

Association d'Entraide des Femmes Benin

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 22

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Good and Bad Practices in Microinsurance

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers, and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website:

www.microfinancegateway.org/section/resourcecenters/microinsurance

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Acronyms

ADMAB	Association pour le Développement de la Mutualité Agricole du Bénin
AEC	Association d'Épargne et de Crédit – Savings and Credit Association
AssEF	Association d'Entraide des Femmes – Women's Self-help Association
BEPC	Brevet d'Études du Premier Cycle (Middle School diploma)
CEC	Caisse d'Épargne et de Crédit – Savings and Credit Fund
CFA F	CFA Franc
CIDR	International Centre for Development and Research
CIMA	Conférence Interafricaine des Marchés d'Assurance
CNSS	Caisse Nationale de Sécurité Sociale – National Social Security Fund
Consortium	Association of Microfinance Professionals in Benin
Alafia	
CRCA	Commission Régionale de Contrôle des Assurances – Regional Committee for Insurance Monitoring
DA	Direction des Assurances – Insurance Directorate
DESS	Diplôme d'Études Supérieures Spécialisées
DNPS	Direction Nationale de la Protection Sanitaire – National directorate of health protection
ED	Executive Director
FECECAM	Fédération des Caisses d'Épargne et de Crédit Agricole Mutuel
FENAB	Fédération Nationale des Artisans du Bénin – National Federation of Craftsmen in Benin
HMI	Health Microinsurance
IARDT	Incendie, Accidents, Risques Divers et Transports – General Insurance
ILO	International Labour Office
MCDI	Medical Care Development International
MFI	Microfinance Institution
MUSANT	Mutuelle de Santé pour Tous
PADME	Association pour la Promotion et l'Appui au Développement des Micro Entreprises
PAssEF	Projet d'Association d'Entraide des Femmes – Women's Self-Help Association Project
PROMUSAF	Projet de Mutuelle de Santé en Afrique – Project of Mutual Health Organisation in Africa
SAF	Service Administratif et Financier – Administration and Finance Department
SCI	Service Contrôle Interne – Internal Verification Department
SISF	Service des Intérêts Stratégiques des Femmes – Women's strategic interests department
SMC	Service Marketing et Communication – Marketing and Communications Department
SNV	Organisation Néerlandaise de Développement – Netherlands Organisation for Development
SONAR	Société Nationale d'Assurance et de Réassurance
SP	Service du portefeuille – Portfolio Department
SPAJ	Service Personnel et Affaires Juridiques – Staff and Legal Department
STEP	Strategies and Tools against social Exclusion and Poverty
WAEMU	West African Economic and Monetary Union

Executive Summary

The Association d'Entraide des Femmes, or Women's Self-help Association (AssEF), is a microfinance institution that was created in 1995, with the aim of contributing to sustainable improvement of the socio-economic situation of women in Cotonou (Benin) and its peri-urban areas.

AssEF today is a network of 112 savings and credit associations and 26 savings and credit funds, with an umbrella structure that provides management, training and financial support to these savings and credit associations and savings and credit funds. The network has approximately 25,000 members, who are primarily poor women engaged income-generating activities in the informal sector.

AssEF experienced significant growth and development from its creation until 2004. More recently, however, the microfinance sector in Cotonou has faced a number of difficulties, particularly related to the tough competition in the microfinance sector.

AssEF's experience with health microinsurance started in 2002, with support from the ILO-STEP programme. The establishment of this microinsurance scheme results from the high demand from women who did not have access to protection from illness-related financial risks. Within this framework, AssEF's goal for the health microinsurance scheme is dual: 1) to protect women against illness-related financial and economic risks and 2) to secure the credit portfolio of the microfinance institution.

A feasibility study carried out in 2002 and 2003 made it possible to better identify the risks faced by and the needs of the women members of the network, as well as to build a system that offers significant protection, with the lowest contribution possible.

AssEF's health microinsurance is based on the third-party payment mechanism and offers members 70% coverage of health expenses from general practice, maternity, and hospitalisation services for women and their children. This coverage is valid within a network of contracted health care providers who, furthermore, participate actively in the smooth running of the system, particularly by verifying entitlement to benefits. The contribution is CFA F 400 (\$0.8) per month per beneficiary.

The microinsurance system is largely rooted in the principles of mutual health organisations (the most developed health microinsurance schemes in West Africa). These principles include solidarity, self-management and participation. But AssEF's health microinsurance is different because it was organised as a new activity of AssEF, and not as an autonomous organisation.

What makes this experience unique is its integrated management within the AssEF network, utilizing its human and physical resources. The microinsurance is managed by the network's Women's Strategic Interest Department, which distributes the product via savings and credit associations and savings and credit funds. Other AssEF departments contribute to accounting and financial management, communications and dissemination of the health insurance

product. With this strategy, women's contribution could be reduced through sharing the operating costs between the microinsurance system and AssEF.

The microinsurance activities started in May 2003. Their development is based on a strategy of controlled increases in membership, with goals of 5% and 10% coverage of the target population in 2003 and 2004 respectively. This strategy was aimed at ironing out the system before widely disseminating the product within the network.

In late 2004, there were 3,316 registered members, but the turmoil in the microfinance sector resulted in many exits and the net membership (total membership minus terminations and dropouts) was only of 1,921 women, or 2,272 beneficiaries at the end of 2004. Thus, the microfinance experienced a significant decrease in membership in 2004 and a standstill in 2005.

AssEF is presently implementing a recovery plan for its microfinance activities. At the same time, a consolidation plan for the health microinsurance scheme has been identified and should be implemented in 2005 to promote growth, recovery and the financial sustainability of the scheme.

AssEF's microinsurance experience is quite recent with only 23 months of operations at the time when the case study was conducted. It is in a critical fine-tuning phase during which the organisation and operations identified during the feasibility study must be tested, with the necessary adjustments being made. However, many lessons can already be drawn:

- The scheme has demonstrated its capacity to organise significant protection for a contribution that is lower than its real cost. However, the structure chosen has made microinsurance highly dependent upon the dynamism of the microfinance network, which was a strength in the beginning, but has been a weakness since 2004.
- The scheme is based on simple mechanisms that can be managed by an organisation that had no previous expertise in the health insurance sector.
- The use of computer-based indicators has made it possible to monitor the evolution of enrolments, premiums and benefits and to make necessary adjustments to the scheme.
- One of the success factors of this experience is the partnership with health care providers. The latter have been carefully selected and contribute to the reduction of premium levels whilst providing quality health care to beneficiaries.

However, it is still facing significant difficulties. Besides problems stemming from the weak business climate in the microfinance sector, AssEF's microinsurance operates in an unsupportive environment. The association is, indeed, faced with the reservations of its target population and operates without a legal framework or any recognition, thus making the service contract with health care providers more complex.

Despite its organisational specificity, AssEF's experience remains representative of the health microinsurance movement in West Africa, which is still experiencing slow and difficult development.

1. The Context

1.1 Macroeconomic Data

Since 1989, Benin has initiated a structural adjustment programme reinforced by the devaluation of the CFA franc (CFA F) in 1994. Subsequent reforms were aimed at economic liberalisation and increased public sector efficiency. All these reforms made it possible to improve the country's external competitiveness, promote profitability in the agricultural sector, and globally accelerate growth.

Yet, the economic situation remains precarious. The government's priorities today focus on fiscal consolidation, creation of a legal framework that is supportive of private sector expansion and job creation, and increasing resources allocated to productive investments and basic social expenditure.

After a rapid decrease in the 1980s, social expenditure was significantly increased from 1990. However, there are still many shortcomings, particularly for health and education.

Table 1.1 Macro Data

Data	Observations
GDP	Euro 3,667 million (\$7.4 million) (WAEMU estimate)
Population	6.8 million
Population density per Km ²	58
Urban population (%)	42%
Nominal per capita GDP (US\$)	368
GDP average annual growth rate (%), 1990-2003	6.7%
Average annual inflation rate (%), 1990-2003	7
Exchange rate	\$1= 496 CFA F
Per capita GDP in PPP dollars	1,060
Infant death rate (for every 1000 live births)	98%
Under five mortality rate	146.4%
Maternal mortality rate (1985-2003 declared) for every 100,000 live births	500
Percentage of the population using drinking water sources	68 (urban 79, rural 60)
Share of budget allocated to the health sector	6%
Per capita government health expenses	CFA F 1,555 (\$3.13)/ inhabitant in 2000
Number of physicians for every 1000 persons	0.1
Hospital beds / 1000 persons (urban/rural)	0.3
Literacy rate	37.4%

1.2 Overview of the Insurance Sector

Legislation, Regulation and Supervision

Before the 1972 revolutionary political trend, the insurance market was led by French companies' representations and branches, which had been operating since the colonial period. In 1974, the insurance market in Benin was nationalised under the monopoly of Société Nationale d'Assurance et de Réassurance (SONAR), a national insurance and reinsurance company. In the 1990s, because of the Conférence Nationale des forces Vives de la Nation, a new political and socio-economic era was born, making the reopening of the insurance market possible.

At the same time, the Ministers of Finance of the Free Trade Zone carried out brainstorming sessions on a healthy insurance sector at the regional level. These sessions led to the establishment of an integrated African insurance markets organization through the treaty of the Conférence Interafricaine des Marchés d'Assurances (CIMA). This treaty introduced legislation specifically for insurance, the CIMA code, for all member countries including Benin, which promulgated its implementing order from April 1994.

The CIMA code regulates insurance companies. To obtain a license, a company must meet the requirement of a minimum capital stock of 500 million CFA F (approximately \$1 million) and submission of a coherent and credible programme of activities based on forecasted financial statements for three years. The CIMA code also sets up prudential standards of solvency and representation of financial commitments.

The CIMA legislation also regulates the professional duties of insurance brokers who must, in particular, show proof of a financial security of 10 million CFA F (\$20,160).

Market regulation is shared between:

a) The Commission Régionale de Contrôle des Assurances (CRCA), which is answerable to CIMA and whose head office is in Libreville (Gabon). CRCA is CIMA's regulatory body with the following functions:

- Control of insurance companies;
- Overall supervision and support of the national insurance markets;
- Verification of licensing requests of insurance companies; the granting of licenses by the national department in charge of insurance is subject to the CRCA opinion;
- Monitoring of enforcement of the legislation;
- Sanctions: warning, fine, limitation or prohibition of all or part of the activities, etc.

b) The Direction Nationale des Assurances is answerable to the Ministry of Finance. Some of its objectives defined by the CIMA code:

- To promote the insurance sector;
- To protect the interests of insured persons and of beneficiaries of insurance and capitalisation contracts;
- To protect savings held with insurance companies;
- To advise national political authorities in the field of insurance;

Information on the Performance of the Sector

Insurance companies in Benin focus their activities on the general insurance market. The automobile liability insurance and import transportation insurance are compulsory. Enterprises are also compelled to base their insurance policies within national territory. These various obligations are not always followed, and their full implementation is difficult to control. Thus, there is significant evasion (insurance localised abroad) and a high rate of non-insurance for motor vehicles.

The market is led by eight registered companies; three for life insurance and five for non-life insurance. In 2003, the market sales amounted to 18 billion CFA F (\$36,290,322). Life premiums increased by 6.7% and non-life premiums increased by 7.5%. Total premiums increased by 7.4% as compared to 2002. Increases in the accident & illness and motor vehicle categories, by 14.4% and 2.4% respectively, led the market results upward. The shares of life and non-life markets are 14% and 86%, respectively.

These figures can be compared with the results of countries in the region. Total premiums in Togo and Burkina Faso are 12 and 16 billion CFA F respectively, in Cote d'Ivoire and Cameroon they are 115 billion CFA F and 84 billion CFA F respectively. These results reflect both the poor development of the insurance industry and more generally, the lower economic development of Benin relative to the most important markets in the zone.

The life insurance market in Benin reflects the insurance sector in Africa. Life insurance represents 80% of the global market. In the CIMA zone, however, it accounts for less than 20% of premiums, which is indicative of poor use of insurance as a means for savings or risk management. Generally speaking, Benin suffers the same handicaps as other countries in the zone, which are:

- Poor development due to the narrowness of the corporate market;
- Low consumption of insurance products due to a lack of information and interest, as well as lack of purchasing power;
- Relatively significant insurance evasion and difficulty in measuring compliance with compulsory insurance;
- Lack of insurance engineering (little innovation and products not always adapted to the specific needs of a low-income population);
- Lack of skilled human resources.

Today, private insurers are seeking to expand their markets by targeting public sector employees for whom the formal social security system offers only low coverage, as well as persons working in the informal economy who lack social protection.

State Policy for the Promotion of the Insurance Sector

Insurance is a growing economic sector that raises interest of the government. Beyond its active involvement in the adoption and implementation of the CIMA code, the government initiates and coordinates training sessions to provide the profession with efficient executives and agents. It also regulates the commissions paid to insurance intermediaries. Concerned with the sustainability of the sector, the government, through the Direction des Assurances, remains very attentive to applications for licenses.

Overview of Microinsurance in Benin

The development of microinsurance in Benin started in the 1990s, but is still in an embryonic state. An inventory conducted in 2003¹ showed 43 schemes in operation and another 11 in feasibility or set-up phases. These microinsurance schemes operate chiefly in rural settings (63% of them) and only offer health insurance products. Approximately one third of these schemes, including AssEF's, are linked to larger organisations, such as microfinance institutions, cooperatives and other social economy organisations.

These experiences fall into two types main categories:

- Cooperative schemes, which combine a health savings mechanism for primary health services with insurance for secondary-level services.
- Mutual health organisations (MHOs), which make up the vast majority of these experiences. These MHOs are based on an associative approach, that is, based on the major principles of the mutual insurance system: democracy, participation, solidarity, autonomy and liability.

AssEF's experience is usually included in the last category. However, it is different from conventional MHOs in that health insurance was integrated into the parent organisation as a new activity and did not lead to the structuring of an independent organisation.

The 43 MHOs operating in 2003 had 43,400 beneficiaries, of which only 32,800 could be considered as really entitled to benefits because the others were not up to date with premium payments. They are therefore small schemes (1,009 beneficiaries per organisation, on average). In Benin, as in the whole, microinsurance development can be considered as being achieved "drop by drop", that is, through the multiplication of small experiences. However, some MHOs are starting to network (project of the International Centre for Development and Research – CIDR, a French NGO – in the north centre of the country).

These experiences are supported by national and international NGOs, bilateral and multilateral cooperation organisations. Since April 2003, the Ministry of Public Health has put in place a community health service, part of whose mission is to promote the development of MHOs in Benin.

At the same time, a national framework for concerted action between the various actors involved in the development of MHOs in Benin was set up; it provides a platform for exchange among MHO developers and the ministries involved.

¹ Consultation among mutual health organisations' development actors in Africa, review of health insurance schemes in Africa: summary of research works in 11 countries, 2003.

Table 1.2 Fundamentals of the Insurance Sector in Benin

Data	Observations
Name of regulatory structure	Direction des Assurances (Ministry of Finance)
Key duties of regulatory structure	The control and regulatory missions are shared between Direction Nationale des Assurances and CRCA: - Licensing of insurance companies; - Supervision of the market; - Control of corporate activities and compliance with prudential standards; - Arbitration between insurers and insured persons; - Sanctions
Minimum capital for obtaining license	500 million CFA F (\$1 million) No specific regulations for microinsurance
Other key requirements for obtaining license	Competence of management, business plan and financial plan over three years.
Capital required from insurance company during current accounting period	NA
Other key requirements of Direction des Assurances	Submit general conditions for all products
Corporate capital required from a reinsurer	NA
Number of private insurance companies	5 General insurance companies 3 Life insurance companies
Annual premiums distributed by registered companies	18 million CFA F (2003) (\$36,290)
Number of public insurance companies / total annual premiums distributed	1 (CNSS) / NA presently
Annual premiums distributed by public companies	NA
Number and type of other licensed insurance organisations	6 Brokers 25 General agents (in 2002)
Annual premiums of other licensed insurance organisations	Brokers: 2.6 billion CFA F (\$5.3 million) or 15.73% of sales General agents: 1.7 billion CFA F (\$3.3 million) or 09.85% of sales
Number of reinsurers	Nil
Reinsurers' annual premium	Nil
Other non-licensed insurance organisations	NA
Certificates required from agents	Licence application with companies, with security of 10 million CFA F (\$20,161)
Key duties of the regulatory structure	- Receive and review licence applications, and forward them to CRCA - Initiate orders for the regulation of insurance markets - Supervise all activities in the insurance sector - Encourage and validate the setting up of new insurance products

1.3 The Role of the State in Social Protection

Government Social Protection Programme

Social protection activities are generally reserved for certain population groups identified as being the most vulnerable (widows, orphans, disabled people). These activities were initially (1953) under the jurisdiction of the Ministère de la fonction publique et du travail (Civil Service and Labour Ministry) and then went successively to the ministries of Public Health, Justice, again Labour and then Health. Then, in 1998, the setting up of a Ministry of Social Protection and the Family (Ministère de la protection sociale et de la famille) made it possible to create a specific framework and to build a national social protection policy. However, these transfers, together with a fragile economy, have prevented the establishment of long-standing efficient mechanisms for social risk management.

