VimoSEWA – An Insurance Cooperative for, with and by Women

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Introduction: The Self Employed Women's Association (SEWA) is a national trade union in India; it was registered in 1972. Today SEWA has over 1.5 million members across 14 states. SEWA members are poor women workers in the informal economy; they include agricultural laborers, service providers, home-based workers, and vendors. This case study describes the origin and growth of SEWA's insurance program. The program started with a life insurance product in the mid-1970s, operating at a low scale of coverage and outreach. It finally took off in 1992, and has since evolved to offer the following products: full service, voluntary, standalone, multi-product insurance cooperative, and protection against natural and accidental death, hospitalization, and asset loss.

The Context

Brief Overview of the Country and Institutional Contexts

India has a population of 1.3 billion and is one of the fastest growing economies today. According to the World Bank it is a middle income country, yet it has a large informal economy. The informal economy accounts for about 93 percent of total employment in the country, which includes both informal sector workers and workers in informal employment in the formal sector.[1] Informal workers lack regular income, and have little access to any kind of social protection. A higher proportion of women (96 percent) than men (91 percent) work in the informal sector.[2] Women tend to be in the lower-paid and less-skilled jobs, and also tend to be less organized. There is increased recognition that women tend to be concentrated in the more precarious forms of informal employment, and supporting poor women in the informal economy is key to reducing women's poverty and gender inequality.[3,4]

Social protection in India

Social protection has assumed a more important role in India in recent years, with increasing recognition of the need to extend social protection to workers in the informal economy. However, coverage remains low. Only 12.5 percent of informal workers are covered by health social protection, and only 24 percent receive a pension.[5] In 2008, the national government launched the Rashtriya Swasthya Bima Yojana (RSBY) for informal workers who were below the official poverty line. As of March 2013 however, only 7.5 percent of informal workers were covered by this scheme.[6]

The Mahatma Gandhi Rural Employment Guarantee Scheme (MNREGS) has been a flagship income security scheme, which provides up to 100 days of waged unskilled manual employment each year. According to a recent news report in February 2016, 127 million households (roughly 50 percent of all households in India) participated in this scheme in 2014-2015.[7]

In 2015 the Government launched three social protection schemes for the low income segments, namely: Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), and Atal Pension Yojana (APY). The first two protect against accidental and natural death, whereas the third is a pension scheme for persons when they become 60 years of age. All three schemes require the beneficiary to have a bank account, which boosts financial inclusion and ensures transparent transactions.

The Insurance Sector in India

Prior to India's independence in 1947, insurance in India was a privately-run industry. In 1956, all life insurance business was nationalized under the Life Insurance Corporation of India (LIC). The general insurance business was later nationalized in 1973, under the General Insurance Corporation. Since these developments, the industry has been dominated by life insurance for individuals - typically males in formal employment, and commercial insurance for businesses. Health insurance, asset insurance, and other types of insurance for individual risks have been negligible components of the insurance companies' portfolio.

In 1999, India liberalized its insurance sector by promulgating the Insurance Regulatory and Development Authority (IRDA) Act. The new legislation opened up the insurance market to private insurers, and in 2014-15, India had 23 private life insurance companies and 22 private non-life insurers. One important component of the new Act was its effort to extend insurance to previously un-served populations, which required each insurance company to incrementally increase its outreach to rural and social (economically weaker) populations. As per IRDA's annual report 2014-2015, 25 percent of new individual life insurance policies and 12 percent of new non-life insurance premiums were in rural areas. In the social sector, 30 million lives were covered under life insurance, and 300 million under non-life insurance. Sex-disaggregated data is not available however.[8,9]

Background and Justification for Starting Insurance

SEWA considered starting an insurance program in the late-1970s in response to the risks and vulnerabilities faced by its women members and their families. Early in its operations, SEWA Bank's loan records revealed that medical crises were one of the major costs borne by poor women, and were a common reason for the loans not being repaid.[10,11]

As Ayeshaben, a garment worker and union leader explained:
"We work hard and save. But one illness or death of a family member means that our savings are wiped out, and we are forced to borrow from money-lenders or pawn our jewellery, and go into debt. So how can we ever stand on our own two feet?"[12]

All SEWA members are workers in the informal economy. They have no employer-worker relationship with their employers and receive no workplace benefits. Insurance was recognized as an important means of protecting these women and their families from the risks of sickness, asset loss, and loss of life.

