

Reducing Vulnerability: Demand for and Supply of Microinsurance in East Africa

Monique Cohen, Michael J. McCord, and Jennefer Sebstad

A synthesis report

December 2003



*“Developing partnerships
to insure the world’s poor”*

**Microfinance
Opportunities**

“Putting Clients First”

Reducing Vulnerability: Demand for and Supply of Microinsurance in East Africa

Abstract

December 2003

Monique Cohen, Michael J. McCord, and Jennefer Sebstad

This paper synthesises the findings from two studies carried out in Uganda, Kenya, and Tanzania. The first study examines the demand for risk management tools by the poor and the second assesses the experience of seven institutions providing microinsurance to satisfy this demand. The paper identifies three major risks faced by poor people in East Africa: death of an income earner, illness, and property loss resulting from theft and fire. It reviews poor people's current options for managing these risks and differences by gender and wealth levels. It then discusses implications for microinsurance, considering issues of coverage, access, timeliness, and affordability – all key issues in assessing the market potential of microinsurance products and services. These issues are considered in light of lessons learned from the seven institutions providing microinsurance. While these institutions focus specifically on health microinsurance, the issues and implications may be applied to other forms of insurance.

The research findings reveal a huge opportunity for microinsurance in the low-income markets of these countries. Formal insurers cover only the top five to ten percent of the population and the rest are left to fend for themselves. The institutions included in this study are all trying to service this market, learning important lessons along the way. The cases show that meeting the demand for microinsurance in a responsible, professional manner will take much effort. The paper includes practical lessons for designing and delivering insurance products drawing on the views and experiences of clients, potential clients, and the institutions that aim to serve them.

Table of Contents

Abstract.....	i
Table of Contents.....	ii
Abbreviations and acronyms.....	iii
Foreign Words and Phrases	iii
Acknowledgements.....	iii
Introduction.....	1
Risk and Risk Management	2
The Impact of Shocks	2
The Risks	2
Risk Management	2
Coping Differences by Gender	4
Coping Differences by Wealth Levels	4
Reducing Vulnerability with Microinsurance.....	5
Coverage	8
Accessibility.....	9
Timeliness	10
Affordability	11
The Clients’ Institutional Options.....	12
Implications for Microinsurance.....	13
Conclusions.....	15
Next Steps	17

Abbreviations and acronyms

AIMS	Assessing the Impact of Microenterprise Services (USAID)
CHeaP	Community Health Plan (Kenya)
CHF	Community Health Fund (Tanzania)
CIDR	Centre International de Développement et de Recherche (Uganda)
HMO	Health Management Organisation
IP	In-patient
KPPS	Kitovu Patients Prepayment Scheme (Uganda)
MBA	Masters in Business Administration
MFI	Microfinance Institution
MIS	Management Information Services
NFP	Not-For-Profit
NGO	Non-governmental organisation
OP	Outpatient
PoA	Poverty Africa Health Programme (Tanzania)
PRA	Participatory Rapid Appraisal
SEEP	Small Enterprise Education and Promotion Network
SHU	Save for Health Uganda
USAID	United States Agency for International Development

Foreign Words and Phrases

<i>Munno mukabi</i>	“friend in need” societies (Uganda)
<i>Harambee</i>	“pulling together” (Kenya)
<i>Edda</i>	A tradition of staying in isolation for three months after a husband’s death
<i>Ex post</i>	After an event occurs
<i>Ex ante</i>	Before an event has occurred

Acknowledgements

This synthesis represents the culmination of work by a number of people. The value of the paper is a result of their efforts.

On the demand side, the country research teams included Altemius Millinga (who also did some qualitative research for the supply side team) and Peter Mukwana in Tanzania, Grace Sebageni and Jolly Namudu in Uganda, and Francis Simba, Jane Mbaisi, Shahnaz Ahmed, and Nthenya Mule in Kenya. Their fieldwork contributed to a new and better understanding of poor people’s experiences with formal, informal, and self-insurance and the market demand for microinsurance in their respective countries. We deeply appreciate the commitment and efforts of these researchers.

On the supply side, Sylvia Osinde was a key partner in developing the cases. Her critical inputs are deeply appreciated. Each of the institutions greeted our research team with openness and an eagerness to share. Without this, the work would have been, at best, deeply frustrating and, at worst, impossible. We are sincerely thankful and indebted to the managers and staff of Microcare, CIDR, and the Kitovu Patients Prepayment Scheme (Uganda), the Community Health Plan and MediPlus (Kenya); and the Community Health Fund and Poverty Africa (Tanzania). When we visited these institutions, we also visited organisations that were related to them through the product. Numerous hospital administrators and doctors, clients and non-clients, and intermediary partners also gave of their time and knowledge to make this work meaningful. We appreciate their assistance.

This work has been strongly supported by Graham A.N. Wright with *MicroSave* funding from Austria, CGAP, DFID, and UNDP. His assistance has been invaluable and is sincerely appreciated.

