

## **Making Our Lives, Secure and Productive—SEWA Social Security**

Our members are active contributors to the Indian economy. They work long hours for very low wages or earn very little from their work. Often they have to toil under very difficult, indeed hazardous, conditions. All of this takes a toll on their overall well-being. And they have no access to statutory social security. SEWA believes that our sisters have a right to social security. They are entitled to it as citizens and especially because of their significant economic contribution. Being poor and vulnerable to sickness and other crises, social security is all the more required by our members.

Over the years we have learned that women cannot be self-reliant without social security. If they are sick, or if they have a leaking roof or no one to take care of their children while they are working, they cannot go out to work, and lose their valuable wages or income. They also have to liquidate their carefully acquired assets or use up their savings.

At SEWA, social security means at least health care, child care, insurance and shelter (housing and basic amenities). SEWA Bank has developed pension for our members in partnership with Unit Trust of India (UTI). This was started in April 2006. At the time of writing this, 28,000 members had started up their pension accounts.

### **Protecting and promoting our health**

SEWA has 30 years of experience in organizing workers on community health. In the early 1970's, it became actively involved in the public health field through the provision of maternity benefits and by emphasizing health education for women workers. Since then, it has been deepening its ties with the community through different health initiatives led by women workers. Starting in 1984, SEWA has been running a community health program in Ahmedabad city and eleven districts in the state of Gujarat. This program has expanded considerably in the last few years. SEWA's Health Team has promoted 4 health cooperatives in Gujarat along with SEWA's district-level associations. The first and largest of these is Lok Swasthya SEWA Cooperative. Currently, Lok Swasthya Cooperative runs 400 health centers (which help in conducting mobile health camps) and 4 medical shops, 400 community health workers (Swasthya Sathis), 60 Sevikas or full-time community health educators, 5000 midwives, and 100 full-time Health Organizers help members and their families obtain affordable health care.

#### **The activities of the SEWA Health Team include:**

1. Provision of preventive health services, including:
  - Health information and education, including information on HIV/AIDS;
  - Immunization, iron and folic acid supplementation, and Vitamin A Supplementation, in collaboration with government services;
  - Ante-natal care (ANC), including weighing, screening for anaemia, and nutrition

Counselling;

- Skills up-gradation (of all SEWA Health functionaries) and training of midwives;
  - Contraceptives – both by providing information and making these available by coordinating with government services;  
Screening for reproductive tract infections (RTIs) and cancer through diagnostic ‘camps’.
2. Promotion of health and well being — Health education and information is made available through a six- module training programme for SEWA members, and slightly modified programmes for their husbands, adolescent girls and boys and traditional midwives.
3. Provision of curative health services, including:
- Low cost medicines;
  - Treatment of tuberculosis through DOTS method and screening and treating diagnosed persons;
  - Mobile clinics called ‘camps’ for reproductive health problems, children’s and General health problems;
  - Acupressure therapy
  - Ayurvedic (traditional medicine) treatment

Our approach is:

1. **Women led:** All the activities under SEWA Health are led by women workers because SEWA believes in the capacities of women to understand and take care of their own health needs and that of their communities. Activities are run by women, for women and for their families.
2. **Need – based and demand – driven:** All our activities are based on the felt need and demand of SEWA’s members, their families and communities.

SEWA’s Health programme during the year 2006 mainly focused on strengthening and deepening its work, which was initiated in 1984. With the changing times and expansion in the programme, a need was felt to build upon our past experience and take an area approach. Besides this, new initiatives during the year were increased dovetailing of Health and Vimo SEWA (SEWA Insurance) as well as expansion in urban areas.

The table below shows our outreach and activities in 2006. The major activities include primary health care including curative care, tuberculosis control, maternal health, health education and reproductive health including family planning.