Social security activities are still under the authority of the Ministère de la fonction publique, du travail et de la réforme administrative (Civil Service, Labour and Administrative Reform Ministry). They are reserved only for formal sector employees through the National Social Security Fund – Caisse nationale de sécurité sociale (CNSS) and the special plan for civil and army officers. The CNSS presently covers only the following risks:

- Maternity risk
- Risks linked with family support
- Occupational risks
- Risk linked with optimum aging
- Disability risk
- Death risk

Public service plan benefits include family allowances, pensions and annuities, as well as health insurance and occupational injury benefits scheme with 80% coverage of health care expenses, with the exception of pharmaceutical expenses. The population covered represents barely 20% of the total population and the social security benefits offered most often do not meet real needs.

For those populations that are neither formal sector employees nor the most vulnerable groups, that is, the vast majority of the population, there is presently no form of formal social protection, except for microinsurance schemes whose coverage is marginal and whose statute is undefined because of a lack of legislation.

Direct State Assistance to Microinsurance

The extension of social protection to currently excluded populations is now a new area of interest of the government. Its vision in the field of social protection today chiefly finds expression in:

- The elaboration of a national policy and social protection strategies paper: this paper provides six intervention axes, each comprising a number of sub-axes that must be considered as programmes to be implemented. Among these axes is (axis 2) the mobilisation of communities for the development of solidarity through the development of mutual social protection organisations;

- The extension of social security by establishing a special social security system for self-employed workers, agricultural workers and informal sector workers in the form of a mutual social security benefits organisations. Within this framework, the Ministère de la fonction publique, du travail et de la réforme (Public Service, Labour and Reform Ministry) was created in 2000, with technical support from the CNSS and the International Labour Organization (ILO), to establish pilot mutual health organisations in the cities of Cotonou and Parakou. These MHOs are run by informal sector socio-professional organizations, but their development is presently slow and their impact is small;
- The establishment, within the community health service of the Public Health Ministry, of a promotion and support unit for mutual health organisations, whose mission is:
 - To promote voluntary and effective participation of the populations in a solidarity system (Mutual Health Organisation);
 - To provide technical and financial support to promote the organisation of the grassroots groups into MHOs;
 - To elaborate a MHOs' development policy and strategy paper.

The Role of the State in Regulating the Informal Microinsurance

The government has virtually no role in microinsurance regulation. Indeed, it has not yet legislated laws on microinsurance, which is currently simply tolerated as it operates on an informal basis. The organizations benefit from a sort of “MHO label” that allows a first form of recognition by the government and health care providers, but entails neither rights nor duties for microinsurance schemes, particularly regarding the enforcement of prudential rules.

Acceptance of ongoing practices indicates the will of the government to organise, in the long run, this important sector that is in an action research phase. To that end, a legislative framework that is both an incentive to and enabling for the development of health microinsurance is being elaborated under the leadership of an inter-departmental committee, with technical support from ILO and financial support from the French Ministry of Foreign Affairs. This legislation will only be for health microinsurance schemes, specifically MHOs.

2. The Institution

2.1 Background of the Institution

The Microfinance Institution

AssEF dates back to 1992, with savings and credit pilots set up by the Netherlands Organisation for Development (SNV), through its support programme for women living in the suburbs of Cotonou. In 1995, these pilots were formalised within the Women's Self-Help Association Project, *Projet d'Association d'Entraide des Femmes (PAssEF)*, which resulted in the creation of the Women's Self-Help Association, *Association d'Entraide des Femmes (AssEF)* in deprived neighbourhoods of Cotonou and its outskirts in 1999.

AssEF's overall goal is to contribute to sustainable improvement of poor women's economic status in Cotonou and its outskirts. The specific objectives of AssEF are threefold:

- 1) Provide sustainable financial services to poor women, through savings and credit funds and associations;
- 2) Establish mechanisms for better managing the development of the network;
- 3) Build the capacity of members to safeguard their practical and strategic interests.

AssEF's target population comprises of low-income women who earn a living through informal sector income-generating activities. These women are very active in produce sales, catering, trading of staple items, sales of fabric and jewellery, and handicrafts.

AssEF comprises of:

- **Savings and credit funds** that are cooperative organisations with a management body and a control body. Membership figures of these funds vary from a few hundred to a few thousand women;
- **Savings and credit associations** that are smaller organisations with at most 35 members, but offering the same types of services as savings and credit funds;
- An **umbrella structure**, AssEF, which provides support in the following areas:
 - Institutional development and organisational strengthening;
 - Technical support in management, monitoring and inspection;
 - Financial support and management of credit lines.

Today, the network groups together 112 savings and credit associations and 26 savings and credit funds, with a total membership of approximately 25,000 women.

AssEF experienced steady and significant growth from its creation up to 2004, when the network started facing external difficulties related to tough competition, and the over indebtedness of its clients. Since 2004, the sector has been also affected by increasing criticism of the authorities about the interest rates charged by microfinance institutions; this criticism results from an attempt at politicising the sector as part of the campaign for the presidential election due to be held in 2006.

These external disturbances have resulted in the deterioration of the loan portfolio, leading to a restructuring of the network and the closure of certain funds and associations. AssEF's membership, which stood at approximately 30,000 women before the difficulties, has decreased since 2004. A recovery plan is being implemented with support from external financial partners. With the experience gained and the skills developed, the network was able to overcome the difficulties and minimize the effects.

The situation that emerged in 2004 had a particularly adverse impact on the development of AssEF's health microinsurance. Indeed, the microinsurance scheme, which is in a start-up phase, remains fragile. But while this situation alone cannot explain the difficulties encountered by the microinsurance scheme, it is quite certain, though difficult to measure, that it accentuated internal problems in the microinsurance scheme.

Box 2.1 Savings and Credit Products of AssEF

Savings products

- **Ordinary savings** are generally contributed by ordinary savers who are not entitled to loans. It is annually remunerated at the rate of 2% to 3%, calculated on the average balance.
- **Prior savings** is the savings required from any subscriber who wants to obtain a loan. It represents at least 25% of the amount of the requested loan amount. It is annually remunerated at the rate of 2% to 3% calculated on the average balance.
- **Compulsory savings** is savings gradually contributed by the member during the different cycles of the group's credit. But, when her group's credit cycles are over, and the member becomes a partner, her saving is remunerated at the same rate as above

Credit products

- **Ordinary credit:** It is given to any member of a fund who has a prior saving of 25% and meets other loan requirements. The loan term varies from one to eight months, with a small 2% interest rate per month on the outstanding balance.
- **"The merchant's" credit** is a small short-term of 1 to 2 months for 10,000-30,000 CFA F (\$20-\$60.5) loan for members and non-members with specific or urgent needs for funds to seize a market opportunity.
- **School credit** is given to members when children to go back to school, to contribute to expenditures in school stationary and fees. It varies between 5,000-30,000 CFA F (\$10-\$60.5) and is for three months, at a rate of 1% per month.
- **The solidarity credit:** loans given to members of savings and credit associations constituted in solidarity groups of 4 to 7 women having prior savings of 25%. Amounts gradually increase at each credit cycle for 50,000 to 500,000 CFA F (\$101 to \$1,008). It is the same for the terms, which vary from 4 to 12 months. The interest is 1.5% per month.
- **Investment credit:** this is a larger loan, for long-standing members, or members who have a relatively high level of activities that enables them to make investment (purchasing capital goods or land plots, building houses, etc). The loan term is 15 to 18 months, with a repayment grace period of 1 to 2 months.

Adapted from AssEF's brochure

AssEF's Health Microinsurance

In 1995, at the members' request, AssEF project initiated an effort to finance health expenses through loans. These credits were managed by relief funds (or caisses Alodo), to which women could register for a contribution of 100 CFA F (\$0.2) per month. Relief funds granted low-interest loans to purchase medicines and to pay for hospitalisation for women and their children. Unfortunately, this first experience was a failure and, in late 2001, AssEF sought support from the ILO/STEP programme for the establishment of a health microinsurance scheme.

AssEF's motivation to create a health microinsurance scheme stems from the great demand of members who have no protection from financial risk related to illness. These members are left only with the following strategies:

- Use enterprise loans obtained from AssEF for another purpose;
- Withdraw from their savings accounts, thus jeopardising their other projects at times;
- Borrow from friends, relatives, even moneylenders with high interest rates;
- Sell a productive asset (sewing machine, etc).

For microfinance activities, the use of loans to pay for health expenses is the major cause of default. Therefore, the aims of a microinsurance scheme are:

- To secure women's financial and economic situation;
- To secure AssEF's loan portfolio.

The microinsurance scheme started after a feasibility study carried out in 2002 and 2003. The steps and results of this study are presented in Sections 4 and 6. Following the feasibility study, the scheme's start-up phase was devoted to designing management tools, training technical staff at savings and credit groups, and training the AssEF's managers involved in the microinsurance operations.

The microinsurance activities started in May 2003 with the intention to gradually expand the outreach. The aim was to promote growth in a way that did not exceed the management capacities of the technical staff. This incremental approach allowed the scheme to iron out problems before operating throughout the network.

Thus, the target for late 2003 was to reach 5% of the network members (or 1,500 women) and 10% for late 2004 (3,000 women). (See Figure 2.1). In December 2003, total enrolments amounted to 1,255 and 3,136 in December 2004.

However, difficulties experienced in 2004 led to decrease in enrolments. Several dropouts (voluntary exit of members) and terminations (termination of insurance contracts for non-payment of premiums) occurred and the number of members affiliated to the microfinance scheme towards the end of 2004 was only 1,921. These difficulties stem partly from the problems in the microfinance sector that led to loss of motivation of certain savings and credit managers, and the dropout of members who left the network and, consequently, withdrew from the microinsurance scheme (being a member of AssEF is a prerequisite to enrolment in the microinsurance scheme).

The difficulties also result from internal factors, in particular problems with premium collection. The microinsurance scheme applies a strict termination policy for members who have over three months of payments in arrears, which is a phenomenon that is largely the cause of the decrease in enrolments. Research conducted by AssEF and STEP has shown that these problems are partly related to the fact that the managers of the savings and credit groups had to spend most of their time collecting loans, at the expense of the microinsurance. In addition, although worked out at the minimum, the premium is high relative to the women's ability to pay, and AssEF has not yet managed to mobilise husbands as well.

Since March 2005, AssEF has initiated a recovery plan for its microfinance network, with the implementation of measures that will be spread over the year. This plan will be implemented together with a strategy of revitalisation of microinsurance with the objective of a renewed growth of microinsurance before late 2005 (see Section 7).

Figure 2.1 Evolution of Enrolment Numbers over 2003 and 2004 Financial Years

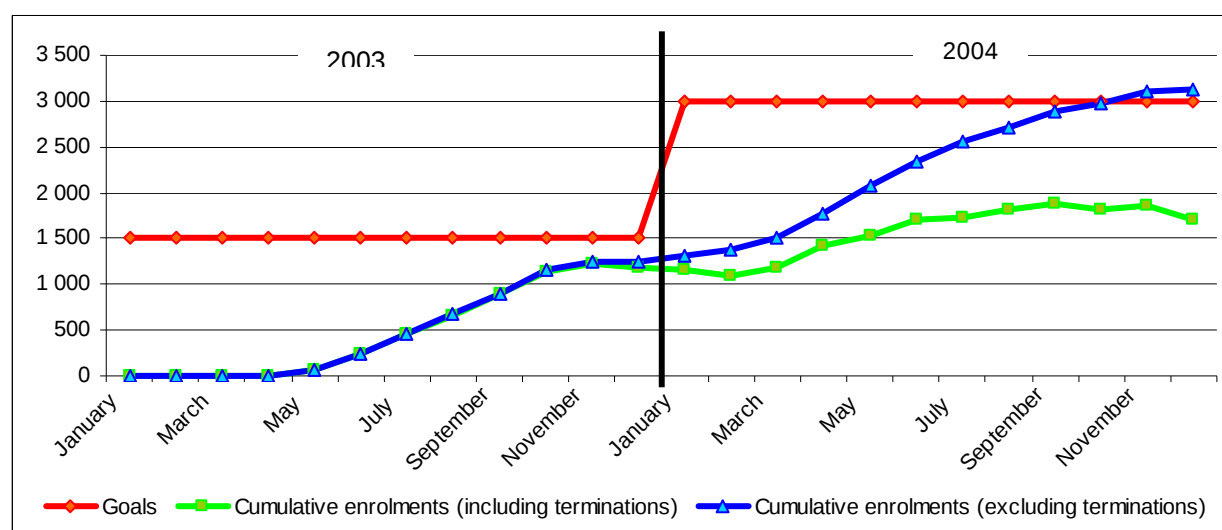


Table 2.1 Baseline Data on AssEF's Health Microinsurance

Data	Observations
Legal status	AssEF is registered as an association. The HMI has no particular status; it is recognised by the Ministry of Health.
License	Framework convention in 2001 for microfinance activities. No license for HMI, for want of legislation
Internal regulations	A specific regulation supplementing that of AssEF has been developed for the HMI. It comprises 16 articles dealing with the following aspects: MHO enrolments, rights and duties, administrative and managing bodies, mandates, sanctions, resignation, deaths, amendment.
Start-up of AssEF's activities	1992: Women's bank 1995: PAssEF 1999: AssEF
Start-up of the MHI activities	2002 in partnership with ILO/STEP: Feasibility study May 2003: start-up of enrolments
Key activity of AssEF	Microfinance
Target market of	Poor women in Cotonou and its outskirts; they set up savings and credit

Data	Observations
microfinance	funds and associations
Target market of HMI	Members of savings and credit funds and associations, their children, spouse, and dependants. AssEF's goal is to provide a solution to the many problems of non payment in the microfinance sector
Activity location	City of Cotonou and urban areas
Relationship with other insurance institutions	Nil
Reinsurance	None

Table 2.2 Operational Results

	Jan-Mar 2005	2004	2003
Total asset (AssEF)		NA	\$3,849,349
Annual Budget (AssEF)		\$576,788	\$435,423
Annual Budget (Insurance Business)		\$13,335	\$6,846
Total Capital (AssEF)		-	\$30,858
Total number of clients (AssEF)		\$25,826	24,359
Total number of HMI members			
Gross (1)	3,193	3,136	1,255
Net (2)	1,439	1,921	1,191
Total number of beneficiaries			
Gross (1)	3,895	3,804	1,555
Net (2)	1,713	2,272	1,437
Number HMI Staff	3	3	1
Staff Turnover (5)	0	0	0
Number of members / HMI personnel	614	640	1,191
Cost of HMI marketing		\$3,440	NA

(1) Gross number: total number of members and beneficiaries before dropouts and terminations

(2) Net number: total number of members and beneficiaries after dropouts and terminations

2.2 Organisational Development

Organisational Structure, Roles and Responsibilities

The implementation of the health microinsurance (HMI) scheme did not entail the organisation of a special, independent structure. In keeping with the decisions made during the feasibility study, it was designed as an additional activity within AssEF, alongside its microfinance activities. Thus, the microinsurance structure was integrated into AssEF's organisational and operational chart.