Reducing Vulnerability: Demand for and Supply of Microinsurance in East Africa

December 2003

Monique Cohen, Michael J. McCord, and Jennefer Sebstad

Introduction

The slow process of increasing income and building assets marks the road out of poverty. In the precarious world of the poor, a shock such as illness, death of a loved one, fire or theft can rapidly erase hard won gains and make the escape out of poverty even harder to achieve.

Vulnerability for the poor is an everyday reality. In the words of one microfinance client, “Life for the poor is one long risk.” To cope with shocks, poor people use many different risk management strategies. They draw on informal group-based and self-insurance mechanisms such as borrowing, saving, and drawing down productive and non-productive assets.

A relatively new option for the working poor to manage risk is “microinsurance.” *Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved.*¹ Microinsurance reaches a clientele this is different from that served by insurers. They are poorer, have fewer assets, less discretionary income, and their income flows often fluctuate considerably throughout the year. In addition, they have risk structures that are different from wealthier households. A majority find themselves in a reactive mode, responding after a crisis.

Microinsurance is more than simply downscaled formal insurance. This market has specialised needs that can best be served by particular products. Most use innovative premium collection methods that facilitate accessibility by the low-income market. These products provide protection to the poor in a way that reflects their cash constraints and coverage requirements.

For microinsurance to succeed, the products and services must be appropriate in terms of coverage, timeliness, accessibility, and affordability. Arriving at the appropriate design requires an understanding of both the demand for and supply of microinsurance and related products – formal and informal. This paper draws together the findings from two papers. The first seeks to understand what poor people are looking for in risk management tools and how attributes that meet risk management preferences of the poor can be incorporated into the design of microinsurance products.² The second, a sister study, examines the lessons from several institutions currently providing health care financing³ services through risk pooling mechanisms.⁴ This synthesis paper, by linking the demand and supply study results, suggests a framework that can be used as a basis for assessing the feasibility of a microinsurance intervention.

Research Design

This paper addresses the demand for and supply of microinsurance in Kenya, Tanzania, and Uganda. The research instruments used in the demand analysis are adaptations of two sets of tools: *MicroSave’s* “Market Research for Microfinance Toolkit” and the AIMS/SEEP “Learning from Clients: Assessment Tools for Microfinance Practitioners,” supported by USAID. Those interviewed were primarily clients of microfinance institutions (MFIs) some of which offered formal microinsurance products.

The supply side analysis offers an in-depth examination of organisations actively offering health care financing products to the low-income market.⁵ The seven institutions studied include:

1. In Uganda: Microcare, CIDR, and the Kitovu Patient’s Prepayment Scheme (KPPS);
2. In Kenya: MediPlus and the Community Health Plan (CHaP)

¹ The Donor Working Group on Microinsurance. “Preliminary Donor Guidelines for Supporting Microinsurance.” October 2003.

² Monique Cohen and Jennefer Sebstad. Reducing Vulnerability: the Demand for Microinsurance”. *MicroSave*. 2003.

³ Although all institutions in this study are offering some type of risk pooling microinsurance product, none of them are regulated insurers and technically they could suffer legal problems if they refer to their products as “insurance”.

⁴ Michael J. McCord and Sylvia Osinde. “Reducing Vulnerability: the Supply of Health Microinsurance in East Africa”. *MicroSave*. 2003.

⁵ Except for one, MediPlus a formal sector Health Management Organisation (HMO).

3. In Tanzania: Poverty Africa and the Community Health Fund (CHF)

This choice reflects the following selection criteria:

- A variety of delivery mechanisms
- A variety of organisational structures
- A mix of urban and rural institutions
- Several cases from each country
- One for-profit institution that serves the middle and upper market but also has an interest in moving towards the low-income market (selected to learn lessons from professionals)

The authors visited each institution for six to ten person days. Discussions were held with management, staff, health care providers, and intermediary partners about the health microinsurance programmes. Qualitative participatory rapid appraisal (PRA) sessions were held with a mix of current, past, and non-clients of each of these programmes. These discussions provided the basis for individual case studies of each of these institutions (available at www.microinsurancecentre.org)⁶.

Risk and Risk Management

The Impact of Shocks

In assessing the potential demand for microinsurance, a key question is: What coverage can be provided at what cost? This paper starts out by turning the question on its head and asks: What is the impact of a shock on poor households in the absence of insurance? How vulnerable are the poor?

Vulnerability is defined in terms of the ability of individuals and households to deal with risk. For the poor in Tanzania, Uganda, and Kenya, the research shows that the impact of a shock is a two-stage process (see Figure 1):

1. The immediate impact of the loss of an asset and/or income, and the need for lump sums of cash.
2. The medium and longer-term repercussions that call for strategic choices by households as they reallocate resources to respond to curtailed cash flows and the loss of assets and work to get back on their feet.