3. **Integrated approach:** SEWA firmly believes that women workers cannot achieve health security if the other aspects of their lives are not addressed. All health activities are developed keeping the primacy of work with work security in mind. In addition, health action has been interwoven with other needs of members like Insurance, Childcare and Housing and Sanitation, which ultimately contribute, to better health and well-being.
4. **Decentralized Services at Women’s Doorsteps:** Services are provided at the doorsteps of its members — be it primary healthcare, diagnostic camps, health education or any other service. In this way, health services are accessible to a maximum number of women and their families and their hard earned resources are not used in transport to and from health facilities. Also, we believe in the decentralization of all our health services.
5. **Partnership with government and private health providers:** Many activities of SEWA Health are run in partnership with government and private health providers with the dual purpose of strengthening the existing government health network and its optimum utilization and a greater access to quality services at a low cost from private providers.
6. **Sustainability:** SEWA has always believed in sustainability of its activities i.e. running these in an economically viable manner and with decision – making by local women themselves. Thus local volunteers are developed as Sevikas and Aagewans. It is through these local women then that all the activities of SEWA Health are implemented.
7. **Policy Action:** The need to organize, unite and demand just health policies for its members has always been an important part of SEWA’s activities. Thus, women come together to voice their concerns before the policy makers. For example, SEWA Health has been engaged in organizing dais in the form of co-operatives. They have collectively demanded and obtained recognition as primary providers in the field of healthcare.

#### **Outreach of SEWA Health**

Sr. No.	Particulars	Women	Men	Boys	Girls	Total
1.	Primary Health care	52,683	23,047	10,640	12,333	98,703
2.	Curative care	-	-	-	-	10,44,147
3.	T B referral	2,118	2,323	346	331	5,118
4.	Family Planning – contraceptive	35,946	25,174	-	-	61,120

	distribution					
5.	Family planning operation	8,892	253	-	-	9,145
6.	IFA supplementation	62,106	13,029	17,809	15,949	1,08,893
7.	Maternal and child health	35,087	6,869	24,705	22,776	89,437
8.	Camps					
	Eye camps - 82	1,892	998	622	545	4,057
	Paediatric camps - 6	-	-	232	129	361
	Gynaecology camps - 242	3,078	-	-	-	3,078
	RCH camps - 132	2,611	-	990	1,002	4,603
	General camps - 189	2,151	1,303	939	1,002	5,395
9.	Health Education	5,823	5,993	5,369	5,610	22,795

10. Sale of low cost medicines: Rs. 1,34,92,977

Some Highlights of our Primary health care work:

**Our tuberculosis (T.B.) control work resulted in significant outcomes this year:**

- Cure Rate— 84% (WHO standard: 85%)
- Defaulter Rate— 4% (WHO standard: 5%)
- Sputum Conversion Rate— 92% (WHO standard: 90%)

These are three standard measures of outcome. Cure rate refers to the percentage of patients who are completely free of the T.B. bacilli after sputum tests. Defaulter rate is the percentage of patients who stop their treatment and Sputum conversion rate is the percentage of patients testing positive for T.B. who are converted into negative—i.e. they no longer have the T.B. bacilli in their sputum.

**Low Cost Medicines**

Lok Swasthya Cooperative has been running four medicine shops, which promote generic medicines. Thus during the current year, the cooperative was able to cater to 2,00,000 people through its four medicine shops and the annual sales was Rs. 1,34,92,977.

Besides allopathic medicines, Lok Swasthya Cooperative has also been producing and marketing traditional medicines through 500 members.

This year Lok Swasthya formally began production of traditional medicines (Ayurveda) in a production centre—Lok Swasthya Ayurved Parishramalaya. We are licensed to produce 15 different products at this time. Apart from providing low cost, local remedies, which have no side effects, this endeavour will provide employment to women workers who will market the products in their own villages and in urban areas.

### **From Dai to Community Health Worker (Swasthya Sathi)**

Our efforts in capacity building at SEWA Health include broadening the role of dais or traditional birth attendants to that of a community health worker, barefoot counsellor, promoter of traditional medicines as well as an insurance promoter. We now call them Swasthya Sathis. 400 dais of Ahmedabad district spread across four talukas were trained in the above - mentioned areas and at present they are successfully working as community health workers of their own villages.

