likely than women to get health insurances from their employers, while women are more treated like charity cases. The fact that women are often paid less for the same jobs than men also means that women have fewer resources to fall back on when they get sick and their control over their own earnings is often limited (Vlassoff, 2007). By closing the gap in health and well-being between women and men, income poverty would be reduced. Many gender differences remain even as countries develop, which calls for focused and sustained public action. If there would be more focus on persistent gender inequalities the policies would yield substantial development payoffs (Revenga & Shetty, 2012). For example if female farmers would have equal access to resources such as fertilizers and land, agricultural production in developing countries could increase as much as 2,5 to four percent (FAO, 2011). Gender equality is essential in its own right. Development is a process of growing freedoms equally for all people, women and men (Sen, 1999).

1.1 PURPOSE

This study examines men and women's different perception on the improved Community-Based Health Insurance and how these different perceptions affect the families' choice to enroll to the insurance. Also understanding in how the roles between men and women in households affect the perception about the insurance.

1.2 RESEARCH QUESTIONS

- What differs in men and women's perception about the importance of the improved Community-Based Health Insurance?
- How do the roles between men and women in households affect the perception about the insurance?

2. COMMUNITY-BASED HEALTH INSURANCE

In 1967 the president Julius Nyerere initiated the Arusha Declaration in order to develop the national economy (Hyden, 1981). A series of health sector reforms was created to increase the access to social services for the poor population and the marginalized living in rural areas. With a struggling economy the free health care started to get strained in the early 1990's. Free health care was removed, but instead the government adopted new health care reforms. This new reform meant that the free health care system changed to cost sharing policies (Kolstad & Lindkvist, 2013).

In 1995 Tanzania introduced the Community Health Fund (CHF) as a new element in the country's health financing strategy. The insurance is a district-level voluntary prepayment scheme, which is introduced in parallel with user fees at public health facilities. They target 85 % of the population that lives in rural areas or/and are employed in the informal sector (Kamuzora & Gilson, 2007). Households can enroll for between USD four to eight per year. The benefits include free outpatient care at a selected primary level public facility. It is valid for one year and covers a family of two adults and four children under 18 (Borghetti et. Al., 2013).

The Tanzanian health system is financed through a combination of different sources, donors contributing an increasing share of total health financing, general taxation and out of pocket that funds the most. Around ten percent of the total public expenditure, which includes general taxation and donor aid, is allocated to health care financing. The government owns about 70 % of all Tanzanian health care facilities, where private and faith-based facilities each account for almost 15 % of the total. Tanzania's government has been increasing the commitment concerning achieving universal health coverage through expanding the health insurance coverage in the country (Mtei et. Al., 2012).

One immense issue that concerns all the marginalized socio-economic groups that has the insurance is the unequal access to the services that the insurance provides (Mtei et. Al., 2012). It is supposed to be pro-poor, but it is often the other way around. Poor people receive a lower share of benefits relative to their share of need for health care. Primary health care facilities, which are the facilities that the CHF patients in the rural

areas use, are often under-staffed and short of drugs. In urban areas it is relatively good network of hospitals and other referral facilities. It is a pro-rich distribution of public health care benefits. Once the facilities have stock-outs of drugs, patients must go to drug stores and pay out of pocket or seek out expensive health services elsewhere. This leads many times to being more costly for the patients to have the insurance than not having it (Mtei et. Al., 2012).

Expensive health can have negative affects like self-treatment, which is common in many developing countries and is also a big problem concerning the mortality rate. People do not have the money to seek care, and therefore they self-treat when they are in need of medicines and treatments at facilities. Self-treatment and self-care is defined as any treatment that does not involve consulting a health care provider or traditional healer. The Community-Based Health Insurance (CBI) has a significant role in reducing the demand for self-care (Robyn, Fink, Sie, Sauerborn., 2012).

In Tanzania one issue is people's ability to pay for the insurance. Further issues that are addressed are bad quality on health care, lack of trust in the insurance and people not seeing the rational in being insured. There are also stock-outs of medical supplies, inappropriate diagnosis due to lack of diagnostic equipment, staff related problems, limited range of services provided, lack of possibility to use health facilities of the members choice and lack of transparency. Corruption at facility level has also been reported (Kamuzora & Gilson, 2007).