Responses to both levels of shock involve different strategies, which vary according to a household's resource endowment and the range of coping mechanisms it can access. The least stressful responses usually involve modifying consumption, calling in small debts, improving household budgeting, or using formal or informal insurance mechanisms when available. Somewhat more stressful strategies involve drawing down savings, diversifying income sources, borrowing either formally or informally, and seeking help from friends and relatives. As a last resort, people may deplete assets, default on loans, take children out of school, or use other strategies that hinder their future productive capacity.

The Risks

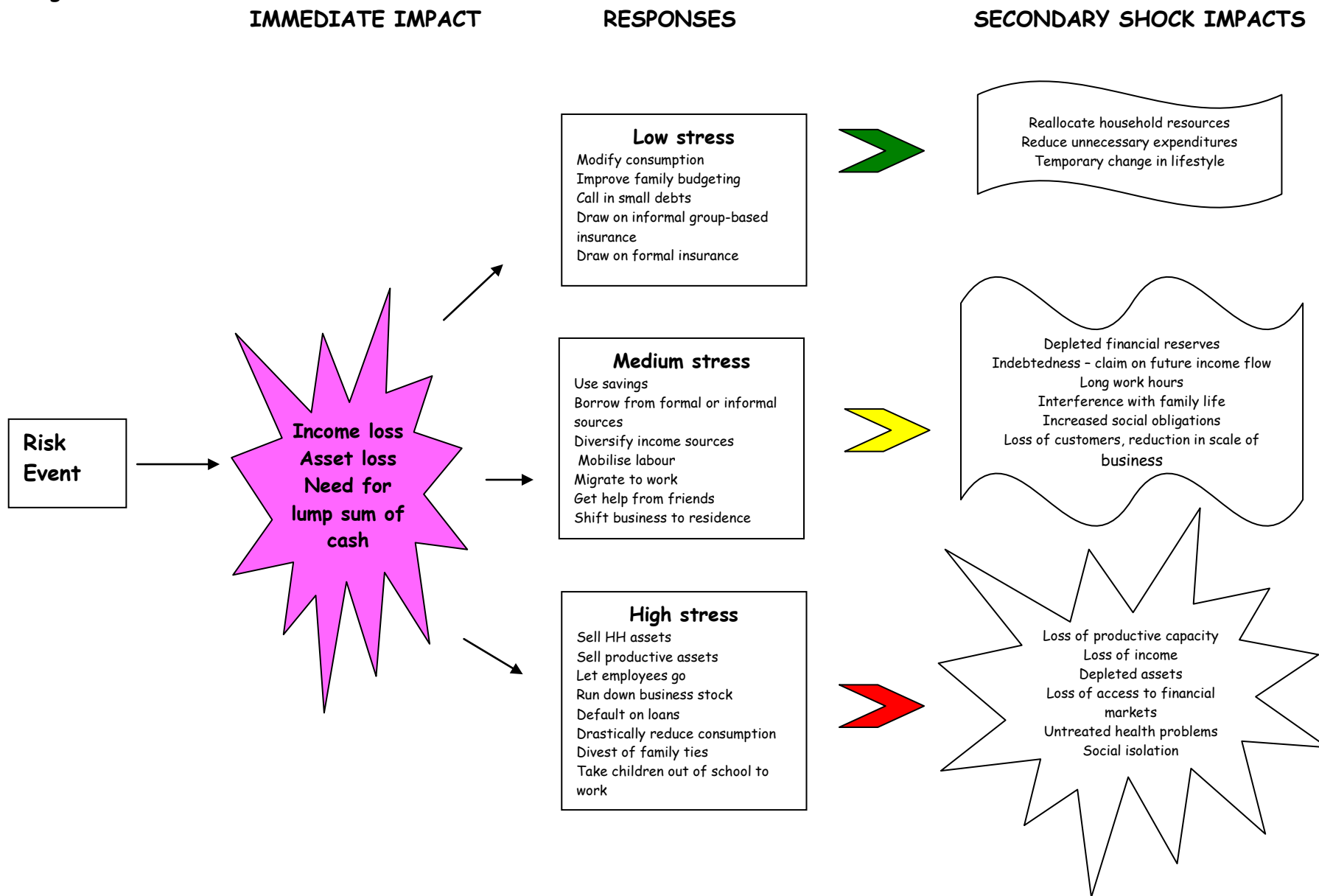
Sickness, death of an income earner or other family member, and property loss as a result of theft or fire were, respectively, the most frequent and stressful risks among the study participants in all three countries.

Risk Management

Among East Africans the dominant mode for responding to these shocks remains self-insurance. The person or family retains the risk of loss themselves by borrowing from MFIs, ROSCAs, or moneylenders, or depleting assets such as savings and consumer durables. Figure 1, below, notes the primary and secondary impacts related to risk events and how individuals and families respond to these shocks.

⁶ All documents referenced in this paper, and many other related works, are available at www.microinsurancecentre.org.