The organisation of the microinsurance activity within the AssEF network includes a decision-making level (the general assembly and the board of directors of the network) and two operative levels:

- Technical and financial management within the network's umbrella structure (AssEF);
- A level at which the insurance is distributed, which includes the savings and credit associations and funds as well as the central office at AssEF headquarters (for subscribers who are not members of savings and credit associations or savings and credit funds).

Technical and Financial Management

AssEF's executive functions are organized within its senior management of:

- the executive management (Direction Exécutive, or DE);
- the administrative and financial department (Service Administratif et Financier, or SAF);
- the portfolio department (Service Portefeuille, or SP);
- the internal verification department (Service de Contrôle Interne, or SCI);
- the marketing and communications (Service Marketing et Communication, or SMC);
- the personnel and legal department (Service Personnel et Affaires Juridiques, or SPAJ);
- a special department created for microinsurance: the women's strategic interests department (Service Intérêts Stratégiques des Femmes, or SISF);
- a central office where premiums and enrolment fees collected by the savings and credit associations and funds and those of the individual members are paid, alongside the microfinance operations.

The technical management of the microinsurance is carried out by SISF, including the management of enrolments, premiums and benefits. SISF is also in charge of raising awareness about the subject of health microinsurance within the savings and credit associations and funds, as well as relations with health care providers (identification, preparation of agreements and settlement of claims).

The accounting and financial management is carried out by the administrative and financial department (SAF). Credit agents and accountants of the portfolio department provide technical support for the savings and credit associations. They may serve as intermediaries between AssEF headquarters and savings and credit associations. The other executive management departments have played a small role in the running the microinsurance scheme.

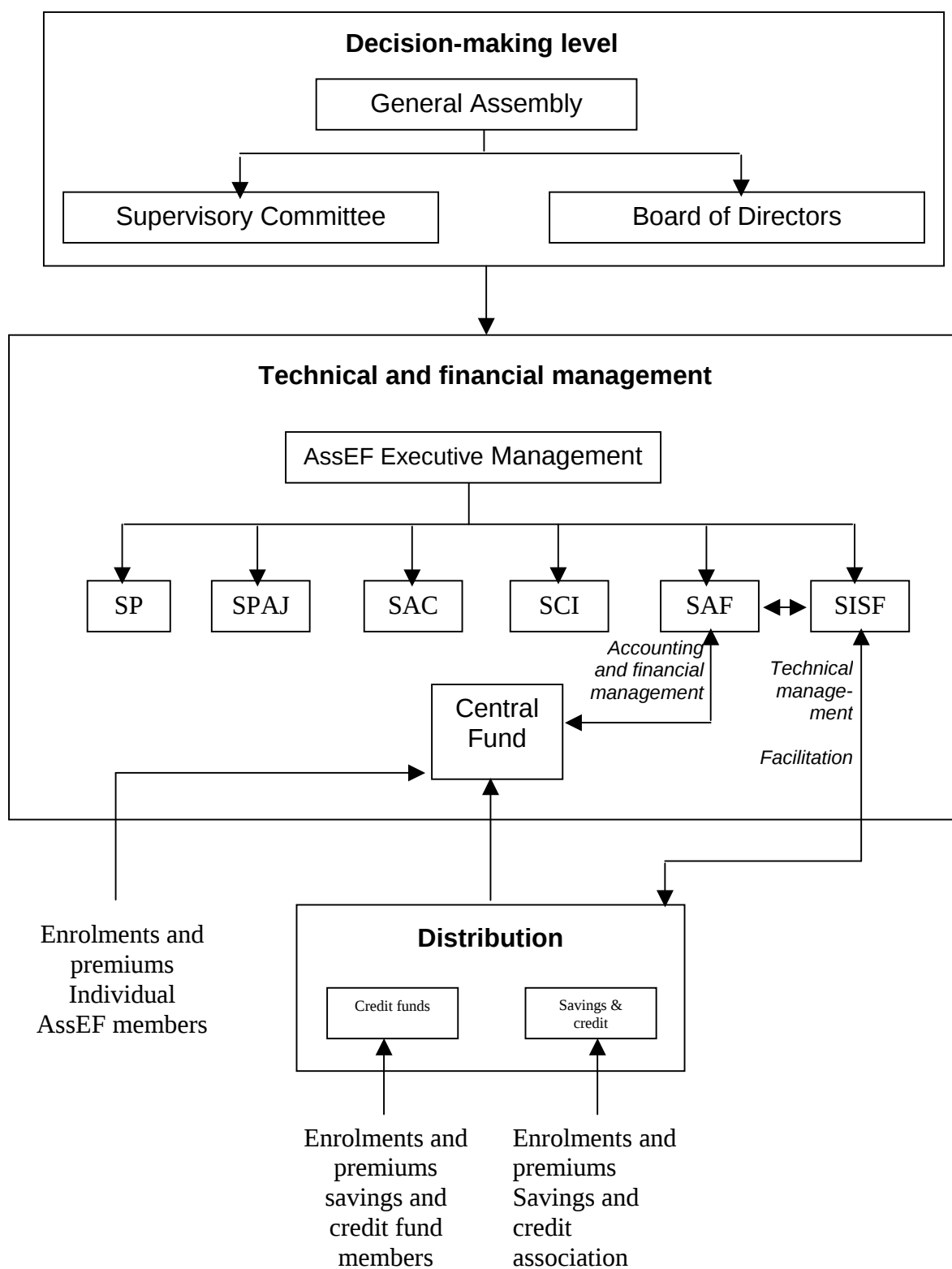
The financial management of the microinsurance scheme is completely separate from that of the microfinance activities. The microinsurance scheme has its own bank account with a commercial bank in Cotonou.

Distribution

The distribution of health insurance is carried out by the savings and credit associations and funds. These two structures act as branch offices for AssEF, and members can use them to enrol, pay enrolment fees and premiums, and drop off their treatment certificates. Within the savings and credit groups, there are three types of actors:

- Salaried savings and credit funds managers are responsible for filling out member enrolment forms and keeping records of payment of enrolment fees and premiums.
- Volunteer group leaders contribute to raising awareness and take part in claims verification.
- Savings and credit association executive committee is made up of three managers, including one who is specifically in charge of the insurance. This function could eventually lead to a new executive position within the association. The role of the executive committee is the same as that of the savings and credit fund manager. The committee also plays a role in claims verification.

Figure 2.2 Organisation of AssEF's Health Microinsurance Scheme



Contracted Health Care Providers

Although the health care providers are not internal actors in the health microinsurance scheme, they play a critical role (see Table 2.3). Under the terms defined by the agreement with AssEF, the health care providers deliver health care services covered by the insurance, collect the co-payment of 30% of the total amount of the health care expense from the beneficiaries, deliver treatment certificates and bill the remaining 70% to the HMI scheme.

The health care providers also assist in claims verification by using beneficiary information and photos contained in the insurance booklets and by asking questions to verify the identity of people seeking treatment.

Table 2.3 Contracted Health Care Providers

Level in the Health care Pyramid	Health Care Providers	Services Covered
Secondary	- Hôpital de Zone Ménontin (religious) - Hôpital de la Mère et de l'Enfant Lagune (public)	- General medical hospitalisation (adults and children) - Complicated deliveries and caesareans - Surgical procedures - Laboratory tests, radiology and ultrasounds - Nursing services - Essential and generic drugs and brand-name and speciality products available at contracted service-providers dispensaries.
Primary	- Hôpital de Zone Ménontin (religious) - Hôpital de la Mère et de l'Enfant Lagune (public) - Centre de santé Saint Jean de Cotonou (religious) - Centre médical Ahmadiyya (religious) - Centre de santé Saint Jean Maria Gleta (religious) - Centre de santé Sainte Marie ASMAP (religious) - Centre de santé Sainte Marie des Anges (religious)	- General doctor's consultations (adults and children) - Gynaecological consultations - Prenatal and postnatal consultations - Nursing services - Minor surgery - Laboratory tests, radiology and ultrasounds - Uncomplicated deliveries - Essential and generic drugs and brand-name and speciality products available at contracted service-providers' dispensaries.

Management Skills

The management skills directly involved in the health microinsurance are all located within the women's strategic interest department (SISF). This department comprises of a manager and an assistant, who make up its permanent staff, and each position has a set of duties.

The SISF Manager. The manager, who holds a university degree (Masters in Economics), was dispatched to SISF from AssEF's microfinance activities where she previously held the

position of credit agent and facilitator in the portfolio department (SP). Her functions in SISF include:

- Taking an active role in the entire process of setting up the health microinsurance in the AssEF network;
- Training the managers of savings and credit groups and ensuring facilitation in all the areas where the product is distributed;
- Regularly informing members of the bodies and beneficiaries of the results achieved;
- Designing simple management tools with support from ILO/STEP;
- Maintaining permanent contact with the accredited health facilities (religious, associational or public health centres having signed agreements with AssEF);
- Producing quarterly activity reports;
- Supervising all other activities related to the strategic interests of the women belonging to AssEF.

The Assistant. The assistant holds a BEPC (middle school diploma) and has completed the final year of secondary school; she was a member of AssEF (chair of the supervisory committee of a microfinance institution, chair of the inter-institution supervisory committee) before rising to the position of Executive Management Cashier. Her new position as an assistant at SISF includes the following functions:

- Filling in enrolment forms;
- Filling in and checking health microinsurance booklets;
- Keeping and monitoring membership registers for savings and credit groups;
- Filling in premium registers;
- Keeping individual premium monitoring files up to date;
- Checking the accuracy of the register and premium monitoring files;
- Collecting treatment certificates;
- Verifying each individual treatment seeking in relation to the beneficiary's entitlement (probation completed, premiums paid);
- Participating in awareness-raising activities on microinsurance;
- Participating in the preparation of training activities ;
- Participating in surveys to assess the department's activities.

Since 2004, these permanent staff members have been assisted by a trainee, who has been specifically placed for processing recorded data for permanent monitoring of the microinsurance scheme.

Expertise

The managers at various levels of AssEF had no previous experience with insurance before the microinsurance scheme was set up. The STEP program provided their training in this area. It has since been consolidated through the experience and know-how gathered on the job. The STEP program also provided all the necessary knowledge for calculating premiums and for the technical set-up of the microinsurance. AssEF's management and technical staff do not yet have the necessary skills to develop new products.

The Executive Management is ensured by a Director, who holds a specialized graduate degree (DESS) in project management and local development. Her colleagues, who head the

different departments, all hold Master's degrees in law or economics. Thus, AssEF has human resources with sufficient prerequisites to oversee the development and management of the microfinance institution and its health microinsurance component.

Governance

AssEF relies on a four-part governance system comprising of:

- a general assembly
- a board of directors
- a supervisory committee
- technical management

The general assembly, AssEF's supreme governing body, includes representatives from the funds and associations. It meets annually and defines the orientation and general policy of AssEF, with the goal of achieving its social objective.

The board of directors is elected by the general assembly and is made up of members of the funds and associations. It is AssEF's administrative body and it holds meetings on a quarterly basis and any time it is necessary for the interests of the Association.

The supervisory committee is also elected by the general assembly and is made up of members of the funds and associations. It is AssEF's supervisory body and, as such, it conducts inspections on at least a quarterly basis at the management and board of directors' levels and reports to the general assembly. The supervisory committee also uses audit reports in its work.

Technical management is led by an Executive Director, who ensures the day-to-day management of the Association. As part of her functions, she is in charge of managing the human, technical and financial resources of the Association and is accountable for her management to the board of directors.

The board of directors is the decision-making body that has the closest dealings with the microinsurance component. Regular reports are produced by the Executive Director and the head of SISF. During the feasibility study, the board members were highly involved in the decisions. In 2004, board membership was partly renewed yet the new members had not received all the necessary information on microinsurance. As a result, there is a partial lack of understanding and decreased enthusiasm among the board of directors, which ought to be one of the driving forces of the microinsurance component.

This decrease in enthusiasm does not mean the new board members and the supervisory committee does not recognize the usefulness of the product for the well-being of low-income women. However, the ownership that could have been expected after two years is stagnating and some apprehension can be seen with regard to microinsurance because of the difficulties encountered in 2004.

2.3 Resources

The microinsurance scheme's self-generated resources include members' enrolment fees and premiums. These resources totally cover insurance benefits and partially cover day-to-day management expenses. These resources are complemented by contributions from AssEF, which are of two types:

- Contributions in kind: the salaries of the head of SISF and her assistant, premises, various supplies and equipment. In addition, the microinsurance scheme relies on network staff, and particularly on the funds and associations, for distribution and management.
- A reserve fund drawn from the social fund of the microfinance system.

These contributions from AssEF stem from a voluntary strategy to share the insurance scheme's operating costs with the microfinance activities in order to reduce the premium for members.

The microinsurance scheme also benefits from external financial resources contributed by the ILO's STEP program. These contributions are primarily for:

- Initial operating costs
- Staff training
- Awareness-raising and information activities directed at network members

2.4 External Assistance

AssEF has been receiving support from the ILO-STEP Program since 2002. The programme's objective is to improve access of impoverished populations to suitable forms of social protection and basic social services.

STEP provides support for informal-sector organisations in setting up microinsurance schemes. On the intermediary level, STEP builds the capacity of federative organisations, support organisations and cooperative organisations promoting microinsurance and the reinforcement of skills and capacities. Finally, STEP organises advocacy activities, principally aimed at governments, to raise awareness regarding the usefulness of such insurance schemes and to promote an environment conducive to their development.

The program has been active in West Africa since 2000, and it has two experts in Benin, supported by sub regional coordination based in Dakar, Senegal.

STEP's support for AssEF's health microinsurance scheme is mainly technical and includes:

- implementation of the feasibility study conducted in 2002 and 2003;
- training for network staff and management;
- setting up of agreements with health care providers;
- management and monitoring of the insurance scheme, regular diagnoses and seeking of solutions to the problems identified.

As part of that support, STEP is conducting a trial with AssEF for monitoring software that includes 11 monitoring indicators. At the time of the present case study, another software

application, aimed at strengthening technical management (enrolments, premiums and benefits) as well as control and monitoring of the insurance scheme, was being tested.

2.5 Risk Management Products

As part of its microfinance activities, AssEF runs a life insurance scheme under which the debt is written off in the event that a borrower passes away. Health microinsurance, a second risk management product, is designed to protect the members against major economic and financial impacts linked to health care expenditures. The two products are currently managed separately.

There is currently a demand among women for a pension scheme, but this is not among the current objectives of the association, nor is it within its capacity. Since other microfinance institutions in Benin are currently developing microinsurance activities, especially in the area of health, it looks as though, in time, the institutions could join together to develop new insurance services for their members.

2.6 Profit Allocation and Distribution

The microinsurance scheme has only completed two financial years. Both financial years achieved a surplus and these surpluses have been used entirely to build reserves.

As the management of the microinsurance component is totally separate from that of the microfinance activities, the results of the microinsurance and microfinance activities are distinct. In the latter case, when a financial year yields positive results, 10% is used to pay the board of directors, while the remaining 90% is used to strengthen the institution's credit fund. If the results of the financial year are in the red, the work accomplished by the board of directors goes unpaid.

2.7 Investment of Reserves

For the moment, the microinsurance funds have to be immediately available and no investment policy has been set in place. This line of conduct is due to the wave of instability that is currently affecting the microfinance environment and disrupting the development of the health insurance. In such a context, and in light of the relative newness of the experience, the reserves need to be immediately available.

2.8 Reinsurance

There is currently no reinsurance system for either the microinsurance sector or the commercial insurance sector.

3. Clients

Only women who are members of AssEF may subscribe to the health microinsurance scheme. The target group is made up of women who are engaged in the informal sector from the city of Cotonou and its outskirts.