People with lower social status and income have limited access to health care, hence higher risk of morbidity and mortality, which results in higher likelihood to need and utilize health services (Chomi, Nahyuha, Muinja, Enemark, Hansen, Kiwara, 2014). Women do often not seek treatment as quickly as men since they do not have that opportunity; they have a double burden, both a job with sporadic income and the job of taking care of the house and children. Because of this, women are affected worse by diseases than men (Vlassoff, 2007). Gender, age and distance are factors that act as barriers to healthcare utilization. The CBI has not reached the most vulnerable groups. Women and children that are enrolled have higher healthcare utilization, especially among poor households (Parmar, De Allegri, Savadogo, Sauerborn, 2014).

3. THEORETICAL FRAMEWORK

This chapter presents the theoretical framework that is used to understand and analyze findings in this study. Each theory is presented separately, Separate Spheres and Behavioural Model of Health Services Use. Separate Spheres is in the findings chapter connected to customers' perception, while the Behavioural Model of Health Services Use is connected to the barriers, as perceived by the informants.

3.1 SEPARATE SPHERES

In Sub-Saharan Africa both gender roles and norms are salient, where the man is the decision-maker when it comes to health issues among other things. Women's empowerment is reflected in their employment status, socio-economic status, household organization and educational levels, which can either, increase or decrease her access to health care utilization. Men work as barriers to women's decision-making about health care utilization; this is due to the patriarchal world, which is even more prominent in developing countries and rural areas (Mosha, Ruben, Kakoko, 2013).

Separate Spheres prescribe and define separate spheres for women and men (Ryle, 2011). This theory argues that men belong in the public sphere, where it is a world filled with economics, law, commerce and politics. This is a world of productive behavior and market relations, a masculine world that also includes paid labor and is best suited for men. The women on the other hand should stick to the private sphere, which contains housekeeping and childcare (Ryle, 2011).

The theory of Separate Spheres teaches us that the woman's place is in the home, she is the natural family member that cares for the children and educate them. The qualities that make the women perfect for this role are their ability to superior feminine virtue and their maternal love. That the woman's place is in the home is sheltering her from the worldly struggles for achievement and success. On the other hand, the man's duty is to take care of his family by being the protector and breadwinner. Women should be good mothers and wives, but also they are supposed to be kind and gentle (Ryle, 2011).

When defining women as the natural family members and mothers it excludes them from being agents of social change. The social reality when it comes to gender relations is not always as simple as many models describe it. It is often defined as women versus men, consumption versus production, nature versus culture, passive versus active and private versus public (Anderson, Reynolds, Gugerty, 2016). There are more different aspects that are essential to add when it comes to studying gender relations, which is often forgotten; marital status, age, race and class. It varies according to financial and social circumstances, time and space, development cycles of families and the abilities and desires of human agents (Rotman, 2006).

If women would get improved access to financial resources they would be empowered in their own house, these empowerment would in turn allow women to challenge more public gender stereotypes (Bradshaw, 2013). Blumberg's Gender Stratification Theory¹ implies that if women had greater economic power, they would get more control over their own lives. Economic power is related to household decisions, therefore financial resources gives the woman a greater household authority, but it also gives her more control over her fertility and sexuality. While financial resources are central for the improvement of decision-making, other assets such as property and social relations are important for the decision-making power. Different aspects such as self-perception and social norms are also important, sometimes access to income alone do not lead to improved decision-making power. The distributions of resources within the households are unequal between men and women, and it generally benefits the man rather than the woman. Women's lack of economic opportunities places them in a weaker bargaining position and the positions within households are linked to the position the person has outside the household. Women's earning do not bring automatic increased bargaining power. Housework compared to paid work limits the woman and decreases her authority. Urban areas and cities often offer women more opportunities for paid work than rural areas. Jobs that are based in urban areas are more likely to be outside the household, which means non-family work. Women's self-perception is important, but also how men see women. Women count their work in the household as contributing, while men often only see women as contributing

¹ Blumberg, Rea Lesser. 1984. *A General Theory of Gender Stratification*. In *Sociological Theory* edited by R. Collins. San Francisco: Jossey-Bass.

when they do so in monetary terms. For women in rural areas this difference is important, due to women's lack of monetary contribution (Bradshaw, 2013).