When SEWA first approached insurance companies in the mid-1970s to provide cover to its members, the response was discouraging. The insurance companies perceived SEWA's members as 'bad risk', and so took the view that insuring this population was beyond their ability. It is an indication of SEWA's pioneering vision that it persisted in its efforts, and eventually succeeded in starting insurance for its women members. This achievement was especially impressive given that at the time there was barely any recognition that informal workers contributed to the economy, let alone there being any social protection schemes for them.

Importance to Women

Need for Insurance to Mitigate Risk

Vulnerable populations require a range of social protection interventions, including protective, preventive, promotive, and transformative measures for coping with risks and enhancing resilience.[13] In line with this thinking, SEWA's holistic approach recognizes that its members need multiple strategies to address their vulnerabilities. SEWA believes that poor women can only emerge from poverty and move towards self-reliance through full employment at the household level. Full employment includes work and income security, food security, and social security. The latter must include at least the basic services and facilities mentioned earlier – health care, child care, shelter with a tap and toilet in every home, insurance, and pension.[14]

Therefore the insurance program is key to helping members to cope with the risks of sickness, accident, asset loss, and death.

Women at Greater Risk

Women and men both face risks and vulnerabilities, especially if they are poor. However, women face certain gender specific risks and others that are exacerbated by gender inequalities and discrimination.[15] For instance, women have a lower representation in formal employment than men, and are therefore less likely to be eligible for state sponsored protection mechanisms.[16] Moreover, they face larger protection gaps due to their longer life expectancy.[17] In addition, women also face gender-specific health risks during pregnancy and childbirth. In most instances, a woman's role as the main care giver also means that the illness of a household member adversely affects her earnings and health.[18] At the same time, women's lower social status (due to patriarchal social norms) places their lives and health at a lower priority.

In many instances, women are heads of households, or are the main earning member, and are therefore responsible for the well-being of the entire family. A study by UN Women found that even where there are state-sponsored social protection programs in India, women-headed households are less likely to access these benefits.[19] Social protection is therefore critical, not only for this half of the population, but also for their families who depend on them.

Poor women are more susceptible to risks because of their low incomes and a negligible asset-base. Furthermore, they often experience insecure and unsafe working conditions, poor housing, sanitation, and security concerns. The key risks faced particularly by women include poor health, the death of a husband, divorce, domestic violence, sexual harassment, old age, and work-related risks.[20]

Early in the 1970s when SEWA started organizing women, it learned the following:

- Women and their families face multiple and frequent risks, which result in huge economic leakages and losses, keeping them in poverty.
- The poorest and most vulnerable of communities - especially women - are disproportionately affected by exposure to risks.
- Risks and crises result in de-capitalization and asset loss. Consequently, women and their families slip deeper into poverty.

- Risks may be chronic or acute. Chronic risks include poverty and unemployment; acute ones include drought, floods, sickness, and natural disasters such as earthquakes.

- Poor women want support to tackle as many risks as possible at a time, thereby reducing their vulnerability. An insurance package is one way to help tackle these risks.

- Poor women are willing to give premium for insurance, thereby protecting themselves against risks.

- Women are more likely not to see treatment for their own illness – and this is exacerbated in the absence of health insurance.

According to the current CEO of VimoSEWA, women like SEWA's members face a larger number of risks compared to men because they carry out a larger number of tasks, both within and outside the house. Furthermore, women are much less likely to attend to their health needs in the absence of insurance, because of the expenditures involved. This neglect of their health needs in turn leads to poorer health and higher morbidity, and also affects their income-earning potential. SEWA has found however, that women are better at recognizing the need for risk protection, not only for themselves but for their entire family. As one member told us:
"The men just come and give us the money they earn – looking after the needs of the household is our responsibility. We are the ones who think about the needs of the children, including the need for health insurance for them."[21]

This is supported by wider research findings from the Indian market, which show that women are more likely than men to be concerned about providing for their children and ensuring that their family is able to maintain the same quality of life in the event that they can no longer provide for them.[22]

Context Prior to the Launch of VimoSEWA

SEWA introduced its first insurance product in the late 1970s, which was a life insurance for its women members. At the time, the insurance industry in India was under state control. Life insurance was the dominant product for individual buyers, it was mostly purchased by workers in the formal economy, and men were the majority policyholders. There was very little health insurance, and where it was available, it catered to formal workers. Even today, the term "insurance" is primarily associated with life insurance.[23]

More broadly, women workers in the informal economy had no access to formal financial services. This was the rationale behind the launch of SEWA Bank in 1974, which enabled members to save safely and take loans at reasonable rates (unlike the high lending rates of money lenders and traders).