Our health programme expanded to the urban areas in Ahmedabad, Surat and Vadodara cities as well. A team of 46 Swasthya Sathis, 12 Sevikas and 3 Supervisors has been developed. Health services were developed for self-employed women workers and their families in more than 100 slums.

### **Convergence between Health and SEWA Insurance or Vimo SEWA**

SEWA promotes microinsurance as one of the many ways to address vulnerability and risk for poor self employed women. SEWA Insurance or VimoSEWA, is promoted using the door–step approach. Further, cashless tie-ups with selected hospitals are being established to enable members to avail of medical facilities without worrying about immediate cash on demand and to facilitate speedy bill settlements after hospitalization. In addition, we monitor for both quality and costs.

Swasthya Sathis have been trained as insurance promoters to sell VimoSEWA policies in their own communities. This past year, Sathis proved instrumental in increasing the insured membership in Sanand, Daskroi, Dholka and Viramgam talukas. In 2006, 400 Sathis insured a total of 16,312 members.

### **Policy Action**

The Dai Sangathan, a statewide network of organizations working with traditional birth attendants, was registered this year. SEWA was one of seven founding partners: Chetna, Deepak Foundation, SAARTHI, SEWA, SEWA-Rural and SWATI. To formally launch the network, a Dai Sammelan was held in partnership with the Health & Family Welfare Department of the Government of Gujarat on 11<sup>th</sup> of April 2005. 1,500 dais participated. The Government of Gujarat formally recognized the Dai Sangathan. Its role

will be to improve public health services in the state with a focus on women and children's health. Through its strong network of dais, the Sangathan holds district, state and national level meetings to raise issues related to dais. These are then taken up for policy action both to strengthen dais and to improve public health in our country. This year a large rally of 1500 dais was organised to press for fulfilling the commitments made to dais by the government.

Besides the formation of the Dai Sangathan, policy advocacy also included active inputs in the National Rural Health Mission (NRHM) under which the Government of India has a clear goal of addressing the health needs of rural population. A new band of community based health functionaries will be developed who will be called ASHA "Accredited Social Health Activists". SEWA is on the advisory of the NRHM.

Thirdly, SEWA's active representation on the World Health Organisation's Commission on Social Determinants of Health (CSDH) brought on board social components interlinked with health issues especially of the self-employed women as well as inequities in health.

Some Achievements this year:

1. Lok Swasthya health cooperative was awarded the first prize for the best cooperative in the district.
2. The cooperative purchased production space—a factory called Lok Swasthya Ayurved Parishramalaya—for the manufacturing of traditional, Ayurvedic medicines.
3. Self-reliance was the cornerstone of our efforts this year—how to ensure that our cooperative, as well as its 500 share-holders obtain regular work and income. All our members obtained income—an average of Rs 500 per annum—through sales of medicines, insurance and linkages with government health programmes for which they obtained incentives for their services.
4. The Swasthya Sathis now maintain their own data bases reflecting their outreach in their villages and urban neighbourhoods.

### **Taking Care of our Children—Child care at SEWA**

Women workers often have to combine the tasks of looking after their small children and working at the same time. Since child-care is generally not available, a woman has to adopt alternatives like taking the child to work with her, leaving the child alone or in the care of older siblings. Where a woman works in hazardous occupations like tobacco-processing or salt farming, the risk to the child is considerable. She literally works at the cost of her child who does not receive proper attention.

SEWA's child care activities stress the overall development of young children and include health care, nutrition, recreational and child development activities. All children at our 250 centres are immunized and weighed regularly. They also have health check ups, are given micronutrient supplementation and referral care for serious diseases. They learn through play, games and child development activities. Increasingly, our centres are stressing children's development through various means including trips to local sites of interest. The children also obtain milk and nutritious food at the centres. The centres run according to the mother's hours of work. Mothers regularly and actively participate in meetings at the centres, monitor the activities and give their suggestions.