3.2 THE BEHAVIOURAL MODEL OF HEALTH SERVICES USE

This study uses the Behavioural Model of Health Services Use (BMH) to explain why customers buy the insurance and what factors impedes them from buying it. Instead of the original "Use of Health Services", this model will describe people's "Use of Health Insurance".

The Behavioural Model of Health Services Use was first developed in the 1960's to measure if people retrieved equal access to health care. The model suggests that different conditions and factors either enable or impede people's utilization and access of health care services (Andersen, 1995).

According to the model the use of health services are determined by three categories, need, enabling factors and predisposing factors. Predisposing factors can be characteristics such as race, age and gender, which are biological imperatives suggesting people's likelihood to need health services. These factors are socio-cultural characteristics of individuals that exist before their illness. Social structure is within the spectrum predisposing characteristics and is measured by a broad array of factors that define the status of a person in the society. Health beliefs are also within the spectrum of predisposing characteristics and are knowledge, values and attitudes that people have about health services and health in general. These different knowledges, values and attitudes might influence people's perception of need to health care (Andersen, 1995).

Enabling factors can be community, access to health insurance, income, travel and family support. These factors are logistical aspects of obtaining care (Andersen, 1995). Previous studies show us one immense factor that enables people's to use health care, the ability to pay for it. Therefore insurance coverage increases the utilization, both outpatient and inpatient. Also important is the availability to community resources, such as personnel and health care services. People need access to these health care services where they live and also the knowledge why to use these services (Hulka & Wheat, 1985).

The need factors can be both evaluated need and perceived need for health care services. Perceived need is how people view their own health, while evaluated health is a professional's judgment about people's health and need for care and treatment (Andersen, 1995). Need for medical care plays the most important role in determining utilization of services (Hulka & Wheat, 1985).

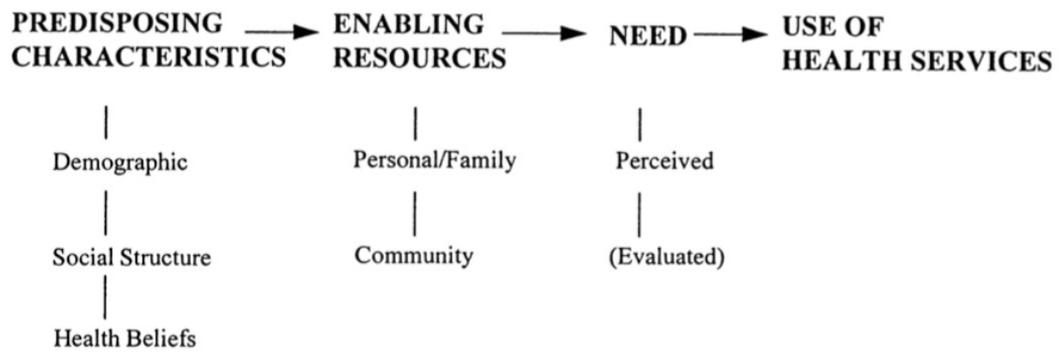


Figure 1. The initial behavioral model (Andersen, 1995).

4. METHOD

The empirical data in this study was collected through a fieldwork in Babati town council during three weeks in the spring of 2017. Babati is situated in the region Manyara in northern Tanzania. The research was carried out in Babati town and in the three villages Nakwa, Mrara and Hanganoni. A field assistant was dispersed, that had the best knowledge concerning the research subject. Before the interviews were conducted the purpose with the study was discussed and explained to the assistant. Directions and rules were brought up, how important it was that no man was present during the interviews with the women and vice versa, and also how important it was for the informant to speak freely. Before the field days we had a few excursions to the villages Magugu, Haraa, Dareda and Mamire-Mutuka to get to know the district. These excursions showed the differences between rural and urban areas, but also experience the infrastructure and visit health care facilities. To be able to conduct this research in Babati, permissions, contacts and field assistants were needed, which was arranged by Södertörns University. The decision of having Babati as the place where the research would be conducted was also made by the university.