Table 3.1 HMI Clients

Issues	Observations
Initially targeted beneficiaries	Members of savings and credit funds and savings and credit associations, their children, husbands, and people constantly in charge of their households
Present beneficiaries	Members of savings and credit funds and savings and credit associations and some of their children ² . Whereas husbands of members may enrol, their participation remains marginal.
Exclusion of specific groups	Health insurance is for AssEF members only. Within the group, no members are excluded from coverage, provided they remain in good standing with their microfinance institution.
General economic situation of beneficiaries	Low-income women
Key economic activities of beneficiaries	Small-scale trade, services, handicrafts and other informal-sector activities
Percentage working in the informal economy	100%
Social characteristics of beneficiaries	Most of the women come from underprivileged social classes. They are illiterate and have very low incomes. Some craftswomen have some literacy skills and may have slightly higher incomes. Some are middle class women who are literate and have good incomes thanks to the support of AssEF, which provides credits of up to 2,000,000 CFA francs in some cases.
Geographic features	Some beneficiaries live in an urban environment (modest housing in areas that sometimes flood during the rainy season) Others live on the outskirts of Cotonou and in the surrounding lakeside villages.
Nature of membership	Voluntary Compulsory membership for women applying for credit was unsuccessful in certain savings and credit funds.
Methods of recruitment of beneficiaries	Beneficiaries are recruited: in savings and credit associations; in savings and credit funds; at AssEF headquarters

² The microinsurance scheme also has a dozen so-called “individual” members, who are not members of savings and credit funds or associations, but hold a savings account at AssEF headquarters. This special clientele of the microfinance institution is made up of a small group of women who are salaried employees in the formal sector, but also carry out activities in the informal sector.

3.1 Social, Economic and Geographic Conditions

The target population of AssEF is made up of low-income women who support themselves through income-generating activities in the informal economy. These women are very active in areas such as produce sales, food catering, trading in staple items, sales of fabric and jewellery, and handicrafts.

The distribution of the economic activities of the members of AssEF is as follows:

- Trade: 79%
- Services: 20%
- Agriculture/livestock: 1%

Some women also earn salaries in the formal economy, but top-up their income through informal activities. AssEF members include women from all the ethnic and religious groups in the city of Cotonou.

3.2 Major Risks, Vulnerability and Primary Coping Strategies

The Caisse Nationale de Sécurité Sociale (CNSS, national social security fund) recognizes that health is a top priority for workers in the informal economy, particularly in urban areas, with maternal and child health as the primary concern.³ Other risks identified included schooling for children and the heavy burden of traditionally large families. Lost income due to the inability to work because of age or illness is also strong factor of insecurity.

Within the population in the informal economy, the groups most vulnerable to social and economic risks were the elderly, children, the seriously ill and low-income women; with the latter group being the membership of AssEF.

The risks identified by the microinsurance scheme feasibility study in 2003 were partially the same as those observed by the CNSS. The women identified the following top-priority socio-economic risks in the following order (from the highest to the lowest priority):

- Spending on food
- Spending on health care
- School fees
- Ceremonial expenses

Surveys conducted during the feasibility study estimated the threshold of financial risk due to illness to be at 2,000 CFA F (\$4). From this amount upward, households among AssEF's target population experience difficulties in financing their health care expenses. Survey findings were as follows:

- Beginning at 2,000 CFA F (\$4), nearly half of the women experienced difficulties
- Beginning at 5,000 CFA F (\$10), over 3/4 faced risk
- Beginning at 10,000 CFA F (\$20), all households were affected.

³ René K. Houessou, *L'extension de la sécurité sociale aux populations non couvertes*, Report from Benin, Presented at the meeting of directors of social security organisations in French-speaking Africa (ISSA), Limbé, Cameroon, 28-30 January 2004.

This funding largely explains the reliance on traditional medicine, medicines purchased on the street or in shops and self-medication in private pharmacies. These are often the first attempts at treatment, either in hopes that they will be sufficient to cure the illness, or as a means of hanging on until enough money can be found to go to a health care facility. When these frontline solutions are not enough, public or religious health centres and private clinics are the main providers for primary health care. Most hospitalisations take place in public or religious hospitals, sometimes in health centres, but virtually never in private clinics.

Using readily available household money (most often the working capital of women's microenterprise) and misusing loans from AssEF were the two main means whereby women financed health care. This observation was a source of concern for AssEF, because in both cases, women's economic activities and their ability to repay their loans were threatened.

It should be pointed out that when an illness occurs in a household, the woman is usually obliged to handle the initial expenses on her own, while the husband only becomes involved when the amounts reach high levels. In the latter case, households are obliged to turn to loans from the family or usurers. Tontines and donations by family members are marginal solutions.

3.3 Relationship between Client Risks and the Institution's Services

Because of these findings, AssEF felt the need to create a health insurance scheme and the strong demand among its membership further strengthens this decision. The objective is to provide greater security, both for the women's economic activities and for AssEF's portfolio.

The aim was, therefore, to respond to a top-priority risk that is faced first and foremost by the women of the household. This does not exclude the possibility of extending protection to other risks in the future, but that can only be envisaged after the health insurance activity is fully mastered by AssEF.

3.4 Familiarity with Insurance Prior to Enrolment

As a general rule in Benin, and particularly among people from less privileged social strata, insurance is viewed as a luxury product that can only be afforded by those who are sufficiently wealthy, except for liability insurance for automobiles that is required by law. Furthermore, the knowledge of people in the informal sector about insurance is fairly sketchy and often incomplete. It is not unusual to hear that "insurers are thieves!" The very idea of risk management is not one that has entered local customs, especially with regard to protection against risks whose probable occurrence is uncertain or distant, when even fulfilling daily needs is already a major hardship for households.

In such a context, health insurance is often viewed as an ideal gateway for initiating social protection schemes for informal sector populations. Indeed, illness is a common risk and the advantages of health insurance are quickly apparent. This introduction to insurance can lead to the development of other products, such as life insurance and old age insurance.

4. The Product

Health microinsurance provides protection against the financial risks linked to illness, especially those arising from extraordinary expenses of secondary health care services such as hospitalisation, complicated deliveries and surgical procedures.

The insurance takes effect from the first franc and uses the third-party payment mechanism. It covers 70% of the following health care services (see Table 4.1):

- General doctor's consultations for adults and children
- Gynaecological consultations
- Prenatal and postnatal consultations
- Nursing services
- Minor surgery
- Laboratory tests, radiology and ultrasounds
- Uncomplicated deliveries
- General medical hospitalisation for adults and children
- Complicated deliveries and caesareans
- Surgical procedures
- Essential and generic drugs, brand-name products and specialities provided by the pharmaceutical depots of contracted service-providers

Table 4.1 Product Details

Heading	Data
Microinsurance Type	Health Microinsurance
Group or individual product	Individual
Term of membership	Membership is suspended if premiums are not paid for one month
Eligibility rule	Must be a member of AssEF
Membership renewal rule	Renewal is automatic. If membership is terminated due to significant arrears, then the member must reapply.
Voluntary or compulsory membership	Voluntary. Compulsory membership for women seeking credit was tested in certain savings and credit associations and savings and credit funds, but the idea was abandoned.
Product coverage (benefits)	Coverage of health care spending within the network of contracted health care providers.
Key exclusions	Specialist services (excepting gynaecology) and brand-name pharmaceuticals are excluded from coverage. All new members must finish a three-month probation period before receiving benefits
Premiums	400 CFA F / beneficiary / month (\$0.8)
Other fees	Enrolment fee of 1000 CFA F (\$2) for each new member

These services are covered only when performed by contracted health care providers, which include health centres and two hospitals, one of which is specialized in gynaecology and obstetrics. Since AssEF is a women's organisation, its microinsurance services have a strong focus on their specific health needs as well as those of their children. The coverage does not

apply to specialist services (stomatology, ophthalmology, glasses, etc.) with the exception of gynaecology, nor does it apply to brand-name drugs or specialities, with the exception of those dispensed by the depots of the contracted health care providers.

Depending on the success of the microinsurance, these services could evolve in the future with the goal of offering the best possible protection while keeping the premium affordable.

4.1 Partners

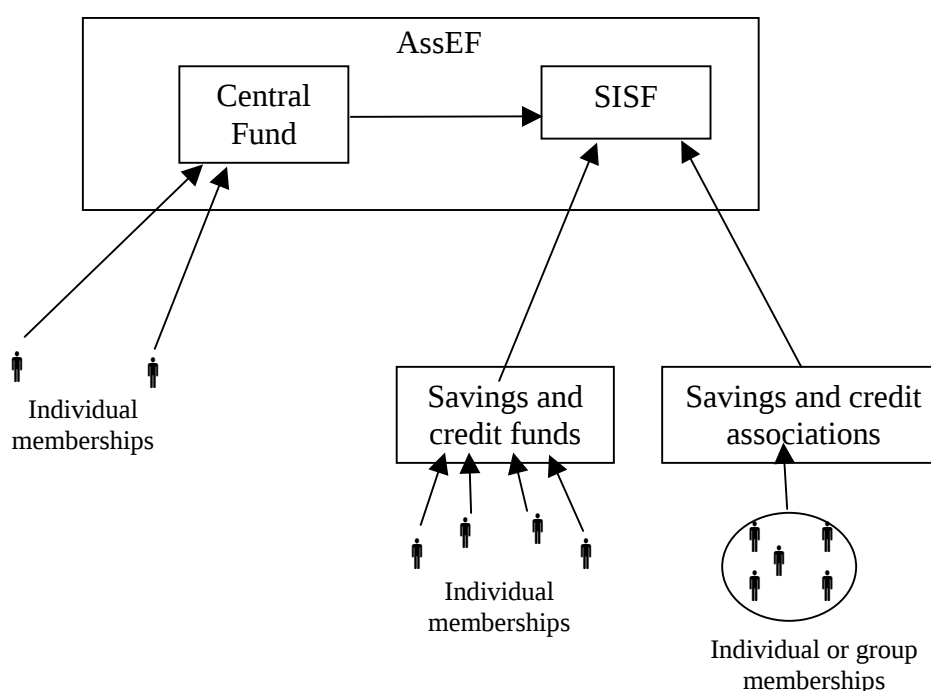
The association's relationship with the health care providers is a partnership that goes beyond the usual contractual relationship. Following the feasibility study, AssEF developed an ongoing relationship with the health care providers to promote the development of microinsurance and jointly monitor benefits. With mutual respect, both parties strive to honour their commitments, particularly the billing for and payment of services, the quality of care provided for the beneficiaries, and the levels of consumption of the various services covered by the insurance.

It is important to note that virtually all the contracted health care providers are private, religious, non-profit organisations. These organisations were chosen at the behest of the women belonging to AssEF and also because they offer the best quality/price ratio. Public health care is inexpensive, but the quality is poor and it is generally mistrusted by the members. Private (for profit) health care is variable in quality and generally expensive.

In addition, these religious organisations are members of the Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin (AMCES, or Private, Confessional and Social Health care Association of Benin). Consisting of 26 health care organizations, the association represents over 40% of the nation's hospital care. AssEF's experience was presented at a general meeting of AMCES and regular contacts take place with its executive management. By joining forces with other health microinsurance schemes, including the Mutuelle de Sécurité Sociale de Cotonou (a mutual health insurance organisation promoted by informal sector associations with support from the Ministry of Civil Service, Labour and Administrative Reform) and sharing the same network of health care providers, AssEF negotiated to obtain better health care rates.

4.2 HMI Product Distribution Channels

The health insurance distribution diagram (in Figure 4.1) reflects the structure of the scheme. Insurance is distributed through savings and credit associations and funds, which are in charge of enrolment and collection of premiums, while the Service des Intérêts Stratégiques des Femmes is responsible for accounting and financial data management.

Figure 4.1 Health Insurance Distribution Channels

Besides registering new members and collecting premiums, the savings and credit associations and funds also raise awareness of their members on an ongoing basis. To join, the members only have to provide all the necessary information regarding their identity and that of their dependants, ID photos and an enrolment fee of 1,000 CFA F (\$2).

This distribution system was very effective at the start-up of the scheme, which benefited fully from the vitality of the microfinance network. But it is also where the difficulties encountered by the microfinance activities were the hardest. The microinsurance scheme has greatly suffered from the loss of motivation among the leadership of certain savings and credit associations, and from the network's focus on debt recovery.

This is undoubtedly an important lesson. Since the scheme was integrated with the microfinance system as an additional service for members, it initially reaped the benefits of the members' confidence and the impetus and resources built up by the network, but this integration also turned out to be one of its greatest weaknesses. It is impossible to say whether a microinsurance scheme set up through a new organisation (for example, a MHO) that had a close partnership with the microfinance network, but that is open to other target groups, might have prevented the drop in membership that took place beginning in mid-2004.

4.3 Benefits

Meeting Institutional and Client Needs

The health microinsurance scheme created by AssEF has two aims: 1) to protect women against the financial and economic impacts of major health expenses and 2) to protect AssEF's loan portfolio, since health care spending is the chief cause of repayment problems.

The level of protection provided is generally considered to be substantial by the members. Microinsurance covers 70% of the principal health care expenditures for both primary and secondary care. There is a demand for coverage for specialist health care and brand-name pharmaceuticals. Contracts with religious health care providers partially fill this demand, since religious health care providers receive donations of brand-name drugs and specialty items from Western countries, which they sell in their dispensaries at prices similar to those of generic products. For that reason, the number (and/or cost) of prescriptions that must be purchased outside the health care structures is much lower than in the public sector or at private (for profit) health care providers.

Box 4.1 One HMI Member's Story

In February 2003, my son suddenly fell sick. My husband and I took him to the health centre, where he received treatment for 3 days (from Wednesday to Friday). After we had taken him home, the pain came back and it was worse. When we reached the health centre, the nurse told us there was nothing he could do for our boy and recommended that we take him to the Ménontin health centre. When we arrived, they told me he had appendicitis and urgently needed an operation. The operation cost was 75,000 CFA F (\$151), to be paid immediately before the operation, plus the cost of medicines. We were so upset we could barely stand it because his father was retired (he used to work at the Onibollo cement works) and we had already paid a lot of money to the health centre for 3 days of treatment.

At that time, I was on my third loan for 250,000 CFA F (\$504) and I was still on the last month of reimbursement. Because of the situation, I was obliged to use my working capital fund to cover health care costs, which totalled 116,250 CFA F (\$234), including 16,000 CFA F (\$32) in hospitalisation costs (7 days of hospitalisation: 2 in a recovery room and 5 in a treatment room).

Afterwards, my sales fell off. My sister even had to help me make the last payment because I could not withdraw any money from my savings account, despite the fact that I had saved 162,000 CFA F (\$327) in preparation for my fourth loan. If I had not had help from my sister, I would have had to make a withdrawal (which I could not do if I wanted to have the amount required for the fourth loan). I was only able to pay back my sister when I received my fourth loan. That was already a problem because I indirectly used part of my credit to repay the money I borrowed from my sister instead of funding new business activities.

So, when the health microinsurance started, I was the first person in my area to enrol with my four children and my husband. Since then, I have received benefits twice because one of my children, a son, was sick in November 2003 and his treatment was covered at the St Jean health centre and I myself had treatment in December 2003. Without health microinsurance, I do not know how long I would have had to go without doing business or how much of my credit I would have used again to pay for health care.

Changes to Benefits over Time

Health microinsurance benefits have remained the same since 2003. Only the network of contracted health care providers has grown from 4 in 2003 to 8 in early 2005. Certain procedures have had to be specified more clearly over time and a nomenclature for services and procedures has had to be worked out across all health care providers (in conjunction with them) to facilitate the monitoring of benefits by the microinsurance organisation.