Sustainability of the centres – both in financial terms, as well as in terms of workers running the centres themselves – are an important feature of our programme. Each mother contributes towards the cost of having her child at the centres. In addition, employers and private trusts also provide contributions. Finally, the government has been providing resources through the Integrated Child Development Scheme (ICDS), Rural workers Welfare Board and Social Welfare Board. Thus, through multiple sources of funding the child care centres are striving for sustainability.

The centres themselves are run by cooperatives of child care workers and local, district-level organisations:

- In Ahmedabad, Sangini Child Care Workers' Cooperative is running centres for infants and young children. It has links with the ICDS and Social Welfare Board.
- In Kheda district, Shaishav Child Care Workers' Cooperative is running centres for 0 to 6 year old children of tobacco workers and agricultural labourers.
- In Surendranagar district, the local association – Mahila and Balvikas Mandal runs Child Care Centres for the children of salt workers. It is running Balvadis (day care centres) in villages bordering the desert, the little Rann of Kutch and in the desert itself alongside the salt pans.
- In Patan district, the Banaskantha DWCRA Mahila Sewa Association (BDMSA), is running centres for the children of rural workers' involved in agriculture, dairying, land-based activities like nurseries, gum-collectors and embroidery.
- In Kutch district the Kutchcraft Association is running child care centres. Most of the mothers are embroidery workers.

SEWA has also been actively working for the inclusion of child care in all our country's development programmes. Together with the Forum for Creches and Child Care services (FORCES) based in Delhi, we have been suggesting the following:

- Flexibility should be encouraged and permitted in child care programmes supported by government. Organisations should be permitted to collect community contributions and other funds, and be given the flexibility to use

allocated budgets in a locally appropriate manner. They should also be directed with decision-making powers on issues emerging from their implementation of child care services.

- Decentralization of child care services should be undertaken. Both decision-making and resource allocation should be decentralized and undertaken at district level. Child care centres should be run by peoples' organisations and NGOs.
- Documentation of child care by NGOs and people's organization should be undertaken.
- Creches for 0 to 3 year-old infants and young children must be an integral part of child care.

In 2006, we took care of 8,775 infants and young children of our members

No.	Districts	Number of centres	Number of children
1	Ahmedabad	131	5775
2	Kheda-Anand	45	1200
3	Surendranagar	15	600
4	Patan	20	800
5	Kutch	10	400
	<b>Total</b>	<b>221</b>	<b>8775</b>

Our centers work towards the overall development of young children: new borns to six year olds exposing them to the joy of learning. We also monitor their nutrition and growth. The several different activities of SEWA child care in 2006 are outlined in the table below.

Health Care at our Child Care Centres (2006)

#### Immunizations at child care centers

	Ahmedabad	Kheda	Surendra-nagar	Patan	Kutch
Immunization	5757	3000	1800	1300	1000
Pulse Polio campaign	55000	10000	1200	1500	600
1. Medical checkups	5757	1000	900	700	300
1. Vitamin A supplementation	5757	200	150	300	50
- children	2520	130	-	-	-
- mothers					
Referral care (free surgery)	12 children	10	-	-	-

1. Tuberculosis referrals	425 persons	-	-	-	-
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In the year 2006, the child care team focused on trying to ensure that each of its centers became self-sustaining. It is still a work-in-progress, but some significant steps forward have been taken. Throughout the year we had meetings with parents, child care centre teachers, local leaders, employers and other possible donors. But first we prepared an income-expenditure chart for each centre. We explained these to our members and their husbands, the parents. The latter have been consistently contributing towards the running cost of the centers. Contributions are collected in cash and in kind. The range of monthly fees contributed from parents is between Rs. 40 and Rs. 10 per child per month.

As the running costs amount to Rs. 200 per child per month or Rs. about 10,000 per centre per month, SEWA and the child care cooperatives raise the required funds through multiple sources. The table below shows the amounts collected every month.

**Parents' contribution to child care centers**

<b>Sr.no</b>	<b>District</b>	<b>Parents Contribution (Rs.) per child</b>
1	Ahmedabad	30
2	Kheda-Anand	25
3	Surendranagar	10
4	Radhanpur	10
5	Kutch	5

Several local donors provide foodgrains like wheat, rice, dal and millet to our centers, as these are located in the neighbourhoods. Our village members bring in fruit and vegetables as well. In the city, some of our members who are vegetable vendors, give greens and other vegetables for our centers.