Figure 1



Beyond self-insurance, a majority of study participants also use a wide array of informal group mechanisms both to manage risk ahead of time (*ex ante*), and cope with shocks after they occur (*ex post*). Burial societies and Friends in Need groups⁷ are widespread in all three countries. These membership groups require payment of dues in return for the right to access group resources, in cash or in kind, for a specified need (for example, funeral transport or burial expenses). For frequent risks that require repeated expenditures of small sums of money, such as sickness, people often draw upon other informal groups such as the extended family and friends. Kenyans sometime use fundraisers or “*harambees*” to mobilise the large sums of money required for hospitalisation or surgery (as well as other expensive activities like weddings).

Poor households interviewed in the demand study had *very few formal insurance options* to respond to risks. Exceptions include:

- Life insurance linked to their credit products is required by several MFIs in Uganda. In the event of the borrower’s death, the outstanding balance is paid and the client’s family receives a lump sum that varies in amount with the size of the loan balance and/or the cause of death. Often these policies also cover the spouse and a fixed number of children. One such product, offered by AIG Uganda, covers the lives of over twelve percent of the entire Uganda population.
- Health microinsurance such as the products offered by the microinsurers studied for this paper.

Coping Differences by Gender

While the occurrence of shocks is widespread, their impact can be uneven. With fewer assets, less control over assets, and lacking ways to exercise their legal rights to assets, women often find themselves more vulnerable than men. Among the informal group-based insurance options, some welfare societies exclude women-headed households. Self-insurance, a key strategy, is a weaker option for women who are resource-poor and thus are more limited in their ability to use savings, divert income, or borrow.

Traditional Practice: Leaving Widows With Nothing

Lea is a client of the Youth Self Employment Foundation in Tanzania. After bandits killed her husband in 1993, she observed “*edda*” (i.e. stayed in isolation for three months) in accordance with Muslim tradition. While she was observing the “*edda*”, her brother-in-law sold all the household’s property including a car and a house that was under construction. He also took all of the household’s savings. Though Lea had used the income from her own microenterprise to help build the household’s assets before her husband’s death, she and her children were left with nothing. Her business did not generate enough income to feed her four children, pay the rent, health bills, or school fees, and she struggled to make ends meet. (Millinga, 2002)

To cope with loss, women exhibit some complex yet inventive risk management behaviours to protect themselves against future risks or to have timely access to lump sums of cash when an emergency occurs. For example, as a precautionary strategy, some women belong to more than one informal insurance scheme or become clients of multiple MFIs to widen their options.

Coping Differences by Wealth Levels

While everyone stands to benefit from formal insurance, few among the poor currently see it as an option. In all three countries, formal insurance is viewed as the province of the rich and affordable by only the top economic levels of the population. There is a sense that only higher-level wealth groups can afford to take more precautionary measures to avert illness and to protect against property loss due to theft and fire.

At the same time, informal insurance already is part of the daily lives of the urban and rural, rich and poor, even if they do not define these mechanisms as “insurance.” Many actively participate in welfare associations such as burial societies, which are informal precautionary mechanisms. However, poorer households primarily depend on risk management strategies involving reacting to a shock *ex post*. Coping

⁷ Known as *Munno Mukabi* in Uganda.

with shocks can bring costs that are way beyond the cash flow capacity of most households and can drain them of existing resources. Feeding the family and keeping children in school when cash flow is reduced or interrupted are among the heavy burdens that must be addressed. Coping strategies that involve borrowing often exacerbate the pressures of debt that overhang many poor households and make the escape from poverty seem ever more distant.

The very poor have fewer options for managing risk proactively and often fall out of informal group-based systems if they cannot keep up with the reciprocal obligations. With often weak state systems of social protection, they must then depend almost entirely on self-insurance mechanisms that are likely to be grossly inadequate. A few are lucky but many remain in debt, moving from crisis to crisis in a permanent race to stay one step ahead of the next shock.

Reducing Vulnerability with Microinsurance

Most of the informal and self-insurance risk management tools discussed above have been well-honed over the years, evolving to respond to new diseases like HIV/AIDS, new pressures such as the privatisation of segments of the health system, changes in the financial services market, and changes in the cost of shocks relative to income.

Meanwhile, microinsurance covering loans, life, and health costs is being tried within the region. So far, these products have met with varying degrees of success. The voices of the respondents in this study suggest such products are not only needed, but are in high demand. The question is, what form of microinsurance is possible on a sustainable basis?