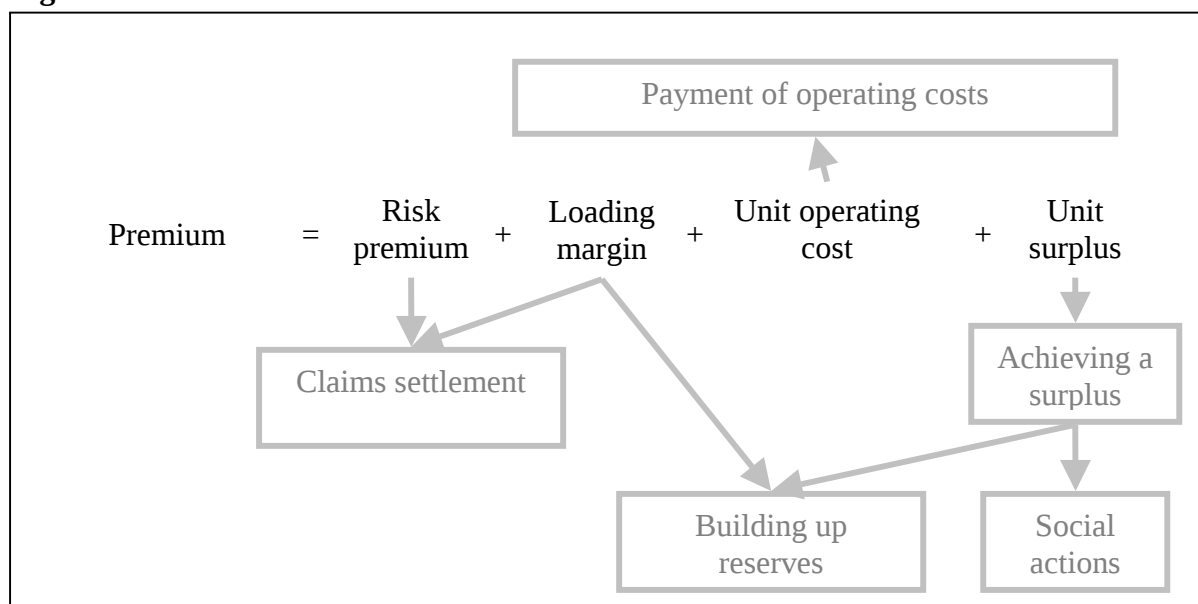
Efforts to Address Special Needs of Women and Children

AssEF's members had a leadership role in defining the health microinsurance benefits. That is why the benefits largely focus on women's needs, with a special emphasis on reproductive health gynaecology and obstetrics. As women are generally left with the sole responsibility of paying for their children's health care, the benefits were also designed to meet children's needs, particularly through coverage for consultations and outpatient care, since they are the primary consumers of those services.

4.4 Premium Calculation

The premium was calculated based on partial self-financing of the operating costs of the microinsurance scheme, while the remaining operating costs are covered by AssEF (premises, human resources, etc.). Figure 4.2 illustrates the method of calculation of the premium.

Figure 4.2 Method of Calculation of the Premium



This method of calculation includes 4 components:

- 1) The risk or pure premium, which corresponds to the average cost of the benefit for each service provided;
- 2) The loading margin, which includes: a) the risk that the average real expenditures of the beneficiaries might be higher than projected (this risk is higher when the number of people covered is low); and 2) the uncertainty of estimates made during the feasibility study in terms of the cost or frequency of utilisation of certain services;
- 3) The unit operating cost, which corresponds to recurring expenses of the microinsurance organisation on supplies, management, documents, travel, etc.
- 4) The unit surplus, established as a percentage of the other costs, which should make it possible to achieve a surplus at the end of the year to build up reserves.

The calculation of the premium was closely linked to the choice of benefits. During the feasibility study, based on a computing grid designed by STEP, members of savings and credit associations, as well as of the board of directors of AssEF, devised a number of scenarios using various services and rates of coverage. The pre-selected scenarios were presented to credit funds members in various areas of Cotonou and the scenario that has obtained the broadest consensus was chosen.

The analytical grid to assess the included four criteria that should ideally be respected:

- **Health care coverage should be pertinent:** Since the women's ability to pay is low, their microinsurance cannot cover every need and should therefore place special emphasis on the situations perceived by the women as the most serious risks.
- **The protection provided should be visible:** In a context where financial resources are scarce, paying premiums is a financial effort that must be visibly rewarded to avoid discouraging the members (such the benefits justify the costs).
- **The premium should be affordable:** If the premium is too high, it will be prohibitive for many members (on the other hand, if it is too low, the protection provided will not be very attractive).
- **The scenario chosen should enable the scheme to protect itself** against the risks inherent of insurance, i.e., it should not contribute to moral hazard, adverse selection, over-prescription, etc.

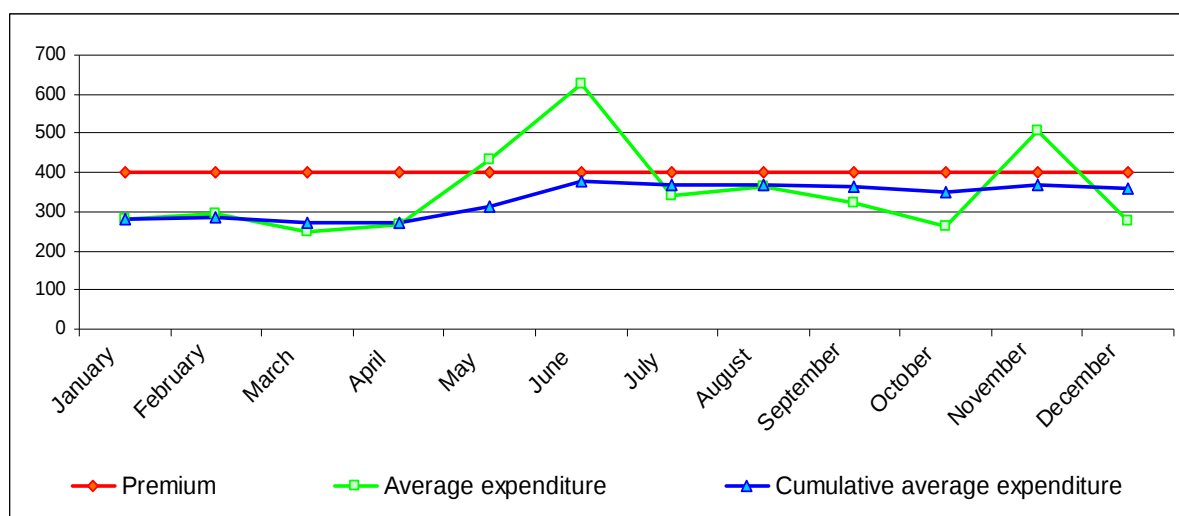
The scenario that was eventually chosen (a premium of 400 CFA F, or \$0.8, per beneficiary per month with 70% coverage of health care expenditures as described above) met these criteria. However, the development of the microinsurance scheme in 2003 and 2004 shows that the women find it difficult to pay their monthly premiums. These difficulties led to a limited retention rate and a low penetration rate per household (a household average of 1.1 person insured out of 6).

Although it was calculated to be as low as possible, the monthly premium remains high in relation to the women's ability to pay, except in cases where they receive assistance from their husbands, which is exceptional.

The premium of 400 CFA F can be broken down as follows:

- | | |
|------------------------|-----|
| ▪ Risk premium: | 80% |
| ▪ Loading margin: | 5% |
| ▪ Unit operating cost: | 10% |
| ▪ Unit surplus: | 5% |

AssEF monitors the average expenditure per beneficiary over a financial year (benefits plus operating costs) and compares it with the amount of the monthly premium. Figure 4.3 shows that average spending per beneficiary over the financial year as a whole was lower than the premium. The spending peaks observed in June and November 2004 correspond to significant coverage and spending on awareness raising that was directly financed by the microinsurance.

Figure 4.3: Average Expenditures per Beneficiary, 2004 (in CFA F)

This monitoring system is used to assess the need to adjust the premium. So far, no adjustments have been necessary.

Risk or Pure Premium

The risk premium was calculated based on the following formula: Risk Premium for a service = Frequency of utilisation of the service X Average Cost of the service.

With a view to making it readily understandable by AssEF members and leadership, this formula has been simplified, so that frequency of utilisation includes the notions of probability and quantity. The frequency and average cost of the different services were estimated based on a survey of 4500 users of around ten different health facilities (on health services and products consumed in various departments by each user) as well as health statistics.

Table 4.2 presents the frequency of utilisation and average cost of the services covered, as estimated during the feasibility study and in comparison with those observed over the 2004 financial year.

In terms of frequency of utilisation, in some cases, substantial differences were observed between projected and actual figures. This was generally due to the lack of systematic health statistics and the need to use assumptions, such as in the case of gynaecological consultations. Other factors also explain these discrepancies, such as the adverse selection that took place with prenatal consultations and with health care providers' change or unexpected behaviour with regard to nursing services and hospitalisations (see Section 4.7 below).

The projections were more accurate regarding average costs and the discrepancies observed in terms of deliveries resulted from a problem of nomenclature, since the health care providers did not all use the same type of accounting procedures for the health services and the consumables used.

For most services, the actual costs were lower than the projected costs. No assessment has been made of the impact of microinsurance on access to health care, but the health care providers believe that the beneficiaries seek health care more quickly and as a result their illnesses are treated more rapidly and require less spending on health services and treatment.

Table 4.2 Frequency of Utilisation and Average Cost (in CFA F)

	Expected Frequency (%)	Actual Frequency 2004 (%)	Estimated Cost	Average Cost 2004
General practitioner's consultations	107	102.4	392	231
Gynaecological consultations	10	3.3	1,400	1,525
Prenatal consultations	12	33.1	259	368
Postnatal consultations	4	0	370	-
Minor outpatient surgery	8	1.2	1,694	1,960
Outpatient nursing services	100	175.9	1,050	1,011
Deliveries (excluding caesareans)	4	3.7	3,360	8,655
Caesareans	0.5	0.6	35,000	35,000
Hospitalisation	10	20.1	2,327	1,373
Surgical procedures (excluding caesareans)	2	0	34,320	-
Laboratory tests	20	58	2,730	2,938
Radiographies	5	4.2	4,865	3,589
Ultrasounds	5	8.1	4,284	4,069
Generic and essential drugs	144	157.1	2,954	2,281

Operating Costs and Subsidies

The microinsurance scheme uses the structure of the microfinance network and the human and material resources of AssEF for product distribution and operations. Consequently, the microinsurance has a number of hidden costs that are difficult to quantify. This cross-subsidy of insurance operating costs by the microfinance system that makes it possible to reduce the premium to the lowest level. However, health care benefits are entirely self-financed.

The STEP program provided subsidies of 1,956,500 CFAF (\$3912), to complement those provided by AssEF, for specific activities involving awareness and information for members, and monitoring of the scheme.

Summaries and Observations

AssEF's health microinsurance scheme has a very simple design, which cannot be compared to private insurance products. It is also different from non-profit MHOs, although it uses many of the same operating principles. The insurance is based on one main goal, which is to provide women with a high level of protection using the lowest possible premium. This goal has shaped the organisational structure of the microinsurance scheme, which was designed as an additional activity for AssEF, rather than as an independent structure.

The premium, and particularly the pure premium, was calculated as minimally as possible with a very small safety margin, for two reasons:

- The vitality of the microfinance network should ensure rapid and continuing growth for microinsurance (the loading margin decreases as the number of people covered increases);
- Contracting with religious health care providers decreases the risk of unjustified consumption and prescriptions.

The second assumption has largely proven true since 2003. The social objectives of the religious health care providers are aligned with the interests of the microinsurance scheme and discrepancies in terms of frequency of use and costs can be discussed and regulated with these actors.

However, the first assumption has proven more problematic. Due to both internal and external causes, the microinsurance scheme has been unable to stabilise its membership portfolio. 2005 will show whether AssEF's recovery plan and the microinsurance consolidation plan can reverse the trend (see Section 7).

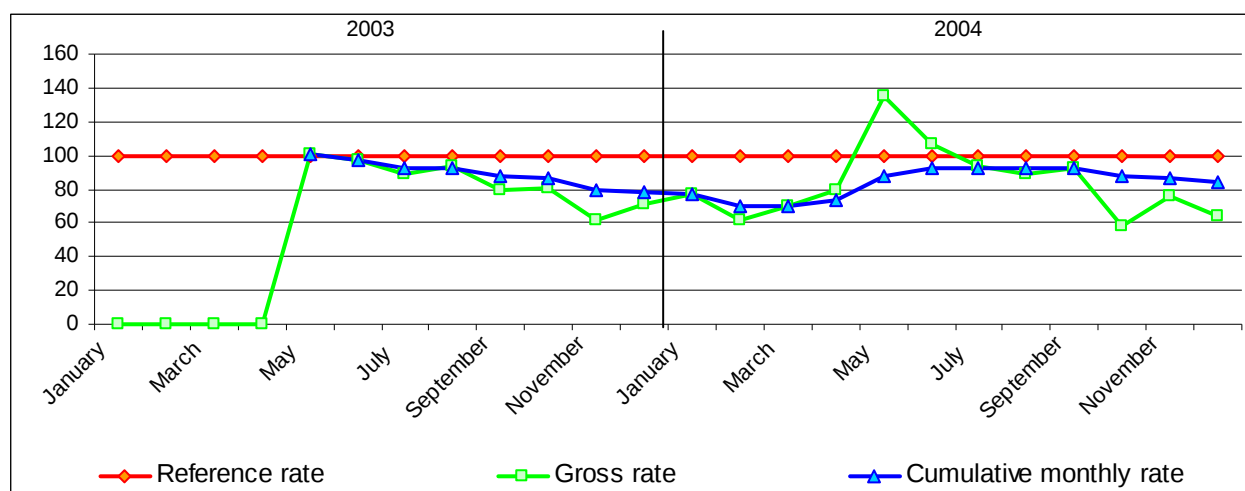
4.5 Premium Collection

Premium collection is carried out by the associations and funds, and by AssEF's central fund. Premiums are paid one month in advance, i.e., the premium for month M should be paid before the 15th day of month M-1. The vast majority of the members prefer to pay their premiums on a monthly basis, although they have the option of paying in advance for as many months as they wish.

In each association or fund, a member in charge of microinsurance is responsible for collecting the premiums and turning them over to AssEF headquarters. When a woman pays her premium, the person in charge validates her insurance booklet for the period covered and fills out a form recording the premiums to enable SISF to carry out its verification and monitoring activities regarding premium accounts and entitlement to benefits. Subscribers who are not members of savings and credit groups pay their premiums at the central fund and have their insurance booklets validated by SISF.

This voluntary payment system relies on the members' self-discipline. Other collection mechanisms, such as deducting premiums from members' savings accounts, have been devised by AssEF, but have not been proposed to the members due to the difficulties faced by the microfinance activities since 2004.

The rate of recovery of premiums (premiums collected / billed premiums) is one of the most important microinsurance indicators. Figure 4.4 shows the evolution of the rate of recovery during the 2003 and 2004 financial years.

Figure 4.4 Evolution in the Recovery Rate over the 2003 and 2004 (as a %)

Since new members must pay their first premium when they enrol, the 2003 financial year began with a recovery rate of 100%, which quickly fell to 71% (gross recovery rate curve) by December 2003, with an average of 78% (cumulative recovery rate curve) over the financial year as a whole.

The 2004 financial year also started off with a low recovery rate (61% in January), which motivated SISF to identify and initiate corrective measures that led to the peak in the gross recovery rate in May (128%) and June (103%). These mainly included awareness campaigns in that resulted in significant recovery of overdue premiums and consistently high recovery rates over the following months (84 - 86%). The recovery rate fell again at the end of the financial year. However, the cumulative recovery rate for the 2004 financial year was 84%, which remains relatively high compared to other health microinsurance schemes in the subregion that use a monthly premium system.

This monitoring made it possible to observe the difficulties encountered by the microinsurance scheme in terms of premium recovery. This aspect of the technical management of the microinsurance scheme demands considerable effort by SISF as well as by the leadership of the savings and credit associations and funds. The difficulties encountered were numerous:

- The time elapsed between the premiums payment and the date of deposit at the central office was sometimes too long and caused SISF to suspend the members' entitlement to benefits when they had actually paid their premiums. The delays were mainly due to the fact that the managers of savings and credit association and funds often had other work and put off going to AssEF to turn in the premiums.
- Some cases of embezzlement of premiums by group leaders were reported, but fortunately they were very rare.
- The members have yet to establish a habit of regularly paying their premiums, so they often have to be reminded to pay.
- Certain months are financially difficult for the members, such as the last three months of the year, when a drop in the recovery rate can be observed.

- Overall, premium management, from collection to updating member accounts, involves considerable work for the local officers and for SISF, despite all the improvements progressively introduced since the start-up of the scheme.

These improvements include encouraging members to pay their premiums several months in advance (particularly to avoid hardship at the end of the year), which some members have started to do. SISF also carries out awareness-raising activities on an ongoing basis with help from group leaders, AssEF management and personnel from other network branches.