An important feature of our child care work is the on-going capacity-building of our child care teachers or "sevikas". We set up a special school for their continuous learning called BalAnand Shala or literally, Children's Happiness School. It has developed ten basic learning modules with the help of a child development expert. These training modules were developed in consultation with the sevikas, and in response to their needs. Strengthening these grassroots-level workers to broaden their knowledge and skills, and to develop their creativity, thereby enabling them to serve the children better, is the main aim of the Shala.

This year we added six new modules to our shala's training.

Finally, this year we had 4 children's and parents' "melas" or celebrations. Children displayed their drawings and craft work, participated in plays, fancy dress focusing on their parents' occupations, games and stalls of various kinds. Women in large numbers came to these events. Fathers also have started coming in strength to our events.

<b>No.</b>	<b>District/Area</b>	<b>Parent's Contribution</b>
1	Ahmedabad	6,80,000
2	Anand-Kheda	2,90,000
3	Kutch	25,000
4	Patan	96,000
5	Surendranagar	72,000
	<b>Total</b>	<b>11,63,000</b>

This year, our Ahmedabad crèches faced a crisis. Due to SEWA's strained relations with the state government, we had ceased to partner with them for running our crèches. In effect, this meant that we stopped taking funds from the state government for our crèches and child care centres, especially under the Integrated Child Development Scheme (ICDS). However, we continued to accept ICDS monies from the central government.

In October 2006, the state government told us that these funds from the centre would no longer be available to us, with almost immediate effect. This put one of our child care cooperatives—Sangini in Ahmedabad—under tremendous financial strain. We did manage to ensure that our trained child care teachers were absorbed by the state, so that they were not rendered jobless. Hence from 131 child care centres, we went down to 57 and then by March 2007 to 29 centres.

We also managed to ensure that the children who had been attending our centres continued to obtain services from centres run by others but in the same neighbourhoods and by mostly their same teachers.

This crisis forced us to re-examine our approach to child care services, and in particular, to strive further for self-reliance. To this end, we have developed an in-house child care fund from contributions by donors and other well-wishers. These monies will defray some of the running costs.

Further, parents and other local persons have increased their contributions, in cash and in kind, to the crèches. These are used for nutrition and other costs that directly benefit the children.

### **Special events and achievements**

- Our two child care cooperatives, Sangini in Ahmedabad and Shaishav in Anand-Kheda have retained their A-grade, given after their statutory audit.
- Despite financial constraints, child care centres continued to serve young children.
- Creche teachers and “graduates” from their centres participated in a national – level meeting of organisations running crèches and ICDS centres in New Delhi. Our children and some of our teachers spoke to a distinguished panel, including Dr. Amartya Sen and Dr. Montek Singh Ahluwalia, Deputy Chairman of the Planning Commission of India. The children, now college-level and graduate students, spoke of the importance of child care in their lives, and how it enabled their mothers to work and earn, and to ensure that the children went to school and stayed there.

### **VimoSEWA or SEWA Insurance: our support in crisis**

SEWA’s experience with providing microinsurance services to women workers over more than a decade points to the fact that microinsurance must be integrated with both financial services (savings, credit and pension) and social protection (health care, in particular), and also with poverty reduction programmes. It must be part of a strategy that aims to reduce poverty by focusing on employment/livelihoods with social security. It is this holistic and integrated approach which will eventually reduce vulnerability and stem the decapitalisation that occurs when risks and crises confront poor families.

Our experience leads us to an understanding of microinsurance that places it at the frontier of both financial services and social protection, incorporating elements of both. Like other microfinance services, it must be run in a financially viable manner, but it needs the universalisation that comes with the social protection approach. Universalisation—making insurance available to all citizens regardless of socioeconomic status-- or at least maximizing coverage to include as many citizens as possible, and especially the poorest, is not only equitable, but also makes ‘good business sense’ from an insurance viewpoint. The larger and more diverse the pool of insureds, the greater is the spread of risk and, consequently the greater the chances of viability.