Health Care Financing Institution	Number of Covered Individuals
<i>Microcare, Uganda</i>	776
<i>CIDR, Uganda</i>	837
<i>Kitovu Patient's Prepayment Scheme, Uganda</i>	1,750
<i>MediPlus, Kenya</i>	65,000
<i>Community Health Plan, Kenya</i>	100+
<i>Poverty Africa, Tanzania</i>	600
<i>Community Health Fund, Tanzania</i>	330,000

Of these institutions, five of them absorb the insurance risk of their programmes. They have no insurance or significant reserves to buffer them from significant claims. MediPlus purchases insurance to cover in patient and outpatient risk, and thus holds no insurance risk. The Community Health Fund is a project of the World Bank and the Government of Tanzania. It is very popular because they collect very small premiums from members. The Government pays for all normal expenses of the clinics and hospitals with funds external to this program. Thus, their fund continues growing. However, the fund is used to purchase additional drugs when those supplied by the government are depleted (which actually occurs infrequently). They also use this fund to construct new clinics, though the Government pays the ongoing operational costs of the facility. Therefore, in the case of CHF, the Government retains the risk and there are limited demands on their premiums.

The study examined seven institutions that work with groups of poor people (see table). Their markets include employers with low-income employees, microfinance institutions (MFIs), village groups, and others. These institutions facilitate the marketing of their product. Those working with employers found this superior to working with MFIs because, usually, a single person makes the decision for everyone. Among MFI clients, there is often the need to convince all members of each group to join a microinsurance programme. This can be a long and arduous process, and is an important distinction between working with employers and MFIs.

In the discussion below, the seven examples of microinsurance are assessed in terms of criteria that must be considered in any feasibility analysis of a microinsurance health product or service – capacity, pricing, controls, growth, reserves, and sustainability.⁸

Capacity

Each organisation studied provides services through either a single hospital or a network of health care facilities. None of them have particularly strong governance, and most have very little insurance business capacity. In two of the institutions, there were some excellent computerised systems and the benefits for the health care programme were evident. However, in neither of them was the data used to its full potential. Manual systems were sufficient for very small community-based institutions where no real data analysis is expected or attempted. Those that grow rapidly to scale, such as Medi-Plus, need to have strong skills in each of the areas critical to insurance provision. These areas include: strong governance, significant insurance based management expertise, underwriting and premium setting skills, a solid financial management expertise to protect capital, and claims management and control. With insurance, especially as one moves towards scale, skilled people, regardless of the delivery methodology, must address all these areas. Even if all are well managed but one. One lapse could bankrupt the company.⁹

Pricing

Pricing has been extremely difficult for all of these institutions. Most began with premiums that were far too low to cover the costs of claims let alone operational costs and something for a reserve. Partly this derives from a desire to charge only “what people can afford” without full consideration of the likely costs to be incurred. If these programmes are to be successful, pricing will have to be outsourced to professional actuaries, and their recommendations implemented.

Controls

The research work identified some good examples of effective policies and procedures to manage risks associated with the delivery of insurance. Two institutions have employees stationed at covered health care facilities, and one has a networked computer system to both confirm identities and to input health care transactions for immediate analysis and invoice control.

Putting Aside Policies For Marketing Expediency

Kitovu Patients Prepayment Scheme developed a policy that they would only insure people in groups, and in each of these groups at least sixty-percent must join in order for anyone in the group to be able to participate. This was imposed to limit adverse selection where only the sick might join. When it became difficult to obtain the minimum percentage of group members and growth was very slow, KPPS management decided to waive this policy. They realized the error in this decision almost immediately when client utilisation dramatically increased, as did their costs. Reserves were quickly depleted.

Most institutions have at least some well-considered controls for adverse selection (waiting periods, requirements that whole groups join or none), moral hazard (co-payments, covered drug lists, restrictions on the volume of usage), and fraud (clinical reviews, claims audits). Usually these efforts were not comprehensive and leave large gaps in the control of these risks. Additionally, for marketing expediency (and sometimes because of poor controls over field staff resulting from inadequate supervision or lack of formal procedures), these controls have occasionally been ignored. In most cases where microinsurers disregard their risk mitigation policies, the institution finds itself with a serious problem.

⁸ For a more extensive discussion of these institutions, see the detailed case studies at www.microinsurancecentre.org.

⁹ Indeed, MediPlus itself went bankrupt in 2003 due to financial control issues, even though generally their controls were strong, and management well experienced in health care financing.

Unenforceable Policies

As another control against adverse selection, institutions like CHaP require that a whole family become insured if one is to be insured. Institutions often find that simply defining the “family” is difficult – Is it everyone living in a house? Is it everyone that “eats from the same pot”? A fixed minimum number in a family? Even when the definition is agreed upon it is still hard to confirm that the insured people actually fit the definition. With large numbers of orphans in the region, close family ties, no national identification (in Uganda and Tanzania), and “flexible” names it becomes extremely difficult to enforce adherence to this policy. It is important to implement policies that can be readily enforced without providing an opportunity for people to cheat the system.