4.6 Claims Management

Health expenses of beneficiaries are covered through a third-party payment mechanism. The third-party payment mechanism is relatively difficult to manage for a microinsurance scheme because it entails the establishment of contracts with health care providers and the development of complex mechanisms to verify members' entitlement to benefits when they seek treatment, as well as service-provider billing and payment.

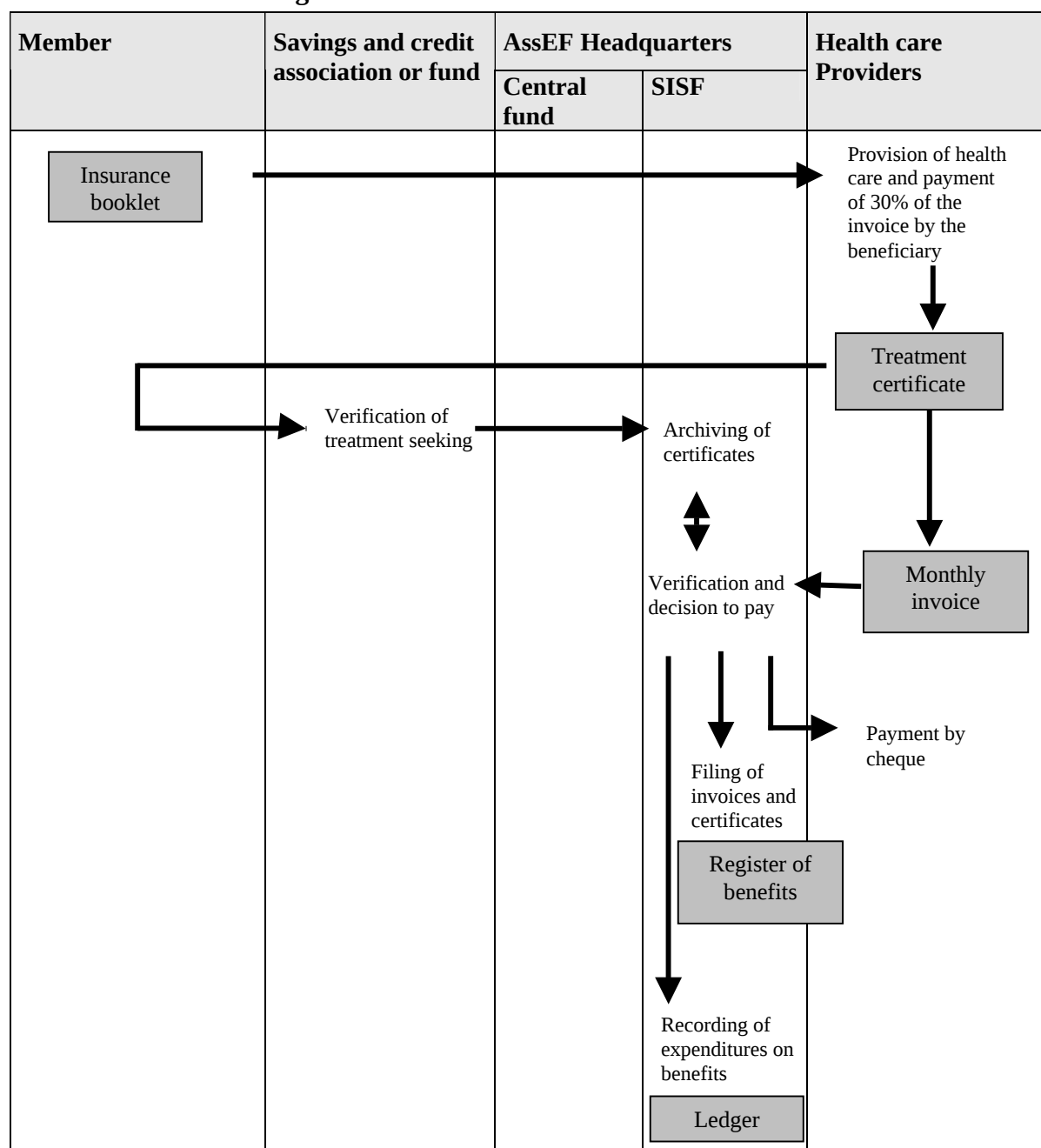
A third-party guarantor mechanism or reimbursement mechanism, where fees are advanced by the members and then reimbursed by the microinsurance, would have been easier to manage, but much less helpful and attractive for the members. Indeed, for members, the principal problem when illness strikes is that they do not have money readily available to pay for treatment. Such a system would not prevent women from using the working capital of their small-scale trading activities or misusing their credit to pay for urgent health care needs. The residual risk of 30% to be paid by the beneficiaries (co-payment) is still a significant burden, but the members feel it is within their means.

The procedures and documents involved in managing claims were designed to be as simple as possible for the members, while providing the necessary information for verifying and monitoring. Table 4.3 illustrates these procedures (templates of the documents used can be found in the Appendix).

Within each health care organisation, a staff member is responsible for reception of the beneficiaries (of AssEF's microinsurance members, as well as those of other schemes) and completing forms, particularly treatment certificates.

To receive benefits, patients must bring an up-to-date insurance booklet (the box for the present month must be validated in the booklet's premium payment chart). The beneficiary receives the necessary health services and treatments. Then staff of the health structure fill in a treatment certificate, indicating the claims in detail as well as the amount to be paid including the co-payment and the amount that will be invoiced to the microinsurance scheme.

The beneficiary pays the amount of the co-payment and receives a copy of the treatment certificate; the health care provider keeps two copies. When he or she returns home, the beneficiary gives the certificate to the manager of her savings and credit association or fund and the latter performs the first check.

Table 4.3 Claims Management Procedures and Documents

At the end of the month, the health care provider combines all the health care services delivered on a single invoice, appends copies of all the treatment certificates issued over the month and sends them to SISF within the first 15 days of the following month. When SISF receives the invoice, it must perform an initial check within 15 days to ascertain whether all the health services invoiced are actually covered by the insurance, detect any accounting errors, etc. If there are no irregularities, the health care provider is paid by cheque before the end of the following month. In the event an irregularity is discovered, the deadline is extended in order to review the invoice with the health care provider.

SISF conducts a second check on entitlement to benefits and may demand reimbursement by the beneficiaries if irregularities are observed (consumption of health care by a suspended beneficiary, fraud, etc.). All beneficiaries whose insurance booklet is up to date are entitled to benefits. Rejections are very rare and are usually due to a health care provider's doubts about the identity of the beneficiary (fraud control).

Beneficiaries who are still on probation and those with at least a month's arrears in payment of their premiums are not entitled to benefits. During 2004, 41% of the beneficiaries enrolled were entitled to benefits (average across the financial year).

Treatment certificates and invoices are made available to the health care providers by the microinsurance scheme. This entails high operating costs (printing fees are covered by the microinsurance organisation, which supplies the forms for the health care providers) but guarantees the continuity and uniformity of claim information. This information makes it possible to monitor frequency of utilisation and average cost on an ongoing basis.

Table 4.4 Claims Settlement Details

Data	Observations
Parties involved in claims settlement	Internal actors: SISF External actors: Network of 7 health centres, and one zone hospital and one hospital specialized in gynaecology and obstetrics distributed throughout Cotonou.
Documents required for claims submission	- Up-to-date insurance booklet - Treatment certificate - Monthly invoice
Claims payment method	Third-party payment with an across-the-board co-payment of 30%
Qualifying period	Three-month probation for new members
Time to pass through any intermediaries	No intermediaries
Average time from submission to payment	15 days, unless the invoice is contested by AssEF
Claims rejection rate	Rare cases

4.7 Risk Management and Monitoring

On a monthly basis, AssEF monitors 11 indicators, including enrolments, premium recovery, entitlement to benefits, frequency of utilisation and average cost of services as well as average spending (claims and operating costs) per beneficiary using a software called "MAS Pilote" (HMI pilot), developed by the STEP program. These indicators are an important component of risk management, since they make it possible to assess differences between microinsurance targets and projections and actual figures. Where insurance risk management is concerned, the indicators can be used to identify adverse selection, over-consumption and over-prescription. More specifically, they make it possible to identify anomalies, which are jointly reviewed by the members, the microinsurance officers and the health care providers.

The monitoring system is one of the main verification and risk management tools. It has been further reinforced by the introduction at SISF of a technical management software (enrolment, premium and benefits management) called "MAS Gestion" (HMI management), also developed by STEP, which ensures quick and effective verification and monitoring.

These computerized tools can only be used for a posteriori verifications. Other risk management mechanisms have been integrated into its design to prevent or at least reduce risks.

Moral Hazard

Two principal safeguards have been set in place against moral hazard. Firstly, the microinsurance scheme requires a co-payment of 30% on all services covered. As a result, the higher the beneficiary's demand for services, the higher the co-payment in absolute terms; this tends to moderate the demand. Secondly, coverage for medicines, which are the items for which moral hazard is highest, is limited to the products sold by the dispensaries of contracted health structures. These dispensaries deliver generic and essential products, but often also have brand-name products with no generic equivalents, which they receive as donations from Western countries and resell at low prices. This measure is particularly important in a context where users prefer brand-name products, and where coverage of such products is particularly expensive for insurance schemes.

Adverse Selection

The three-month probation for new members is the principal barrier against adverse selection. This safeguard appears to be sufficient to reduce opportunistic behaviour with regard to outpatient consultations and hospitalisations; however it remains to be proven in terms of programmable health services. On the other hand, monitoring of claims clearly shows a strong adverse selection phenomenon with respect to prenatal consultations and deliveries, as shown by the Figures 4.5 and 4.6.

Figure 4.5 Frequency of Utilisation: Prenatal Consultations (as a %)

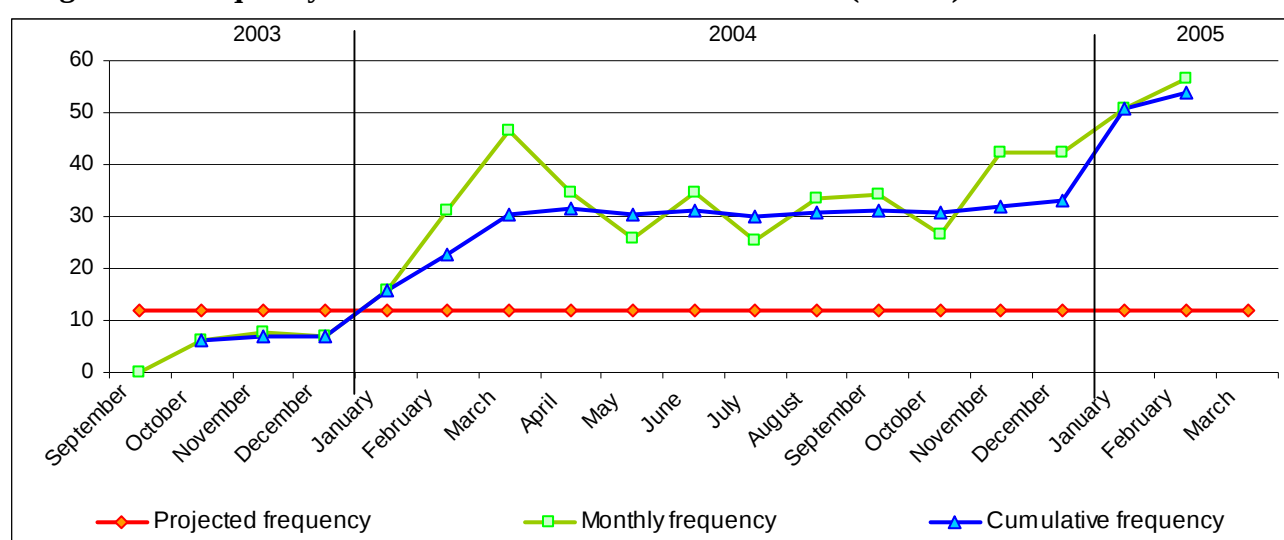
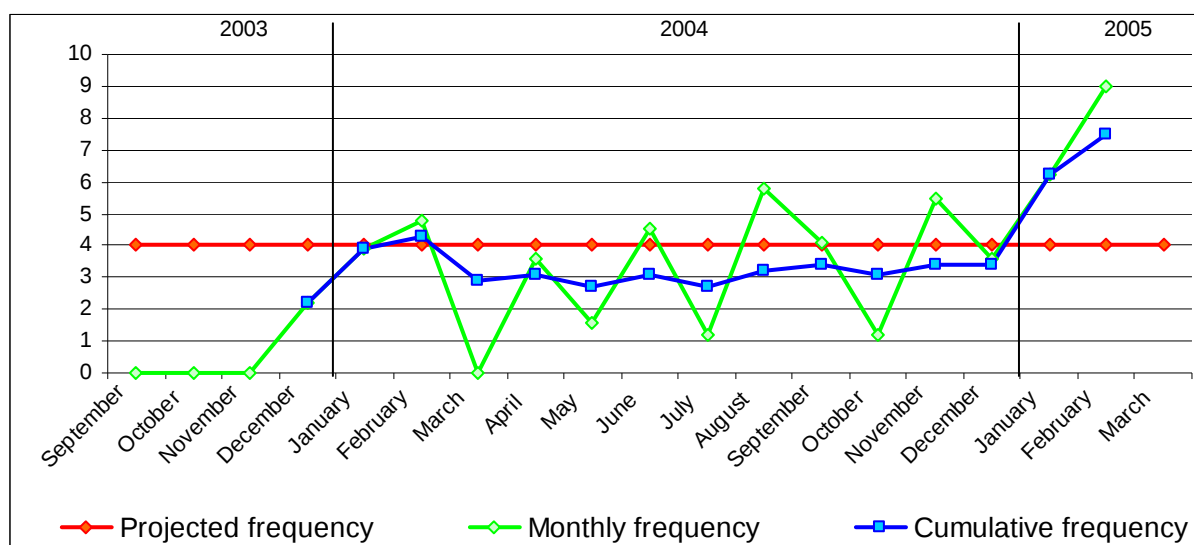


Figure 4.6 Frequency of Utilisation: Deliveries (excluding Caesareans – as a %)

Since 2004, adverse selection was clearly apparent in the prenatal consultations and, logically, deliveries a few months later. This phenomenon was heightened for those two services in 2005 following the numerous terminations and dropouts that began in mid-2004, since many of the remaining women were pregnant. The phenomenon was also heightened by the fact that the initial estimates of frequency of utilisation were calculated based on the target population as a whole, including men, women and children, on the assumption that the clients would also enrol their family members (husbands and children). However, since 2003, only women have enrolled, sometimes with a few children (the average size of an insured household is 1.1 member as compared to an average household size of 6 within the target group). As a result, the frequency of prenatal consultations and deliveries observed in the insured population (essentially made up of women of childbearing age) is higher than that original calculated for the total target population.

Specific measures could have been implemented to curb the risk of adverse selection, such as increasing the probationary period for prenatal consultations and deliveries. However, a decision was made to use the phenomenon towards the product's marketing rather than trying to put an end to it. As the claims in question were not out of control, they could be used to increase the visibility of the microinsurance, particularly with a target group made up of women. The frequency of utilisation is very carefully monitored and measures could still be implemented if the risk of adverse selection becomes too significant.

Fraud and Abuse

Measures against fraud and abuse rely firstly on the insurance booklet, which contains an ID photo of each beneficiary and various pieces of identity information (code, first and last name, date of birth, etc) and, secondly, on the contracts with the health care providers.

The health care providers play an important fraud control function by checking the identity of the beneficiaries who seek care. Several attempts for fraud (false identity, attempts to pass off an uninsured child as an insured child, etc) have been reported by health care providers, who

disallowed the expenditure and informed AssEF. However, this does not mean that the risk has been totally prevented and it is likely that cases of fraud have gone undetected.