4.1 CHOICE OF METHOD AND LIMITATIONS

The primary data in this study was collected through semi-structured interviews. Due to the character of the study and the limited time, semi-structured interviews and qualitative data were selected as methods. Semi-structured interviews do not have the same amount of closed questions that are used in structured interviews. These closed questions means that there are predetermined answer options such as yes or no. This leaves less room for the informants to float out and answer more expressively. With semi-structured interviews the interviewer can ask follow-up questions, which can provide important answers. Compared to a quantitative study a qualitative offers to gain different type of knowledge (Bryman, 2008). Bryman (2008) also states that quantitative studies generalize more the qualitative studies do, but still, qualitative studies try sometimes. However, due to small samples of informants qualitative studies are hard to generalize (Pathfinder International, 2006). This study does therefore not attempt to do that; it is only generalizing this particular situation with these particular informants.

The interviews were conducted during nine days in three different villages and the informants were found and contacted by the field assistant. There were three target groups of informants that were interviewed, they all had different criteria's to be counted as a valuable informant. The first three interviews were pilot interviews, after these interviews the questions were changed and improved to make them easier to understand. The purpose of a pilot study is to test the interview guide and see if the informants understand the questions (Bryman, 2008). First interview was conducted with a Schemes Administrator at the improved Community-based Health Insurance (iCBI) office. After the interview with the Schemes Administrator 14 interviews with informants that had the insurance and worked in the informal sector were conducted. These informants had to be both women and men in households that had enrolled to the insurance, since the study has a gender aspect it was essential to interview both genders. After the interview with the Schemes Administrator at the iCBI office, contact information about educators that were called iCBI Forces were handed out to the field assistant. These educators were the final informant group, they educated people about the insurance at their houses, village assemblies, smaller gatherings and in churches. There were three interviews conducted with iCBI Forces, whereby two of

them were enrolled to the insurance and got questioned about that as well. All interviews but one were conducted in Swahili; therefore the field assistant also functioned as a translator. In total 16 interviews were conducted, due to limited time in total and with the field assistant a quantitative study would not have been possible. To not miss out of any information and to be able to keep an interesting and fluent conversation it was decided that the interviews would be recorded. The subjects in the interviews were not too sensitive, therefore the informants kept answering honestly and a fluent conversation could be completed with no interruptions. Notes were also taken during the interviews to be able to go back in the papers during the interviews and ask follow-up questions.

Secondary data was collected through scientific articles, websites and books. Before the fieldwork articles and reports were found and read, in order to take part of previous research regarding the subject in the study. Majority of the scientific articles were found through searching on databases such as SöderScholar and Google Scholar. In order to find relevant material different combination of keywords was used: “Community-Based Health Insurance”, “Decision-making in Tanzania”, “Gender differences in health use”, “Gender differences in health decision-making”, “Behavioural Model of Health Services Use” and “Separate Spheres”.

In the result section in this study the data is divided in three main parts; first part present information about the insurance and the different informants, second part is about the customer’s perception about the insurance and the third part is about the barriers to the insurance. These parts will return to the theories, and use them as tools to clarify the results.

4.2 CHOICES AND STRUCTURE OF INTERVIEW QUESTIONS

The interview with the Schemes Administrator was conducted to collect more information about the insurance, but also the office focus in gender differences when it comes to enrollment to the insurance. Questions were asked about the services that are offered, the biggest barriers, utilization of the insurance, gender differences when it comes to enrollment of the insurance and the company’s strategy to address these issues and barriers. The people that had the insurance were asked about their age, gender, individuals in the family that were living under the same roof, their education

and profession. More specific questions were then asked; who had the responsibility to buy the insurance, which person in the family wanted the insurance the most, who has the responsibility when it comes to the family's money and who has the responsibility when it comes to the family's health etc. The interviews started with structured questions, then some questions about the insurance and its services, then some questions about the different responsibilities in the family. The responsibility-questions were conducted to be able to see the gender differences in the family and the different priorities that the man and the woman had. Questions that were asked during the interviews with the iCBI Forces focused on the gender differences in; interest of the insurance, attendance at the village assemblies, wanting the insurance and who is the decision maker when it comes to purchasing the insurance. The main focus on the interviews with all informant groups was to bring up the gender differences when it comes to enrollment of the insurance and the priorities and responsibilities when it comes to the household's money and health. (See appendix 1, 2 & 3)

Collected material will be compiled and analyzed regarding different informant groups. Men and women's answers will be separated and compiled by gender due to the study's gender approach.