Growth

As with traditional insurance, microinsurance is a business of numbers. To manage their own risk these companies require large numbers of premium payers to make the risk pool as homogeneous as possible. This should result in a risk pool that exhibits enough diversity to minimise the potential for covariant and other mass risks that can deplete an insurers capital base. The study found that overall, *low-income microinsurance policyholders are obtaining access to better health care than those who remain uninsured. Additionally, these products are offered at premium levels that are generally more affordable to the low-income market than traditional insurance products.*

While renewals for all employee-linked groups reviewed have been high for low-income clients, other groups have shown relatively low renewal rates, which creates difficulties regarding growth. Among the reasons for this lower growth in non-employee cover include: individual decision making versus the centralised decision making, some moral hazard issues with people obtaining cover to treat a historical ailment and then do not renew once they feel themselves “cured”.

Reserves

Financially, all of these institutions have weak or non-existent reserves except the Tanzanian government programme, CHF, where local groups collect premiums for the fund but the government pays for the medications and the care. This allows the fund to grow unimpeded by health care expenditures. All the programmes studied except the CHF, have had capital problems. Only the commercial HMO, MediPlus, has insurance to cover its claims. At the time of the study, only the CIDR programme had reserves, but these have since been depleted.

Sustainability

For all of the institutions assessed, sustainability is still distant and questionable. Those accepting risk will be limited in the volume of growth they can absorb, and are continually at risk of collapse due to substantial claims volumes. Although MediPlus is insured for medical care costs, their balance sheet is somewhat precarious. Finally, with the CHF programme, the Government covers medical costs. Such coverage is unlikely to be sustainable over the long-term. Once the fund is accessed to cover medical expenses, there will need to be a likely upward adjustment in the premium, and this is sure to cause issues with members as their reserves pool is depleted over time.

Collapse!!

The one for-profit institution in the sample, MediPlus, showed a very weak capital structure and dangerous cash flow. Their systems were good and control structures seemed well conceived and implemented. However, subsequent to the study, this institution went bankrupt leaving fully paid “insured” people without any coverage and no return of their premium.

When considering the above criteria all the institutions showed strengths in one or more areas. At the same time, all showed significant vulnerabilities. The good news is that for most, vulnerability can be mitigated. For some of the smaller programmes, the remedies are likely to be beyond their capabilities. Even so, there are other mechanisms with the potential to achieve the desired result. Outsourcing certain requirements such

as pricing may be one answer. However, caution is needed. In the insurance business, one weakness even in the midst of an otherwise strong company can yield the downfall of the entire programme.

Client perceptions and preferences

To identify appropriate risk management models, both the effectiveness of the ‘established’ ways people protect against risks and the ways they cope with shocks were assessed. The following questions were analysed:

- What works well for the poor of today?
- What does not work?
- How effective are the different risk management tools in terms of criteria deemed important to the clients? (See Table 1).

The resultant findings are summarised below and organised in terms of four major categories: coverage, access, timeliness, and affordability.

Coverage

Self-insurance is used by most people but is rarely able to meet the full costs of shocks, particularly the more costly. Insufficient funds to meet the costs of a loss compel people to ‘patch’ together multiple resources to cover expenses. The resulting transaction costs are high. For many of the poor, reliant on variable incomes, the full costs of even the smallest shocks prove too much.

The findings suggest that existing formal and informal precautionary options for death cover are in demand. People contribute small regular amounts to group funds over time and gain access to lump sums of cash to meet the urgent expenses. They also come with limitations. They tend to lack consistency about the exact amount that will be forthcoming after a shock; exclusionary clauses in life insurance policies, for example for terminal illnesses, are limiting in East Africa where HIV/AIDS prevalence rates are high.

The Half-Way “Solution”

Doctors and their patients often report that after patients have paid for the consultation and the diagnostics, their funds are depleted. Thus, they will commonly buy only the amount of the medication that they can afford. This often results in situations that have important short and long-term implications for disease treatment and prevention. For example, with malaria infections, the patients may take the few pills they could buy and when the medication runs out they simply get sicker and curative care becomes more expensive. A long-term effect is an increase in drug-resistant strains of malaria. In the case of bacterial infections, they take the drugs they can afford to buy, usually enough to make them feel better but not enough to completely kill off the invading bacteria. They may improve, but sometimes get sicker – again, curative care becomes more expensive. The long-term effect: strains of bacteria that are resistant to antibiotics.

When considering microinsurance for health care, all the microinsurers visited except one offer a comprehensive curative package inclusive of in- and out-patient cover, medications, and diagnostics. CIDR groups offered exclusively in-patient care. Some, like CIDR and KPPS, offered access to preventive services such as the opportunity to purchase insecticide-treated bed nets at a discount, or health care presentations at group meetings.

With all of these programmes, exclusions and limitations are minimal yet clients still become agitated when they do not fully understand the restrictions. Microcare, for example, excludes treatment and medication for chronic illnesses. Clients do not fully understand the intention of the coverage, that is, to cover acute events. Medication for chronic illnesses like hypertension and diabetes, for example, are often more appropriately addressed by savings products than with a microinsurance programme which needs to keep its overall costs contained to maximise outreach.