The government-owned insurance companies were unwilling to provide any kind of non-life insurance, e.g. health insurance or asset insurance, until 1992. Poor self-employed women were seen as being 'un-insurable' and 'bad risks'.

The Learning Curve: Development and Implementation

This section describes the evolution of VimoSEWA from a small scale insurance program in Gujarat to India's first women's insurance cooperative society, serving women and their families across seven states.

Background and Overview of the Journey from Conceptualization to Implementation

VimoSEWA's journey from the late 1970s has been driven by the needs of SEWA's women members. Along the way, VimoSEWA has experimented with various types of insurance products, distribution, client servicing strategies, and changing management systems. The journey has had many successes and some challenges, and many lessons have been learned. The following sections discuss the various aspects of this journey.

Lessons along the way

SEWA offered a life insurance product to its members in the late 1970s, but the coverage amount was small and the outreach was limited. It was only in 1992, when SEWA's membership reached 50,000, that the insurance companies were finally ready to discuss insuring informal women workers. During discussions, potential women clients made it clear that they needed both life and non-life insurance, i.e. health, accident, and asset insurance.

Products and product development – responding to women's needs

In 1992, there was a single bundled product for women. By paying a single premium, a woman could be covered against her own death (natural or accidental), her husband's accidental death, her hospitalization, and the loss of livelihood-related assets. This bundled product was a major innovation – while the client paid a single premium for a basket of covers, VimoSEWA segregated the premium amount to go to different insurance companies.[24]

In 2000, based on demand from the members, VimoSEWA introduced life and health insurance for the husbands of its insured members. In 2001, two additional bundled schemes with higher levels of premiums and benefits were also added. In January 2003, once again in response to member demand, VimoSEWA introduced children's health insurance. As a result, by 2003 SEWA was providing insurance protection to the entire family, as long as the primary member was a woman.[25]

VimoSEWA worked with insurance companies to adapt their products to serve women's needs. It organized small workshops with women and actuaries from insurance companies to actually develop microinsurance products. For instance, the initial health insurance product offered by the insurance company did not cover gynecological ailments, which was were important for SEWA members. To remedy this, SEWA succeeded in persuading the insurance companies to expand the coverage to include gynecological illnesses. Similarly, insurance companies initially refused to honor hospitalization or death resulting from work-related hazards, such as falling off a tree while picking tendu leaves[26] or being bitten by a snake while working in the fields.

Over the years, the insurance products have become more varied and now have higher risk coverage, all in response to member needs. When VimoSEWA started offering its bundled products in 1992, insurance was a new concept, and women were conservative about the premium amount they were willing to pay. The early products therefore had very low premiums and only provided limited coverage. Over time, however, women's understanding of insurance matured and their trust in the program increased. As a result, they started asking for higher coverage amounts, even when it meant they would have higher premium amounts. Furthermore, SEWA membership has benefitted from the country's socio-economic growth, and members are now able to afford more expensive insurance products. For example, when health insurance was first offered, the coverage was Rs. 2,000 for an annual premium of Rs. 30.[27] In 2016, a popular health insurance product has coverage of Rs. 15,000 for an annual premium of Rs. 1,130.

In 2008, the government of India launched RSBY, a health insurance scheme for families who are below the official poverty line (BPL). This scheme covers a family of five members for an annual sum insured of Rs. 30,000. The premium for this floater policy is paid by the government; each family is required to pay a nominal amount of Rs. 30 for enrolling in the scheme. Since the launch of RSBY, VimoSEWA aagewans have helped eligible members to enroll in the scheme by helping them to fill out enrolment forms and access medical care at listed hospitals. In addition, VimoSEWA offers these families the Saral Suraksha Yojana (SSY), a hospital cash product that covers incidental expenses and wage loss. (See Box 1).

In some cases, the women enrolled in RSBY choose to take additional health insurance through VimoSEWA. The reason, according to some aagewans, is that these members feel more secure with VimoSEWA's health insurance. At VimoSEWA, members have constant access to an aagewan to provide clarifications and hand-holding support for servicing claims. Members have mentioned that they find it difficult to navigate the RSBY systems and procedures when they become hospitalized or need to file a claim. According to Mirai Chatterjee, Director at SEWA Social Security, "(Members like to) keep one foot in VimoSEWA which they trust as their own, and for which they have tested out experience of receiving claims, even if it sometimes takes some time."