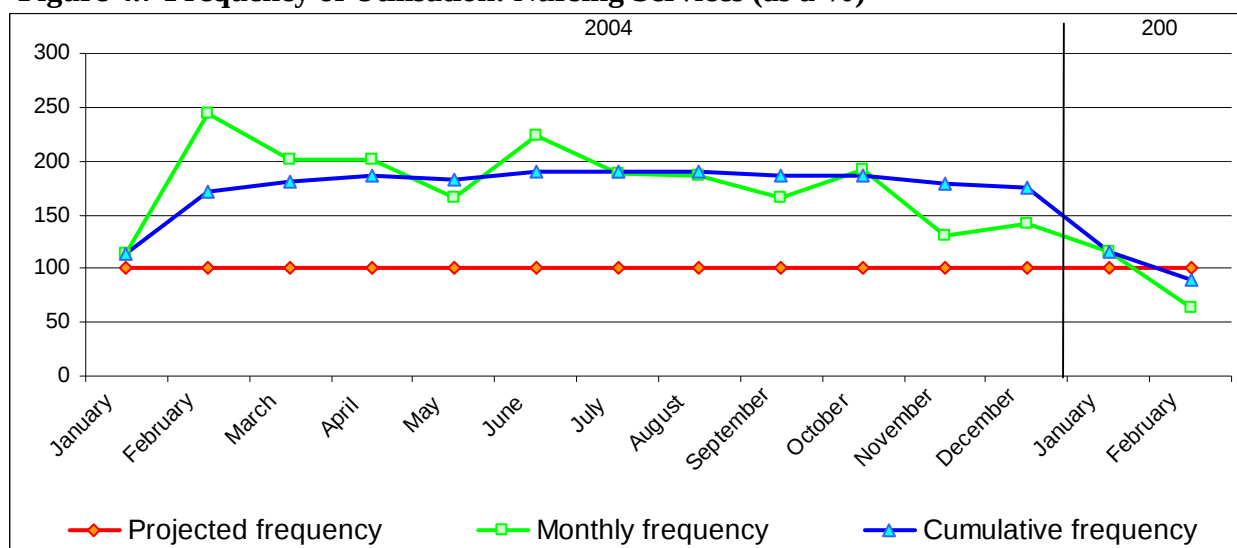
Cost Escalation and Over-Prescription

Here again, the contracts with the health care providers play a key role in controlling health care costs, since they make a commitment to deliver the quantity of services needed to provide quality treatment. No over-charging has been observed for the services covered, although certain discrepancies have been noted. As mentioned above, these are more often due to a lack of precision in certain projections during the feasibility study and to the phenomenon of adverse selection (for deliveries and prenatal consultations) than to a problem of over-prescription.

On the other hand, serious discrepancies have been noted between projections and actual figures regarding nursing services and hospitalisations and are effectively linked to a problem of over-prescription.

Microinsurance clearly led to a behaviour change in one contracted health care provider which, because the beneficiaries are insured, asked them to come back several times during the same illness to provide treatment; the first visit is recorded as a consultation and the subsequent ones as nursing services. Since it happens to be the most commonly used health care provider, the impact on frequency of utilisation was particularly high.

Figure 4.7 Frequency of Utilisation: Nursing Services (as a %)



Monitoring data on the frequency of utilisation of this service was reported back to the relevant health care provider (centre de santé Saint Jean de Cotonou) and jointly reviewed in November 2004. This resulted in a gradual but definite reduction in the frequency of utilisation, which returned, in 2005, to the level projected during the feasibility study (the graph in Figure 4.6 presents the frequency of utilisation calculated for all health care providers, including the Centre de Santé Saint Jean, which is the main centre used for primary health care by the microinsurance beneficiaries and therefore has a strong impact on the frequency of utilisation curves, especially in terms of nursing services). This cannot be

described as over-prescription, but rather as “overzealousness” on the part of a health care provider that tried to improve the quality of service by taking advantage of the improved financial access of AssEF’s microinsurance beneficiaries.

The problem with hospitalisations was quite similar, although it occurred with another health care provider (Hôpital de zone Ménontin). The review conducted with hospital staff effectively showed a greater tendency to hospitalise patients with insurance, but that in all cases, the hospitalisations were justified and actually corresponded to an improvement in the quality of care. Uninsured patients generally preferred to turn down hospitalisation and stay at home. The hospitalisations were due to malaria, which is particularly prevalent in Cotonou, since many poor neighbourhoods (where a high proportion of AssEF members live) are built in flood zones or on swamplands.

4.8 Marketing

Communications and information are one of the weaknesses of AssEF’s microinsurance. Interviews with members of the savings and credit groups showed that a high proportion are under-informed about microinsurance, do not understand its advantages or lack arguments to help convince their friends or spouses to enrol.

It is important to stress that the goal of AssEF during the start-up phase was to test technical management documents and procedures before seeking a high level of memberships among its target population. Target population coverage rates set for the 2003 and 2004 financial years were 5% and 10%, and awareness-raising activities were carried out to achieve them. During the setting up phase, AssEF wrote a letter to women and their spouses explaining microinsurance and distributed it very broadly. Communication aimed at members of AssEF was essentially carried out by the managers of savings and credit groups using awareness-raising tools developed by SISF, which also provided training on the subject. SISF also organised awareness campaigns, but these usually focused more on premium recovery.

Certain managers have developed their own communication methods and media, which are often very simple, such as the Dandji credit and savings fund, which has hung a board in a highly visible spot in its premises with the following inscription:

“MUTUAL HEALTH ORGANISATION! Huge Membership + Regular Payment of Premiums = Good Health for All. **Risk Management and Solidarity for Better Health.**”

The message is simple but apparently effective, since this fund has the highest enrolment rate in the network, although the vitality of its managers also counts for a lot.

Implementation of a real communication plan was scheduled to start in the latter half of 2004, but it was postponed due to the difficulties encountered by the microfinance activities. Indeed, it did not seem appropriate to undertake this type of activity in such an unstable context. It has been included in the microinsurance consolidation plan scheduled for 2005.

4.9 Beneficiaries' Satisfaction

No evaluations have been conducted to assess client satisfaction, but regular self-assessments carried out by AssEF and STEP within the savings and credit associations and funds note that, overall, women express satisfaction with their health microinsurance benefits. They feel that the protection provided is high and reduces extraordinary health expenses. However, some complaints were expressed regarding patient reception at certain health care facilities and especially in relation to claims procedures, but perhaps it is simply the zeal used in checking the identity of the beneficiaries that they find objectionable.

The numerous member terminations and dropouts between mid-2004 and early 2005 cannot be viewed as signs of a high level of dissatisfaction, since they were partly due to the difficulties faced by the microfinance activities, in addition to problems with premium recovery. As pointed out previously, many women were obliged to drop out of microinsurance when they left the microfinance system, despite the fact that they wished to maintain their membership.

With the “MAS Gestion” (HMI management) software, it will be possible to measure the exact member retention rate. Microinsurance enrolment takes the form of an automatically renewable contract ending when a member drops out or is terminated, most often due to excessive premium arrears (more than three months).

5. Results

The documents and information used to measure the results and performance of the microinsurance scheme are based on:

- **Record-keeping documents:** membership sheets and registers, premiums sheets and registers, treatment certificates and monthly invoices, documents relating to accounting;
- **Monitoring tools:** monthly monitoring sheets and computerized indicators (“MAS Pilote” software).

These tools have been further consolidated by the installation of the “MAS Gestion” technical management software, which will promote improved verification and monitoring, and produce assessment indicators.

5.1 Operational Results

At the time of the present case study, the microinsurance has been operating for 23 months (May 03 – March 05). The main outcomes of this experience can be summarized as follows:

Enrolment: Growth in enrolment was initially rapid, confirming the assumptions underlying the scheme’s design, but it later took a clear downward trend and stagnated due to the disturbances experienced by the microfinance sector in Cotonou. The microinsurance scheme recorded a total of 3,193 members and 3,895 beneficiaries. However, membership terminations and dropouts were numerous beginning in mid-2004, and the microinsurance scheme had only 1,921 members and 2,272 beneficiaries at the end of 2004. The net population coverage rate ((enrolments – terminations and dropouts) / target population) was 4% at the end of 2003 and 8% at the end of 2004. The gross population coverage rate (total enrolments / target population) was respectively 4% and 12%.

Premiums: From May 2003 to December 2004, total billed premiums stood at 12,726,800 CFA F (\$25,659), while premiums collected stood at 10,621,350 CFA F (\$21,414), with an average recovery rate of 83% over the first two financial years. This is a high rate compared to other microinsurance schemes collecting monthly premiums in the region. However, these positive results should not mask the difficulties linked to premium affordability, which have led to a low rate of coverage within each household (1.1 person out of 6) and numerous terminations due to sizeable arrears.

Benefits: In 2003 and 2004, the monthly average percentage of enrolled beneficiaries that were entitled to microinsurance benefits stood at 37% (27% in 2003 and 41% in 2004). This low figure is partly due to the fact that the microinsurance was in a growth phase, with a high proportion of beneficiaries on probation, and also due to the relatively high number of beneficiaries in arrears. Total expenditures on claims covered by the scheme stood at 8,033,098 CFA F (\$16,196) for the 2003 and 2004 financial years, for an average of 267 CFA F (\$0.54)/month/enrolled beneficiary.

5.2 Financial Results

The microinsurance scheme's accounting is done by the financial department of AssEF. Accounting data is processed using software developed for microfinance activities (ATHENA).

The microinsurance accounting system is relatively simple, since both the variety and number of economic transactions are limited. Table 5.1 provides a breakdown of performance during the 2004 financial year (the only complete financial year in the lifetime of the microinsurance activity).

Table 5.1 2004 Income Statement (in CFA F)

Expenses		Revenue	
Claims	7 356 862	Premiums (billed)	9 765 600
Recurrent operating costs	1 414 755	Membership fees	1 881 000
AssEF staff	3 691 488	Other revenue	9 900
Communications/awareness	1 706 500		
Trainee staff	250 000		
Total expenses	14 419 605	Total revenue	11 656 500
Technical income before subsidies	- 2 763 105 (-\$5 571)		
		AssEF internal subsidies	3 691 488
Total expenses	14 419 605	Total revenue	15 347 988
Technical income before donor contributions	928 383 (\$1 872)		
		External subsidies (STEP)	1 956 500
Total expenses	14 419 605	Total revenue	17 304 488
Technical income	2 884 883 (\$5 816)		
Total	17 304 488	Total	17 304 488

Based on its own resources, essentially made up of premiums and membership fees, the microinsurance is not profitable. But this is due to the decision to finance certain operating costs using resources from AssEF's microfinance activities in order to reduce the premium.

The scheme's financial viability should be analysed based on its income before external subsidies. Thus, the microinsurance shows a positive performance for the 2004 financial year (928,383 FCFA). However, this outcome remains fragile, as it depends on the microinsurance activity's ability to maintain a high rate of premium recovery and continuing membership growth. On the latter point, the difficulties encountered since mid-2004 constitute a real threat to the financial viability of the scheme.

Table 5.2 Key Results (\$)

Headings	Jan-Feb 2005	2004	2003
Net income (net of donor contributions)	-	23 501	8 319
Total premiums (value)	3 150	19 689	5 970
Growth in premium value	0	0	
Claims	3 234	14 829	1 367
Claims / total premiums (%)	103	75	23
Administrative costs (excluding awareness)	806	10 799	3 425
Administrative costs / premiums (%)	26	55	57
Commissions	-	-	-
Reinsurance / premiums (%)	-	-	-
Additional reserves for the period / premiums (%)	-	14	38
Additional net income for the period / premiums (%)	-	-	-
Claims cost / total number insured	0.85	0.6	0.3
Growth in number of insured	-	158	-
Income earned from investments	-	-	-
Percentage of profit distributed	-	-	-
Renewal rate	-	-	-

The microinsurance activity is still in the start-up and adjustment phase. Its natural fragility at this stage has been accentuated by the unfavourable changes in the environment. As a result, it is difficult to conduct a meaningful analysis of the ratios presented above. This applies particularly to the early months of 2005, for when it is difficult to make projections, since they will depend on the results of the recovery plan currently being implemented by AssEF.

5.3 Reserves

Reserve funds accumulated during the 2003 and 2004 financial years were 2.5 million CFA F (\$5,098), or 34% of total claims in 2004, an amount equal to approximately 4 months of claims. The generally recognized standard for health insurance in the subregion is that the reserve for a given year should equal between 6 and 9 months of claims for the previous year.

AssEF's microinsurance is still building its reserve fund. This growth could be slowed during the 2005 financial year, which may yield a negative income if microinsurance enrolment does not increase. However, the scheme has some security due to the potential for contributions from AssEF through its social protection funds and subsidies from the STEP program. The goal for the 2005 financial year is to uphold the operations of the microinsurance activity until AssEF's recovery plan starts to produce an impact and growth can resume.

5.4 Impact on Social Protection Policy

AssEF's microinsurance is a small-scale experience whose target population is restricted to the MFI's membership. As such, its direct impact on the social protection policy of Benin is unclear. However, as a pilot experience, this scheme and similar experiences, being run by national and international actors, are used by the national consultation framework as a basis for lobbying the national government for a more conducive environment for microinsurance and the extension of social protection to all strata of the population.

6. Microinsurance Product Development

6.1. Concept Development

The setting up of AssEF's health microinsurance was preceded by a feasibility study started in July 2002. The study consisted of three main phases:

1) *Preparatory phase:*

A study methodology was defined jointly by STEP and AssEF. A study steering committee was set up including members of the board of directors of AssEF, technical staff and representatives of savings and credit associations and funds.

2) *Surveys and information collection necessary to design the scheme to be set in place:*

Two major surveys were conducted:

- A survey of 480 households regarding their makeup, health care seeking behaviour, financial risks linked to illness, the most commonly-used health care providers, etc.
- An average cost survey using a sample of 11 health structures and over 1,600 patients to determine user spending on health services and pharmaceuticals in the various health care departments.

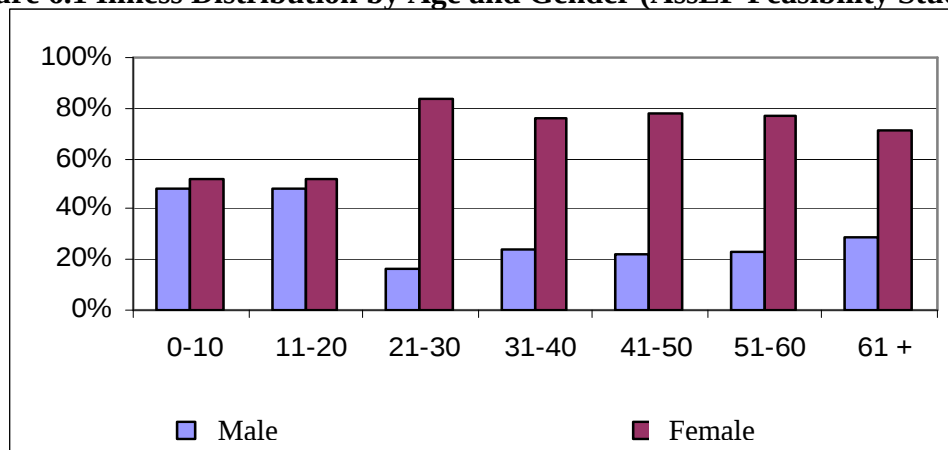
This phase also included facilitation by savings and credit association and savings and credit fund members in all three pilot areas and collection of available health data.

3) *Scheme design:*

The findings of the previous phase were reported and reviewed in conjunction with the various actors involved (AssEF, health care providers, etc.) so as to progressively define the health microinsurance scheme (see Section 6.2).

The principal findings of the information-collection phase regarding demand can be summarized as follows (see Section 3):

- *Health care needs:* The average household size among the target population is 6 people. Based on a household survey, the morbidity rate was estimated at 1.54 case of illness per person per year. This rate dovetails the WHO's estimate for urban areas in the sub-region. As shown in Figure 6.1, children 0 to 10 years old and women are the most vulnerable to disease. That is largely why AssEF's health microinsurance focused on developing a product essentially tailored to their needs.

Figure 6.1 Illness Distribution by Age and Gender (AssEF Feasibility Study)

- *Care-seeking behaviours in the event of illness:* The household survey showed that treatment is sought an average of 1.7 times per illness. Due to a lack of money, virtually all patients initially try traditional medicine and self-medication before turning to modern health care services. These treatment attempts are used either to cure the illness, or as a means of hanging on until enough money can be found to go to a health facility. When these solutions are insufficient, religious health facilities and private health centres are the main health care providers. In such cases, households seem to place the perceived quality of health care services above affordability.