At SEWA, time and again we have seen that the poor, and particularly women workers, will pay, or at least contribute substantially, towards the cost of services, if they are

appropriate and of acceptable quality. Once they are convinced of the service's utility, no further marketing is required. This is equally true of microinsurance.

In our experience, there are two aspects to the servicing of microinsurance:

- Claims-servicing—This must be timely, have simple procedures and be at the women's doorsteps; cash-less systems for sickness coverage through tie-ups with hospitals are required.

\* Contact with the insured— It is important to have as frequent contact as is possible, and at least twice before renewal of insurance; even if members do not face any crisis, they need to feel involved and connected. Such face-to-face contact (individual, house-to-house or in small meetings) presents a good opportunity for preventive health education as well as education on insurance and other SEWA schemes.

VimoSEWA has been constantly improving its services based on our members feedback. We have also been trying to reach our members in different ways, in order to increase our outreach and services to workers. Some ways that we used in 2006 are:

- small and large meetings (sammelans)—these need to be held repeatedly
- gram sabhas or village-wide meetings
- linking with SHGs—livelihood-based groups, savings and credit groups and others to get a “chunk of insureds” on the one hand, and lowering transactional costs on the other
- developing special premium payment plans—monthly savings towards annual premium, one-time lump-sum payment which is put in fixed deposit (and the interest accrued is used to pay the annual premium), loans for fixed deposit-linked insurance
- linking with loanees of SEWA Bank
- linking with individual depositors of SEWA Bank and taking premium directly from their savings accounts with their consent
- linking with NGOs in other states
- linking with specific groups of workers—like members of a cooperative

VimoSEWA increased its outreach to 194,879 in 2006. Its membership now includes seven states in addition to Gujarat: Bihar, Madhya Pradesh, Uttar Pradesh, Delhi, Rajasthan, Kerala and Tamil Nadu. Many of our insured members in these states are from our sister SEWAs in SEWA Bharat.

**Insurance outreach (December 2006)**

	<b>Women</b>	<b>Men</b>	<b>Total No. of Children</b>
<b>Scheme I</b>	104864	48406	29302

<b>Scheme II</b>	5782	3197	3096
<b>Total</b>	110646	51603	32398

**Details of Insurance outreach by district NGO (upto December 2006)**

<b>Particulars</b>	<b>Dec'06 Persons</b>
<b>1. Ahmedabad City</b>	<b>64455</b>
Ahmedabad district	16295
Anand	37361
Vadodhara	6217
Saberkantha	6933
Kutch	9619
Patan	4729
Surendrnagar	2051
Mehsana	5749
Gandhinagar	4210
<b>2. Districts sub total</b>	<b>93164</b>
<b>3. Other Gujarat</b>	<b>594</b>
Delhi	2719
Munger	1142
Bhagalpur	1132
Bikaner	945
Indore	2224
Chhatarpur	943
Murshidabad	71
<b>4. SEWA Bharat sub total</b>	<b>9176</b>
Nidan	21266
Shepherd	6210
<b>5. Other NGO total</b>	<b>27476</b>
<b>6. Other India</b>	<b>14</b>
<b>Total</b>	<b>194879</b>

## Claims-processing: highlights in 2006

1. In 2006, VimoSEWA arranged for cashless tie-ups in several government and trust hospitals in Ahmedabad. A few such tie-ups were effected with private practitioners as well. In all, 18 hospitals linked up with VimoSEWA to provide our insured members with affordable and quality services. Most importantly, our members did not have to pay out of pocket when admitted. Selected aagewans or union leaders were equipped with a mobile phone and on being informed by a member (admitted in one of the above hospitals), they visited her and obtained all details of her illness and its possible cost. They then confirmed that she was a member in our main office and paid out 80% of the member's hospital costs to her. The remainder of expenses were paid to the member at the time of discharge when the final tally of costs was obtained.