Similarly, a savings-linked life insurance product was launched in 2010.[28] Savings is an important need among women, and clients wanted their life insurance to be combined with their savings. The savings-linked life insurance product combines risk coverage with asset building, both of which are important social protection measures. This product continues to be one of VimoSEWA's most popular insurance products. Today VimoSEWA offers 15 different types of bundled and standalone products, with a price range of Rs 50 to Rs 1200 p.a.[22, 30]

Box 1: Gender-sensitive Hospital Cash Product

VimoSEWA developed a unique product that recognizes a woman's dual role as both a worker and a caretaker for her family. VimoSEWA developed SSY, a hospital cash product that pays the member a fixed amount per day not only in case of her hospitalization, but also in in the event of a family member's hospitalization. This is in recognition of the fact that if a family member is hospitalized, the women is the one who will be in hospital with the hospitalized family member and therefore lose her day's wages. SSY has subsequently emerged as an important add on product for members who are covered by the government's RSBY scheme.

Member education and distribution – ensuring women are reached

Vulnerability to risk does not directly translate into demand for microinsurance. [31] VimoSEWA's insurance is voluntary, which means that each policy that is bought by choice. VimoSEWA's experience has shown that educating women workers on their insurance policies has a direct impact on the membership and utilization of the insurance. VimoSEWA has ensured that all of its members understand the concept of insurance, and member education has been carried out through group meetings, workshops, and individual door-to-door contact. The concept of a risk pool, to which all contribute but only some obtain benefits by way of claims, was an idea that took time for women to digest.

The distribution and servicing of VimoSEWA's insurance is carried out by local women leaders called aagewans, who are supported by a team of full-time staff. It has been found that a women-led sales force is better able to understand the risk protection needs of the entire family. In addition, women clients are more comfortable engaging in discussion with women agents.

VimoSEWA aagewans go through thorough orientation and training covering the concept of insurance, and covering techniques for effective communication. Trust in the person distributing insurance is crucial to the buyer. While the buyer values the product education received at the time of distribution, her faith in the promoter and her sense of being able to reach the promoter at any time is of immense value. The aagewans' strong linkages with the communities in which they work position them strategically to effectively distribute and service VimoSEWA members.

As one member said:
"Each year Kamalaben (the aagewan) explains the details of the product to me, and each year when it is time to renew I ask her to tell me again as I have forgotten the details." [32]

Fairness and transparency in claims have been important features in building credibility among the clients. One member stated:
"My husband was admitted to the hospital, but I could not file a claim because I had only recently bought insurance. The aagewanben had explained to me that pre-existing conditions are not covered. I still continue to buy insurance because adverse events can strike anytime." [33]

At one point VimoSEWA tried using men to distribute insurance to women, but this experiment was unsuccessful. The men who took up the work did not have the same attitude when explaining the products to the women. Their attitude was more that of salespeople selling insurance, rather than offering a mechanism for social protection.

"When we approach the woman, our aim is to explain insurance as a mechanism of social protection. We use different tools like flipcharts and short films to explain the concept. We found that the male agents saw it more as a sales job rather than one of educating the member."[34]

VimoSEWA also distributes insurance through SEWA Shakti Kendras (SSK). SEWA SSks are convergence and coordination centers located in the areas where members reside. They aim to empower communities by strengthening members' capacities to access entitlements through mobilization, building awareness, initial hand-holding, and nurturing grassroots leadership. At the SSKs, community members can get information on SEWA initiatives, government departments and schemes, and application support.

Claim servicing – at the women's doorstep

VimoSEWA has found that effective servicing claims effectively is important for building client loyalty. When a client needs to file a claim, she contacts the VimoSEWA office on a toll-free number, and a staffer from VimoSEWA goes to her doorstep to collect the required documents. Many clients are home-based workers or work in the vicinity of their homes. If they were required to go to the VimoSEWA office to deposit claims related documents, they would lose a half or full day's wages.

VImoSEWA as a cooperative – inclusive by design

By 2009, women had enough microinsurance experience to set up their own cooperative. The National VimoSEWA Insurance Cooperative was formally registered with 12,000 share-holders, all informal women workers, from five states. This form of organization is by nature inclusive and democratic, and the elected board of trustees represent the client community, makes decision about types of products, and design product pricing in line with of their clients' needs. This is the first insurance cooperative of its kind in India; it is used, managed and owned by women workers, and the Share-holders and policy-holders are all.

Evolution of staffing patterns – entry of insurance professionals

Until the late 1990s, none of the persons staffing VimoSEWA had any direct experience in the insurance industry. As the program grew, people with experience in the insurance industry started to join (first women and then men). This enhanced VimoSEWA's internal expertise and aided its negotiations with the insurance companies.