4.3 METHODOLOGICAL DISCUSSION

All interviews with the informants but one were translated from English to Swahili and then the other way around, which gives a risk for misinterpretations, misunderstandings and information-loss. During semi-structured interviews all of the answers may not be written down, and some misinterpretations and misunderstandings may occur (Bryman, 2008). It can also be a risk that the field assistant summarize the answers and/or interpret the answers differently. Due to the limited time the sample size could not have been larger, also no follow-up interviews could be done to get a deeper understanding of the socio-economic factors that could influence the informant's decision-making and priorities. To record during interviews can be a risk due to the informant's may feel uncomfortable and not answering honestly. During the interviews other people sometimes were present, in the same house or nearby. Presence of other people can make the informants feeling uncomfortable, not expressing themselves or not being honest. Different informant groups give different results, much due to different types of interview questions and objectives.

5. FINDINGS & ANALYSIS

In this chapter the collected data from the conducted interviews is presented. It is divided into three main parts; first part present information about the insurance and the different informants, second part is about the customer's perception about the insurance and the third part is about the barriers to the insurance.

5.1 IMPROVED COMMUNITY-BASED HEALTH INSURANCE

During the interview with the Schemes Administrator new information about the insurance came up. The Community-Based Health Insurance had developed and was now called improved Community-Based Health Insurance. The iCBI was operating as a pilot from Kilimanjaro to Manjara and was intended to be working all over the country later in 2017. Next town to implement the insurance in was Arusha. The insurance is nearly evenly spread out in the different areas in Babati, this is much due to Tanzania Social Action Fund (TASAF), which helps people to enroll to the insurance. Instead of giving people money, TASAF gives them an ID and the insurance. This help results in many of the poorest people having access to the insurance. There were some differences in the improved insurance compared to the old one, the old one was still operating in some regions. Services like inpatient for five days was added, but also treatment for chronic diseases, such as diabetes, asthma and blood pressure. Dental care and surgeries (depending on how advanced they are) were also offered and if the patients need to be inpatient for more than five days, need an ambulance, advanced surgeries or more advanced medicines, their insurance does not cover. The insurance costs 60.000 shilling (27 US dollar); the government pay 30.000 and the remaining 30.000 the household that enrolls to the insurance pay. A primary and secondary facility is included, where primary is a dispensary or health center and the secondary is a hospital.

The Schemes Administrator explained about the developed and improved insurance, what was included, how it worked and the barriers and how they worked to address and tackle them. People that are enrolled to the insurance are not sufficiently educated about the insurance and therefore they expect more from it, services like ambulance and higher quality on the health care facilities. Sometimes stock-outs on facilities leads to patients being required to buy the medicines on drugstores, with money that

comes out of their own pocket. The iCBI Forces takes a great responsibility in both addressing and tackling the barriers. They are employees that spread information and educate the population about the insurance.

The information that is spread by the iCBI Forces includes: the costs of the insurance, what services that are included and that the insurance is improved. Information and education is conducted at village assemblies, group gatherings, churches and in households. First they try to motivate and influence the possible customers to come together, the information about the insurance can easily be spread on for example village assemblies. By spreading information about the insurance on village assemblies, radio programs, road shows, speakers on vehicles, in schools and on meetings every Sunday in churches the educators tries to inform the population.

Before the customers had the insurance, their health care was very costly. This insurance had reduced expenditures for families and the families were now able to seek health care more often and stay less sick. Nether of the households had been enrolled to the insurance for more than seven months, and therefore questions about past experiences about the insurance were not necessary. All customers often heard commercial about the insurance, on the village assemblies, radio, TV, church, etc. Both women and men often heard about the insurance, there was no obvious difference in access to commercial about the insurance. The decision if the families should take the insurance was very easy, they sat down and discussed and decided it had many advantages. Earlier they paid great amounts when they needed to go to hospitals for checkups and treatment.

Almost all of the informants identified themselves with one job but worked with additional business on the side. Most identified themselves as farmers, besides of two people that worked with small business and construction. All of the informants had a standard seven education and the sizes on the families that lived under the same roof were between six to 16 persons. The insurance was most important when the families got sick, and since they did not know when they would get sick the insurance was important all the time. During the rain seasons the diseases spread and the farmers did not have much money, therefore the insurance was used most during that time.