The balance between what microinsurance covers and what the premium costs (and thus accessibility) is among the most difficult in microinsurance, and one with which all these organisations struggle.

Institutions that offer options for comprehensive and in-patient-only care are finding that low-income people are opting for the comprehensive cover. For example, subsequent to the visit, CIDR Uganda transferred the programme to local ownership and it is now called Save for Health Uganda (SHU). Under SHU some groups have added outpatient care to their traditional in-patient only cover because their members wanted it. Other health microinsurance programmes (outside the sample group) that offer both comprehensive and in-patient-only products find that the paid demand is much greater for comprehensive cover than for in-patient. Still, offering the options seems the best solution at least in terms of client accessibility.

Accessibility

There are several aspects of accessibility that must be considered, including access to quality health care, access to microinsurance, cost of premiums, and potential obstacles within a microinsurance system, such as making claims.

Access to health care is largely determined by cost and availability of enough cash flow to cover the costs. However, a prerequisite to health microinsurance provision is the presence, within a reasonable distance, of quality health services. Without this, health microinsurance products will not likely succeed. The weaknesses of the public health social protection systems require poor people to seek other mechanisms to manage health risks. To meet this need, such households rely largely on self-insurance and informal insurance mechanisms. Informal group-based mechanisms have the advantage of being based locally and thus can be easily accessed in times of crisis. The close family and ethnic relationships that bind much of the membership translate into group solidarity. However, these mechanisms are sometimes closed off to the more disadvantaged, both the very poor and many women. Additionally, these funds frequently cannot sustain more than one or two crises over a period, and thus there is risk in relying on them fully. This forces people to identify and manage multiple relationships in order to maintain their access, which further increases their costs.

Location often limits poor people's access to microinsurance programmes. The lack of access to quality health care providers with integrity has a stated limiting effect on the potential for microinsurance – in fact, that health microinsurance only makes sense where good quality health care is within relatively easy reach of its potential customers. Especially in rural areas, the poor are further marginalised since lack of quality health care services severely limits the potential for microinsurance. Improvement in the quality of health care systems is critical to government efforts if increased accessibility is a priority.

Transport also influences accessibility. For many people, payment of transport costs for the patient and a caregiver is the first financial hurdle they meet on seeking health care. Savings and emergency loans are effective ways to meet such needs.

Another dimension of accessibility relates to the client's relationship with the insurer. Many of the users commented that they found the *claims process* for formal life products to be burdensome. It requires complex paperwork, which is difficult for the illiterate. In terms of health cover, all the institutions visited avoided this issue completely by paying claims directly to the providers. This eliminates the need for policyholders to generate a large pool of funds to cover the costs of their care in advance and then submit a claim for reimbursement. This method significantly increases access to health care, has the added benefit of getting people cared for earlier in the disease cycle,¹⁰ and provides greater control over quality and cost to the insurer.

The comprehensive nature of most of these health care products has the potential to cover a wide range of issues from which low-income people suffer, and thus offers a greater overall level of accessibility to health care. However, it is necessary to consider the impact of premium price on accessibility.

¹⁰ Michael J. McCord. "Health Care Microinsurance – case studies from Uganda, Tanzania, India, and Cambodia." Small Enterprise Development, Volume 12, Number 1, March 2001, pp. 25 – 38.

Several Key Components That Increase Accessibility For The Poor

- Microinsurance products that meet needs of the poor
- Premiums that fit their budgets while providing valued coverage
- Innovative mechanisms for generating and paying the premiums
- Claims payments that are made directly to the health care provider without requiring people to waste time generating funds to pay for care
- Rapid payment of claims
- Simple processes
- Quality care providers
- Profitability of the insurer to maintain accessibility for people

Finally, it may be important to think about the current links between loans and some microinsurance products, as this has a bearing on accessibility. Most of the formal insurance provision to the low-income market in Uganda is through the AIG programme with MFIs. The participating MFIs make these products mandatory for all clients, but because it is completely tied to the MFI loan, cover is unavailable if the client is between loans, or simply saving. The linking of insurance products to loans poses a significant risk to clients (unless the covered item is directly related to the loan such as credit life insurance, or insurance covering fire or theft of a fixed asset purchased with a loan). Clients see themselves as the losers when such systemic imperfections arise. This problem highlights an issue that warrants attention: how to de-link loans and insurance. The answer is complex and raises the issue of the cost of alternative collection mechanisms both for the MFI as well as the clients. Also, the requirements of the insurer must also be considered since de-linking from a mandatory product tied to loans will increase the insurer's risk. Institutions that offer savings products could shift the linkage to a savings account to facilitate low-cost transactions.

Tying Access To Borrowing Can Create Systemic Vulnerability

The Kitintale Women's Group, which is composed of Faulu Uganda clients, found themselves with a large number of angry members following the death of member in another Faulu group. The family had not received any compensation even though at the time of the death the deceased had been approved for a loan but it had not been disbursed. Since she was technically not in the loan cycle, she was not covered by the Faulu Life Insurance Scheme (Sebageni, 2002).