Working with other organizations for larger outreach

VimoSEWA started working with other organizations, mainly NGOs, in 2003, when these organizations wanted to offer insurance to their women members but lacked the expertise of doing so independently. VimoSEWA therefore started working with organizations in Tamil Nadu and Bihar. After several years these organizations learned how to run their own microinsurance programs and so started running independent operations. Meanwhile, other new organizations came under VimoSEWA's umbrella. Currently, in 2016, VimoSEWA has 27 partner organizations that benefit from the group policies VimoSEWA purchases from the insurance companies.

Opportunities and Challenges

The fact that the insurance program it is nested within a larger member-based organization has been a significant opportunity and asset. The development of products and their pricing has always been done in consultation with the potential insurance buyers. The SEWA community leaders who go to sell insurance are known and trusted, and this allows them to access new members. SEWA initially received technical and financial support to start its insurance program from GIZ (then GTZ), CGAP, the Ford Foundation, and the Asian Development Bank.

One of the biggest challenges, especially in the early years, was explaining the concept of insurance to members, and making them understand that insurance was a risk-pooling mechanism where the premium was non-refundable in the event that no claim was made. The support of these insurance companies was significant in SEWA's member education interventions. This issue continues to be a challenge when one enters new areas where insurance is an alien concept however. VimoSEWA has also learned that no shortcuts can be taken when attempting to enroll new members. Women are unwilling to enroll unless they fully understand what they are buying.

Another major challenge has been achieving financial sustainability. Ensuring that each client is educated about insurance, and about the scheme she is buying, is costly. Servicing claims in a timely and transparent manner also incurs costs. VimoSEWA also has to strike a balance between having products that are affordable but at the same time provide adequate coverage. Achieving financial sustainability has continued to be a challenge for many years, and Oza et al.'s study on the topic describes how VimoSEWA has succeeded in achieving financial sustainability.[33] This has been an important success, given that VimoSEWA continues to be a stand-alone microinsurance cooperative offering voluntary insurance.

Effect of insurance product/service on women clients

The insurance program has had several positive outcomes for its women members and their families. Most importantly, insurance has provided a significant source of financial support to women who suffered adverse events. In the last 10 years, VimoSEWA has paid out claims totalling almost Rs. 159 million (US$ 2.38 million).[36]

Insurance has also alleviated anxieties arising from the potential risks of death and illness. This is borne out by the fact that many members continue to renew their insurance policies despite not having filed a claim for any adverse event. Women feel they are able to fulfil their role as caretakers because of the insurance coverage. According to a VimoSEWA aagewan:
"If a woman's children or husband need hospitalization, she immediately takes them for the required care. She may be tardy about getting hospitalized herself, because of her household responsibilities, but the insurance helps her ensure that her family members get the required health care."

The woman is the insurance policy holder - the policy is sold to her and the insurance education is also given to her. This has led to an immense increase in the understanding of risk management and the role of insurance. Women have learned the intricacies of insurance, and have learned to assess the costs and benefits of different options. Gaining an understanding of insurance has also led to the building of a common bond among the insured members, both as a risk-pooling mechanism and as a solidarity fund. The claim cheque is always made in the name of the woman policyholder, even if the health claim is for the husband. According to VimoSEWA's core team members, they value the fact that the primacy of the woman is recognized. More broadly, it has strengthened their sense of self-worth as workers – whose social protection is as important as that of any male member.

The Future: Further Implications and Lessons

VimoSEWA has successfully shown how insurance services can be offered to low-income women workers in the informal economy. In this section we discuss the implications of this for broader financial inclusion, and for the identity and self-esteem of women clients. Finally, this study will discuss VimoSEWA's efforts to further make insurance regulations better meet the social protection needs of people with low incomes.

Addressing financial sector needs and issues

The government of India has been trying to expand financial inclusion and financial literacy to the majority of Indians, who are outside the ambit of the formal financial system. As India's RBI governor has said "in order to draw in the poor, the products should address their needs – a safe place to save, a reliable way to send and receive money, a quick way to borrow in times of need or to escape the clutches of the money lender, easy to understand life and health insurance and an avenue to engage in savings for the old age."[37]

For many members, VimoSEWA has been the entry point for their linkage with the formal financial system. Several women have opened bank accounts to save money to pay the VimoSEWA annual premium. According to Savitaben, an aagewan:
"It is difficult for many of our members to pay an annual premium of Rs. 2000. So we tell them to open a recurring deposit account and deposit Rs. 100 to 200 each month. I have helped so many members open accounts in the post office in our village."