5.2 CUSTOMERS PERCEPTION

The following two headings explain the difference in men and women's perceptions about the insurance.

5.2.1 WOMENS PERCEPTION

Women wanted the insurance because of their children's health, they are responsible for the family's health, and since they are home more with their children they knew if they were sick. It was also more common for the woman to take the children to the hospital. Women in the households that were enrolled to the insurance wanted the insurance more than their men, since they have responsibility for the children's and their own health. If the children get sick, it is generally the woman's problem because she spends most time with them. Women do not have the power over the family's money and therefore they cannot buy the insurance, if the women are not able to convince their husbands. If women would have a greater power over the family's money more insurances would probably be bought according to the iCBI Forces and the Schemes Administrator. The responsibility women have over their children results in them being more interested in the insurance and more willing to buy it. Women's social relations are often directed by their husbands, the husbands can often decide which people the women should meet with. This impedes her to connect and build social relations, which also decreases her decision-making power and chance to contribute in social change.

According to Ryle (2011) women's place is in the home, she is portrayed as the natural family member and mother, who care the most for the children. The woman's housework compared to paid labor limits her and decreases her authority. Women needs to be associated with the public sphere in order to take a clear place there and to be equal to men in it. Also important is to stop defining women as only a caring mother and housekeeper for them to be able to break into the public sphere. If women would be defined as equal labor force compared to men they would get a greater decision-making power and have more power over their earnings in the future. Women's lack of economic opportunities therefore places them in a weaker bargaining position; these positions within the households are also linked to the positions outside the household (Bradshaw, 2013). According to Vlassoff (2007) women spend more time at unpaid work, while men spend their time in productive and paid work, this result in

women having fewer resources to fall back on and their control over their own earnings is often limited. Bradshaw (2013) states that if women would get improved access to financial resources they would be empowered in their own house. These economic powers are related to household power and decision-making power; with a greater economic power a woman would get a greater household authority. Women have both the responsibility over their children and the household but also a job outside of the house, this results in a double burden, which inhibits her from, for example, getting a higher paid job. By sheltering women from the outer world's struggles it also shelters women from achievements and maintains the social structures and patriarchy (Ryle, 2011; Andersen, 1995). Financial resources are central for the improvement of the decision-making, but also other assets such as social relations are important for the decision-making power. Women do not get access to all of these factors that can help her getting access to financial resources, still men see it as women only contributes if they do so in financial forms (Bradshaw, 2013).

5.2.2 MENS PERCEPTION

Men wanted the insurance in order to save money and decrease some expenses. A few of the male informants also mentioned that they never knew how successful the next harvest season would be; therefore they needed the insurance when they had a bad season. Men belong in the public sphere where money has the greatest significance, they do not belong in the private sphere and therefore their children are not their responsibility, which results in men having different priorities than women. Men have the responsibilities for the family's money, purchases, communication and also the farms. A woman can advise what to buy and not, but it is still the man's decision and this results in men being responsible to buy the insurance as well.

The man's duty is to take care of his family through protecting them and earning money (Ryle, 2011). According to Vlassoff (2007) both income and earnings bring greater decision-making power, but also respect in the society and independence. Ryle (2011) describes that the separate spheres means that men belong in the public sphere, where it is a world filled with economics, law, commerce and politics. This public world is a masculine world that is built on productive behavior and market relations; it also includes paid labor and is best suited for men.

5.3 USE OF HEALTH INSURANCE

The three headings that follow are describing the barriers, as perceived by the informants, with the insurance and it is divided into the three categories in the BMH, which describes factors that either impede or enable people's access to health (insurance) care utilization.

5.3.1 PREDISPOSING CHARACTERISTICS

Some barriers that are addressed are the difficulties to convince people that the insurance is improved, how important it is and why it costs more than the earlier one; also making people understand how the insurance actually works. People often expect more services than the insurance provide. The earlier insurance had a bad rumor, that rumor has been spread to this improved insurance. Therefore the knowledge about the insurance, which is spread by the iCBI Forces, is essential to be spread out due to people's perception of needing the insurance.