This system proved so popular with our urban members that we decided to increase the number of hospital tie-ups and rather than voluntary as in 2006, have this system compulsory for all our Ahmedabad city members in 2007.

In the rural areas too, such cashless, hospital tie-ups exist in five districts and ten talukas, but on a voluntary basis—members may or may not choose to avail of this cashless tie-up system. Here too, however, the experience shows that if the tie-up is appropriate and if the cashless service is efficient, members prefer this system.

VimoSEWA would like to gradually extend this type of claims service to all of its members, as it prevents them from using up their savings, mortgaging and even selling off their assets to defray hospitalisation costs, and hence prevents indebtedness.

2. Over the past three years, increasing numbers of unions, cooperatives and NGOs have been asking us for insurance coverage. VimoSEWA now has several partners in Gujarat, Rajasthan, Bihar, Tamil Nadu and Uttarakhand, in addition to its sister SEWAs of SEWA Bharat. The most essential part of this partnership has been setting up the claims-servicing so that it is prompt, efficient, according to insurance principles, and eventually conducted by the concerned organisation.

We have offered a structured capacity-building programme of five days for our partners, to understand all aspects of our insurance services, and especially claims-servicing.

- Regular monitoring has enabled us to improve our servicing standard. Average processing time is as follows.

### Time taken for claims processing

	Urban	Rural

Health Insurance	21 days	35 days
Asset	35 days	39 days
Natural Death	22 days	33 days
Accidental Death	32 days	23 days

With proper planning and team work, VimoSEWA the rural team and district associations managed to process the 3500 flood claims in 2 months.

Table 9.7

**Claims paid**

	No. of approved claims	Submitted claims	Claims Paid in Rs.
Health Insurance	7252	8799	12257801
Maternity	131	131	393000
Asset (Flood)	6856	7201	11419453
Natural Death	471	627	2955000
Accidental Death	19	20	328000
<b>Total</b>	<b>14729</b>	<b>16778</b>	<b>26999554</b>

In 2006, we had floods in five districts of Gujarat—Anand, Kheda, Ahmedabad, Vadodara and Sabarkantha.

These were particularly severe this year and stretched our district teams as well as our VimoSEWA claims team to the fullest. We had more than 7000 claims which had to be surveyed and assessed, after which claim cheques were issued to a total of ---6242 members. The table below shows the details of our flood claims work. All of this was completed ( including payment) within three months of the disaster.

From our experiences we have developed a rapid action assessment team to meet any such event in future.

A major thrust in VimoSEWA is helping our members understand the “in’s and out’s” of insurance. Training sessions on the various products in our insurance package, how to put in one’s claim, what are the exclusions and other aspects of our insurance services are brought to the doorsteps of our members. In particular, we have found that house-to-house visits and small area meetings help to both spread an understanding on insurance and also to market our services.

All of the above operational and educational work was possible because we have an on-line data-base of all information, carefully collected and compiled over the last fifteen years. Our data-base gives us information on each and every member, her claim history

and that of her family members. It also provides us information on trends and rates, all essential for actuarial calculations and under-writing.

In addition to our existing data-base, it is important to periodically go back to our members and determine their views on our services, what works for them and where they would like to see changes in products and processes.

This is carried out by our research and development team which includes grass root researchers—daughters of SEWA members.

For more information on VimoSEWA and our latest figures and reports, see our website: [www.sewainsurance.org](http://www.sewainsurance.org).

Some special events in 2006

1. The Asia and Oceania Association (AOA) branch of the International Cooperatives and Mutuals Insurance Federation (ICMIF), of which VimoSEWA is an affiliate, organised its meeting in Ahmedabad in VimoSEWA. Delegates from Japan, Korea, Singapore, Sri Lanka, India, Malaysia and the ICMIF participated in this meeting. It also included exposure to microinsurance and VimoSEWA's work.
2. We organised weather insurance for farmers in three districts together with our colleagues in the district associations.
3. We initiated quarterly insurance premium collection in Ahmedabad city.