Similarly, all claims payments are made by cheque,[38] and there continue to be clients who do not have bank accounts in their name when they receive their first claim cheque. In such instances, the aagewans helps the member to open a bank account.

VimoSEWA has played a key role in making insurance understandable and available to large numbers of women workers and their families. Typically, insurance in India was equivalent to life insurance, even among the well-to-do. Furthermore, it only males took life insurance. VimoSEWA has contributed to the government's agenda of making social protection available to low income women and their families through life and health insurance. Consequently, these women benefit from a deeper financial inclusion, one that includes not only savings and loans but also insurance.

VimoSEWA has contributed at the national level for the promotion of insurance and social protection for women. For instance, learnings from VimoSEWA were incorporated into the RSBY, a government sponsored health insurance scheme that was launched in 2008. The Indian Parliament's insurance committee, in recognition of the importance of microinsurance as a risk mitigation tool and an anti-poverty measure, invited VimoSEWA to depose before a multi-party committee of Members of Parliament. SEWA has thus been a trail blazer, and has demonstrated how insurance can work for poor women workers in the informal economy.

Link between insurance and women's value and identity as an individual and family caretaker

All of VimoSEWA's products are developed in consultation with the women clients and aagewans, and as per their clients' needs. The products also recognize a woman's role not just as a worker, but also as a caretaker and provider in the family. The woman is invariably the policyholder, and her family gets insurance cover through her. Being an insurance policy holder has added to the empowerment of women.

"When we have an area meeting where we are doing insurance education for new members, we often use an existing client to share her experience with insurance. Often a woman sitting in the group will ask 'so your husband has insurance?' And she proudly says no, I am the policy holder."

Looking forward - what more needs to be done

Currently VimoSEWA follows the partner-agent model of insurance, and the insurance companies carry the risk for a majority of the products sold by VimoSEWA. These companies are also the final arbiters for claims settlements. Unfortunately, the typical products offered by insurance companies do not cater specifically to women's needs or paying capacities, especially low-income women workers in the informal economy. The servicing of claims by insurance companies has also been unsatisfactory, and this is an ongoing area of struggle.[39]

In fact, to provide better service to its members VimoSEWA has carried out almost all the tasks of insurance during its lifetime. These include negotiating with the insurance companies to develop suitable products, distributing insurance and educating the members about this concept, and engaging in the screening and settling of claims. VimoSEWA has taken on these tasks because its vision is not one of simply 'selling insurance', but also of helping its women members be agents in developing social protection mechanisms for themselves and their families. VimoSEWA believes it can better serve low income women and their

families if it has greater freedom in product development and claim settlement. One long standing example is SEWA Bank, which is fully viable and continues to be so after 40 years.

As a recent report on insurance for women states, women in lower income segments (particularly those in rural areas) lack access to insurers' sales channels. Currently, insurance companies cater primarily to the middle and high-income brackets, leaving the majority of the Indian population — and therefore the majority of women — without insurance coverage. Awareness about protection mechanisms like insurance is poorer among women than among men. Insurance companies have also not been able to establish linkages with women for the sale of policies.[40] Most insurance sales agents in India are males, and media coverage shows that women may prefer buying insurance from women.[41]

The VimoSEWA cooperative is a step in this direction, but current regulations prevent it from being a full-fledged insurer. While the IRDA has issued microinsurance regulations, these only apply to intermediaries offering microinsurance products; there is no separate recognition of microinsurance insurance companies. The capital requirements for mainstream insurance companies, and those who would offer only microinsurance products remain the same, i.e. Rs. one billion (about US$ 20 million). The VimoSEWA cooperative has been advocating for appropriate regulations for microinsurance cooperatives, including lower capital requirements, which would be more in line with the smaller financial scale of its operations.

Conclusion

The National VimoSEWA Insurance Cooperative has been a pioneer in successfully demonstrating how insurance can be provided to low-income women workers in the informal economy. Lessons from SEWA's experience have helped several organizations, and even the central government, to offer insurance as a social protection mechanism. Change has been a constant in SEWA's insurance program, and products, servicing strategies, and management systems have evolved over time in response to client needs, lessons learned, and the need to achieve financial sustainability. However, through this evolution, women workers in the informal economy continue to be at the center of the insurance program, and their needs and inputs will continue to guide and shape it.

Endnotes

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