When the iCBI Forces go and visit households they are not allowed to just talk to the woman in the family, they first have to talk to the head of the household, the man. This results in men being more educated about the insurance when the iCBI Forces visit households, however their ambition is always to sit down with the whole family, both the woman and the man, and talk about the insurance. At the village assemblies there are more women that participate, therefore more women are educated at the village assemblies. It is harder to recruit farmers, due to them working on their farms all day and the educators cannot ask them to stay home from work. Since most of the customers and possible customers are employed in the agricultural sector many miss out on important information about the insurance.

Andersen (1995) explains that lack of knowledge can work as a barrier for people's perception of need to health care and that gender structures and social structures that arise impedes people's access to health care utilization. Gender is a biological factor that affects the likelihood to need health care (Andersen, 1995). Biological, women are a larger risk-group and need more access to health care, but have less access to it because of their lack of decision-making power in the household (Vlassoff, 2007). Health beliefs and lack of knowledge can effect women's use of self-treatment instead

of health care facilities (Robyn et. Al., 2012; Andersen, 1995), therefore this education that is spread about the insurance by the iCBI Forces is essential.

5.3.2 ENABLING FACTORS

One of the enabling factors is income, which women do not have the same access to as men. With greater access to an income and power over the family's money the woman would have a greater decision-making power and therefore being able to decide if the family should buy the insurance. Women's double burden impedes her from getting a higher paid job, which results in a smaller income. All customers have to pay the whole amount at once; which is a large barrier as well, since many people cannot afford this lump sum.

The iCBI Forces are employees that inform potential customers and customers about the insurance, they educate the inhabitants on village assemblies, in households and on different gatherings. Sometimes the houses are so far away from each other that employees cannot educate the amount of households per day as needed or set as a daily goal. Health care facilities can be very far away; sometimes the services that are offered at the primary and secondary facility are not services that the customers are in need of. This results in people not getting the treatment they need, because they cannot go outside of their district (due to iCBI policy) and choose another hospital. These distances to households and health care facilities impede both the iCBI Forces to educate and the customers to getting access to facilities, which also can result in people not buying the insurance or customers stop using it.

During the rain season farmers does not have the same amount of money and cannot buy the insurance. Rain season does not bring them money nor food, which spread diseases and increases need of health care. But due to lack of income the farmers cannot provide their family with the insurance, which can result in families getting caught in a poverty spiral.

The majority of the customers did not think that the insurance had reached their expectations; they did for example not get access to all the services that were promised. There was no access to larger facilities with better equipment, shortening of staff at

facilities and stock-outs of medicine. Patients with the insurance were also less prioritized at hospitals than the patients that paid with cash. Facilities did sometimes say that the medicine that the patient, with the insurance, needed were out of stock and that they needed to go and buy it in a drugstore, the next patient that paid with cash and needed the same medicine got it.

Income is a factor that makes it easier for people to obtain their health care. With an income they can easier pay for transport, medicines, hospital visits and insurance. The distances also work as an enabling factor that impedes people from obtaining their health care or health insurance (Andersen, 1995). Men often gets access to a health insurance through their work, health insurance is also a factor that can make it easier for people to obtain their care (Vlassoff, 2007; Andersen, 1995). This also means that men has one additional factor that makes it easier for them to access health care, which leaves the women in a weaker position, where she wants an insurance for her and the children.

5.3.3 NEED

Women are a larger risk-group than men when it comes to diseases; therefore they want to enroll to the insurance to always have access to health care, for themselves and for their children. Many of the male informants mentioned that women are a bigger risk group, while women did not mention their own health status, only their children's. Women are in bigger need of the insurance but do not have the ability to buy it, due to lack of money and authority in the household.

In his theory Andersen (1995) describes the perceived need, which is how people view their own health. Women's self-perception is important, but also how men see women. If women need health care men treats them as charity cases (Bradshaw, 2013).

6. SUMMARY

The results in this study show that men and women have different perceptions about the insurance and that their perceptions are affected by the roles between men and women in households. Men see the insurance as an opportunity to save money and

decrease expenses on health care, while women want to enroll to the insurance for their children to get easier access to health care at all times. Due to women's responsibility over the children and their health they are more interested of the insurance, this show clearly that the roles in the households affect the perception about the insurance. Men's role are head of the households and breadwinners, having responsibility over the family's economy and purchases, this results in men also being responsible to decide if the family should buy the insurance or not. Because men do not have the responsibility over the family's health and does not know first if the children are sick (due to not being home with the children like women) they are less interested by the insurance. Men do not have responsibility over the family's health, but instead they have the responsibility over the money, therefore their priorities are not the same as women's priorities. A woman does not have the choice to decide if the family should enroll to the insurance, she can advise her husband and try to convince him, but it is still the man's decision.