Table 6.1 Health care-seeking Behaviour

	Treatment sought per Illness Episode (%)
No treatment	0
Traditional medicine	20
Medicines from street or shops	31
Private pharmacy	30
Dispensary	3
Public/religious health centre	32
Doctor's office	10
Private clinic	27
Public/ religious hospital	15
Other	3
Total	171

- *Financing of health care expenditures:* On average, households use 1.6 sources of financing to cover health care expenditures. Household survey findings and reviews conducted jointly with savings and credit association and fund members demonstrated that women are primarily responsible for seeking money to pay for health care. First, they use the money readily available within the household. Using their AssEF loan was the second major source of financing. The survey findings made it possible to further define this as:
 - Using part or all of a loan to pay for health care (improper use) when illness strikes; or

- Using the working capital of their small commercial activity (the vast majority of AssEF members are merchants).

In either case, the consequences are the same, since by using these sums in such a way, the women compromise the development of their income-generating activities either partially or completely, and if they have borrowed money, they reduce their ability to pay it back. As a result, this source of health care financing is a threat to both the members' economic activities and AssEF's credit portfolio. The third source of financing of health care expenditures comes from husbands, who essentially become involved only when large amounts of money are required.

These various elements, plus the information presented above on financial risk linked to illness, were used as a basis for awareness-raising and facilitation activities by savings and credit association and fund members, and for working with these women to define the services that should be offered by the microinsurance scheme.

6.2 Product Design

The development of the health insurance scheme included three main steps:

- **Financial feasibility component design:** Identification of health care providers to be covered, development of premium scenarios and selection of the optimal benefits/premium combination.
- **Technical and organisational feasibility component design:** Design of management mechanisms and tools and integration of the insurance scheme into the existing AssEF organisation.
- **Development of agreements** with health care providers and a procedures manual for the various stakeholders in the insurance scheme.

Product design was largely determined by the need to have the lowest possible premium while providing substantial and attractive protection. The different aspects of AssEF's health insurance product design were discussed in Section 4.

6.3 Prototype Development and Testing

Based on the feasibility study, the initial strategy was to set up a pilot scheme in three areas, which would then be progressively extended throughout the network. The overall demand among AssEF members, however, convinced the organisation to extend the product throughout the network. Thus, strictly speaking, there was no test phase, although to test the technical management components designed during the feasibility study, a decision was made to limit the growth of microinsurance to 5% of the target group in 2003 and 10% in 2004. This gradual growth made it possible to test the different mechanisms and make the necessary adjustments during the early months without causing widespread upheaval, since the number of beneficiaries and contracted health care providers remained low. A permanent monitoring system designed to detect anomalies accompanied the development phase.

7. Conclusion

The microinsurance scheme is currently undergoing a period of stagnation following a drop in enrolment. At the end of 2004, consolidation measures were identified with support from the STEP program; they are scheduled for implementation in 2005, but depend on the recovery plan for AssEF's microfinance activities. Several lessons can be learned from this experience due to its many ups and downs, but also due to its specific structure of the microinsurance scheme, which was offered as an additional service by the AssEF.

7.1. Adjustment Plan

The difficulties encountered by AssEF's microfinance activities were due to external and internal factors. The external factors were linked to a period of economic difficulties faced by the microfinance sector and the consolidation of the microinsurance scheme cannot be dissociated from the stringent and ambitious recovery plan undertaken by AssEF.

Recovery plan for AssEF's microfinance activities

As this case study does not focus on AssEF's microfinance activities, we will only provide a general outline of the plan. The plan's objective is to reorganise and revitalise the network. The main lines of this plan, which began in 2005, are:

- Reinforced debt recovery
- Improved credit procedures
- Increased accountability for officers and continuing professionalism of the management of the credit institutions
- Reduced operating expenditures
- Orientation of AssEF's activities towards geographic areas where the competition among microfinance institutions is less strong.

Health microinsurance consolidation plan

In late 2004, a microinsurance diagnosis measured the impact of the difficulties encountered by the microfinance activities on the development of the microinsurance scheme. A consolidation plan was developed based on the following:

- **Stronger technical management:** This initial consolidation measure was being set in place at the time of the present case study. It is based on the implementation of management software developed by STEP ("MAS Gestion"). The software was designed for health microinsurance scheme managers as a tool to help them quickly and easily record, verify and monitor enrolments, premium payments and claims. It also includes an accounting module that can be used to calculate annual technical results, although it is not accounting software. It uses the same indicators as the "MAS Pilote" monitoring software also developed by STEP. This software enables AssEF to monitor premium payment accounts and manage entitlement to benefits more effectively, and makes it possible to monitor claims instantly and on an ongoing basis. These management tools will allow the microinsurance organisation to react more quickly to any anomalies.

- **Stronger premium recovery:** Premium recovery is one of the weaknesses of the health microinsurance scheme. The target is to return to an average rate of over 90%, which was achieved from May to August 2004. Toward this end, the consolidation plan will reinforce awareness activities for savings and credit association and savings and credit fund members. Focusing awareness activities on the most active savings and credit associations and funds should also help further the objective by improving the quality of the insured portfolio.
- **More relaxed rules governing entitlement:** From the time of its inception, AssEF adopted very strict operating principles for the management of its premium accounts and entitlement to benefits. Any member who is over a month late in her payments is suspended from entitlement to benefits, along with her dependents. When a premium is over three months late, the member is terminated. This mechanism makes it possible to ensure that women do not build up too large a debt towards the microinsurance scheme and become unable to return to beneficiary status. While the members understand the mechanism, it discourages women who are in arrears not because of an unwillingness to pay, but due to a lack of financial means. At the request of the members of the savings and credit associations and funds, the termination mechanism will be revisited to enable women with large debts to benefit from softer terms of payment and avoid systematic terminations. A number of solutions, currently being reviewed by SISF, will be reported to and discussed with the savings and credit associations and funds in order to identify the most suitable formula.
- **Focusing microinsurance consolidation on the most active savings and credit associations and funds:** Different savings and credit groups have faced the difficulties experienced by the microfinance activities in different ways and some have proven more energetic than others in terms of distributing the health insurance product and collecting premiums. In 2005, communications activities and reinforcement of microinsurance operating mechanisms will be conducted first in the most active savings and credit associations and funds. This should make it possible to create a stable membership base.
- **Implementing a communications plan:** Communications were another weakness of the health microinsurance scheme, but this was due to a distribution strategy to iron out the procedures and management documents with a small membership pool. As the adaptation phase can now be considered complete, the microinsurance scheme is now ready to be distributed more widely, beginning with the most active savings and credit associations and funds.

A communications plan will be reviewed and implemented in 2005 (as soon as the impact of the recovery plan undertaken by AssEF is felt). The goal of the communications plan is to increase the number of members and beneficiaries, but also to improve the level of understanding of health microinsurance. Towards this end, it will identify the best messages and media for the target population. Special emphasis will be placed on:

- Husbands' contribution towards payment of premiums. Some men actively pay premiums alongside their wives to provide insurance for their entire households, but this is still unusual;
- The services offered by the microinsurance scheme and how it works;

- More generally raising awareness and raising the level of knowledge on the subjects of insurance and risk management.

7.2. Lessons Learned

The uniqueness of the health microinsurance scheme set up by AssEF resides in its organisation as an additional service offered by the microfinance institution. This organisational decision was aimed at enabling the microinsurance scheme to lower its operating costs by making full use of AssEF's human and material resources as well as the name the microfinance institution has built for itself since its inception. Despite its short history, there are many lessons to be learned from the experience.

The following points are drawn from the opinions of the various actors involved (AssEF officials, savings and credit association and savings and credit fund members, health care providers, and the STEP program).

Major Breakthroughs

The microinsurance scheme is able to offer substantial protection to the members of the microfinance network with the lowest possible premiums

The self-assessment sessions conducted since 2003 by AssEF and STEP indicate that the women generally appreciate the level of protection provided by the health microinsurance scheme, whose services were essentially designed to meet their specific needs and those of their children. The 70% coverage rate significantly reduces financial risk for members, so that the insurance helps protect both their economic activities and AssEF's credit portfolio. The proposed premium is actually lower than its real cost due to the fact that certain operating expenses, such as SISF staff, are covered by AssEF. This provides the microinsurance scheme with the necessary means for effective management while distributing the cost between the premiums and income from the microfinance activities. However, this does not prevent the premium from being beyond the means of the women alone. Hence, AssEF's aims to involve husbands in payment of premiums so that all the members of the households can be covered.

The system pays for itself through the resources generated by the microinsurance scheme and AssEF's internal resources, while external subsidies (STEP) merely added slightly to a financial result that was already positive. As the most substantial operating expenses are fixed costs (personnel), the microinsurance scheme should eventually be able to rely entirely on self-generated funds. During the feasibility study, the break-even point was estimated at approximately 10,000 beneficiaries (around 6% of the target population). However, this target can only be achieved if the scheme can collect a high percentage of premiums and cover a high proportion of the members of each household.

The microinsurance scheme is simple and manageable for an organisation that does not have prior health insurance skills

In a context where there is no social protection system for the most disadvantaged populations, AssEF has set up its own health microinsurance experience. The mechanisms used, which are similar to those used for the microfinance activities, are designed so that data can be recorded very simply. The microinsurance scheme is tailored to the structure of the

microfinance operations. However, it should be noted that the technical support provided by the STEP program has been decisive, particularly with the implementation of the feasibility study.

Claims mechanisms are simple and effective for the beneficiaries

AssEF health microinsurance applies the same principles as mutual health insurance societies. There is no selection at the time of enrolment and the only prerequisite for membership is being an AssEF member.

No formalities need to be accomplished before seeking care. When a beneficiary is sick, he or she goes to a health care organisation with his or her insurance booklet, receives treatment (as long as the premiums are fully paid and the probation period completed) and pays 30% co-payment, while the rest is billed to the microinsurance scheme. This ensures quick access to health care and significant protection against financial risk.

Setting up of an effective monitoring system

The claims system is convenient for the beneficiaries because it provides rapid access to health care services without complicated formalities. It also includes safety measures against insurance risks partly since a minimal safety margin was used in calculating the premium. Measures are based on constant monitoring of memberships, premiums and claims. The monitoring has made it possible to detect anomalies and make the necessary adjustments.

Major Challenges

Microinsurance is new and needs to overcome some reluctance

Although AssEF's health microinsurance experience was sparked by requests from women belonging to the network, it still faces considerable reluctance and needs to prove its worth to a target population:

- that is mistrustful of insurance and has not developed the habit of risk management. Many simply put their trust in their religion;
- whose income is low and irregular. Women have difficulty covering their day-to-day expenses, which does not motivate them to pay premiums for risks that are not immediate.

Women who have already received microinsurance benefits progressively realise their worth and help promote the insurance scheme. However, AssEF needs to broaden its communications to motivate more women to purchase this new product.

The integration of microinsurance as an additional activity of the association makes it dependent on the dynamics of the association

The main characteristic of the health microinsurance scheme is the way it is organized as an additional activity of AssEF. This choice presents numerous advantages but also creates direct dependence by the microinsurance on AssEF. The situation that arose in 2004 made the dependence more visible, but it is uncertain whether if the impact would have been reduced had the microinsurance had been set up through a new organisation (institutionally independent from the network).

The microinsurance scheme is operating in an environment that is not yet very conducive to this type of system

Despite the growing interest expressed by the national authorities and the numerous experiences being conducted throughout the country, the environment is still not very conducive to health microinsurance. The insurance schemes that have been set up have no status and have to negotiate with the health care providers individually without necessarily having all the knowledge and experience.

Pooling these experiences through the national framework for concerted action is a step towards a solution that national and international organisations that are involved in the development of microinsurance should continue to promote.

Best Management Advice to Others

Select health care providers very carefully

When possible, i.e. when there is a variety of health care providers, the feasibility study should allow for a careful selection of health care providers based on the best quality/price ratio, the perceptions of the target population and the health care providers' willingness to work with the microinsurance scheme.

During AssEF's experience, the selection, that was made effectively, helped offer members the optimum premiums/benefits combination. Religious health care providers, whose main goal is social welfare, offer quality services at a reduced cost. In addition, these health care providers contribute actively to fraud control and eligibility checks.

Monitor on an ongoing basis

The health microinsurance premium was calculated to be as low as possible in order to maximise its affordability to an impoverished target population. The scheme has a small safety margin and is vulnerable to potential deviant consumption or pricing. AssEF has computer-based indicators ("MAS Pilote" software) that allow it to monitor a set of eleven indicators to track changes in enrolments, premiums and benefits. Because such monitoring entails considerable data entry and processing work, it constitutes a constraint, but it has enabled AssEF to pilot the insurance effectively.

Ensure that the necessary management tools are in place

Although the management mechanisms established are simple, the scheme is dealing with a unique and complex tool: health insurance. Its complexity is largely due to the fact that insurance is based on forecasts and the cost of the product remains unknown until the end of the financial year. Furthermore, the scheme's viability depends on how insurance risks are managed. For these reasons, it is necessary to have the requisite staff and resources to ensure effective management. In this regard, AssEF's microinsurance scheme has distinguished itself from the vast majority of experiences at the national and sub-regional levels (which often rely on volunteer management) because it can rely on AssEF's salaried staff and resources for the distribution and management of its health microinsurance product.

APPENDIX 1: Information Letter

REPUBLIQUE DU BENIN

ASSOCIATION D'ENTRAIDE DES FEMMES

B.P. 1048 Cotonou - Tél. (229) 30 22 51 / 96 30 83 E-mail : assef@leland.bj - assef2001fr@yahoo.fr

N° /2003/AssEF/IS

Cotonou, le 5 Mai 2003

Objet : lettre d'information

A

**Toutes les femmes de l'AssEF
et à leur Mari**

Mesdames, Messieurs

Dans le but d'aider toutes les femmes de l'AssEF et partant tous les membres de leur famille à avoir une santé parfaite et durable, AssEF a mis en place un programme de Micro Assurance Santé avec l'appui technique du BIT / STEP.

AssEF saisit cette occasion pour informer toutes les femmes membres de AssEF et leur mari du démarrage dudit programme et les invite à y adhérer sans réserve pour leur bien être et celui de leurs enfants, car désormais l'Assurance Santé ne sera plus seulement la chose des fonctionnaires d'Etat mais aussi des acteurs du secteur informel.

La dite assurance a la particularité de couvrir beaucoup de maladies avec un taux de prise en charge de 70% et une cotisation de 400 francs par mois et par tête à la portée des familles à faibles revenus.

Cette assurance est uniquement réservée aux femmes membres de l'AssEF, à leur mari et à leurs enfants.

Nous vous invitons donc à vous inscrire massivement afin d'assurer à vous et à vos enfants une santé durable.

Tout en vous souhaitant bonne réception, nous vous prions de recevoir Mesdames, Messieurs, l'expression de nos meilleures salutations.

La Directrice Exécutive,

AGNIKPE Janine

APPENDIX 2: Enrolment Form

ASSURANCE SANTE ASSEF
Fiche d'adhésion



N° de titulaire :.....

Adhérent :

Nom :

Prénom :

Date de naissance : Sexe :

Nom CEC : ou AEC :

Adresse de l'adhérent :

N° de compte

Activité économique :

Frais d'inscription: Payé le:

Date d'entrée (versement de la première cotisation) :

Période d'observation : du Au

Date de sortie :

Personnes à charge

N° de bénéficiaire	Date d'entrée	Nom et prénom	Date de naiss.	Lien de parenté	Date de sortie	Remarques
2						
3						
4						
5						
6						
7						
8						
9						
10						

Observations :

.....

APPENDIX 3: Treatment Certificate

N°	ATTESTATION DE SOINS			
Nom et Prénom du bénéficiaire :				
Date de naissance : Sexe :				
N° de bénéficiaire : / <i>Merci de vérifier la validité du livret d'assuré</i>				
Prestataire de soins :				
SERVICES DE SANTE				
Dates	Services	Actes	Montants	
TOTAL				
Ticket modérateur (30% du total)				
MONTANT A FACTURER A L'ASSURANCE (70% du total)				
Date :				
Signature et cachet du prestataire			Signature du bénéficiaire	

APPENDIX 4: Monthly Invoice

[illegible]