7. CONCLUDING REMARKS

The results in this study show that there are clear differences between men and women in both their roles in the household and their perception about the insurance. The gender approach is essential in all developing projects, for countries to be able to develop their population is the starting point, and gender differences is one of the greatest issue that impedes the population to develop. It is essential for all developing projects to have local partners, who are involved and can design a sustainable project template. Without these local partners a project can easily be designed according to the western perspective and priorities, which are not designed to fit all places.

If women could avoid the double burden they would have the ability to get a more highly paid work, with more women out on the labor market the women would get more authority in the household and make more decisions concerning the public sphere. Countries would also benefit if more women came out on the labor market. With greater access to financial resources women will become more independent and able to make their own decisions. Even though men are not as badly affected by these gender differences and structures as women are, they still get painted as the one that

wants to belong in the public sphere, having responsibility over economics, law, commerce and politics. These masculine rules limits men from showing a caring and loving side, with more gender equality men and women would not be divided and limited into two separate worlds, which would benefit them both.

Some further research about the subject is definitely necessary. How for example these gender differences in households can affect the enrollment of the insurance. If more families would enroll to the insurance if women had a greater decision-making power over the family's money. The iCBI Forces and Schemes Administrator are convinced that this is correct, but to be able to make a conclusion about this a larger study and additional time would be needed. Research about how to add gender questions in the implementation process and what gender questions that are most important for the development of the insurance is essential. Also what questions that are most important to take into account to see how both genders should get equal access to the insurance.

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Figure 1. Source: Andersen, Ronald M., 1995. Revisiting the Behavioral Model and Access to Medical Care: Does It Matter? *Journal of Health and Social Behavior*. 36: p. 1-10

9. APPENDIX 1

Interview questions with iCBI-customer

Name:

Gender:

Age:

Education level:

Individuals under the same roof:

Profession:

1. Do you experience your family as a healthy family? Why?
2. How much money did you approximately spend on health care every year before you had the insurance?
3. For how long have you had the insurance?
4. Who in the family got to know about the insurance first?
5. How often do you see or hear commercial about the insurance?
6. How was the decision about the insurance made?
7. Who was responsible to buy the insurance?
8. Who wanted the insurance the most?
9. What was the main reason why you took the insurance?
10. What did you expect from the insurance?
11. Has it lived up to your expectations? Why?
12. When is the insurance most important? Why?
13. What is more important than the insurance? For example money, your farm, your cows, tin roof?
14. Who is responsible for what the family's money goes to?
15. Who is responsible for the family members health?
16. Do you have anything you would like to add?

10. APPENDIX 2

Interview with the Schemes Administrator

Name:

1. What is the price for the insurance and how many family members are included?
2. What services are included in the insurance?
3. What do you think the biggest barriers are in the implementation process?
4. Do you take gender differences into account when you implement the insurance?
5. Is there any difference in utilization of the insurance between men and women?
6. Is there any difference in how many men and women that enrolls to the insurance?
7. Do you think gender differences are a barrier when it comes to enrolment of the insurance, and if, what is the barrier?
8. Is there any difference in why men and women chose to enroll to the insurance?
9. Are there any differences in barriers or limitations depending on which area you live in in Babati?
10. How is your company trying to improve these barriers and issues?
11. Has there been any focus in increasing the knowledge about the insurance?
12. Would you like to add something?

11. APPENDIX 3

Interview with iCBI-Forces

Name:

Gender:

Age:

Education level:

Profession:

1. What type of information are you spreading when you educate possible future customers?
2. What gender is more interested in the insurance?
3. When you visit households to educate, which gender do you educate more often?
4. Why do women want to enroll to the insurance?
5. Why do men want to enroll to the insurance?
6. If women had more power and responsibility over the family's money, what would happen to the insurance?
7. What are the obstacles with the education procedure of the insurance?
8. What type of obstacles do you meet when you educate men?
9. What type of obstacles do you meet when you educate women?
10. Who in the family is responsible to decide if the family should buy the insurance or not?
11. Who wants the insurance the most in the family?