Timeliness

Timely disbursement of claims, flexible systems of premium payments, the trust that underlies their basic tenets of reciprocity and their integral role within the community help to explain the popularity and persistence of the many welfare associations that provide funeral insurance and, in some instances, emergency loans. They are well understood by the target populations they serve and can quickly verify claims of death. Two of their inherent weaknesses are fraud and systems of payouts that often depend on an irregular flow of funds.

Although accessing credit from both formal and informal institutions is a widely used self-insurance strategy in the region, the experience is mixed when time is of the essence. When one is mid-cycle with the MFI or it is not the time for a draw in a ROSCA, these mechanisms are weak. Burial societies that offer lines of credit, ASCAs, and moneylenders can respond quickly. Some charge high rates of interest, making them rarely primary sources. However, they fill the gaps when families find themselves needing to meet expenses quickly.

Formal life insurance as currently delivered through MFIs provides an example of a timeliness problem. People purchase the policies usually to address three issues:

1. To pay off their loan in case of death
2. To pay for their funeral and all that goes with it
3. To provide some additional funds for the family's economic transition

Two of these are not particularly time-constrained, but paying for the funeral does require significant funds very soon after the death. The formal insurance structure has not been able to get claims paid within the one

to two days that are required for this aspect of the claims utilisation. Often these claims take two weeks or more to be disbursed.

Timeliness in claims settlements is critical in terms of health care cover as well. It was observed that the period between receipt of the invoice and payment to the health care providers was lengthening month after month for some of the health microinsurers. This reflects negligible reserves, as well as a poor cash flow, both of which can be attributed to pricing problems. This sets in motion a long-term downward spiral. Health care providers cease to treat “covered” patients without cash. This reduces the credibility of the microinsurer so people stop paying premiums, and the insurer begins to fall into an ever-deepening financial pit. As noted, one institution, MediPlus, was closed for this reason.

Affordability

Affordability is a critical ingredient in any product. If the market cannot afford the product, the organisation will have wasted its time developing it. This research showed that for poor people and institutions trying to sell microinsurance to them, affordability should be looked at in a broad sense.

Affordability is not simply a question of whether or not the family has the money to buy the product, it is also integrally linked to the willingness to pay in its broader sense. These broader components include:

- ❑ How well do the product and its components match the specific demand from clients? Institutions that conducted demand research, like MediPlus and CIDR, found that people were extremely interested in the product. CheaP, which responded entirely to client desires (neglecting the needs of the institution), had tremendous demand. This makes demand research critical. Product flexibility is often required in terms of the supply – demand match. Often coverage components are adjusted to find just the right fit for the client and their budgets. For example Medi-Plus offered comprehensive, inpatient only, and outpatient only products that allowed clients to choose the appropriate risk management tool for their needs.
- ❑ How will people have to pay the premiums? As with microfinance, these institutions have found that if they can break the premium into smaller pieces the product becomes more affordable. Microcare saw this when one of their MFI partners began offering a loan that allowed for a stretching of the payments. It is often difficult for the poor to generate large lump sums in a short period. Institutions need to work more on developing efficient mechanisms for collecting periodic premiums. An additional consideration is the timing on their income flows. MFIs need to develop mechanisms to take seasonal payments where appropriate.

Seasonality Sensitive Premium Payments

With the collapse of crop prices, people in rural Mbarara have had real poverty issues. They barely manage to meet the MFI repayments. However, it was also clear that incomes and savings are relatively high during the harvest season and this would be the best time to charge a one-time premium for an insurance product. If a premium were to be charged in instalments, it would make sense in the rural areas to tie the scheduling of the payments to the harvesting season, even if it overlaps across two years (Sebageni, 2002).

- ❑ What is the total cost of the cover? KPPS clients found that even though the premium cost was relatively low, those who lived in town suffered heavy transportation costs. CIDR members found that their cost was reduced by only covering in-patient care, but two of every three who went for care were not admissible and thus were required to pay for the consultation at the hospital as well as the transport for them and a caretaker. When institutions can keep the total cost down, these products are more likely to be successful.
- ❑ What is their understanding of the product and do they trust those who deliver it? Microcare found that distrust of their marketers make sales of their product difficult. When MFI credit officers tried to sell the product, they had much more success (as long as they were well trained). Additionally, it is difficult to sell a product to someone who does not understand the product, so CIDR conducted extensive trainings for their potential members before they even tried to sell the product. This is a common problem with trying to assess how much someone

will pay for a microinsurance product. Too often, as with CheaP, people are asked how much they would pay for an undefined “insurance” product. This then becomes the basis for the costing and it always leads to disaster. There is a need for much client training as a foundation for marketing.

- ❑ What is their disposable household income? What funds they do have are certainly relevant to affordability.

The cost of outpatient care for institutions that offered it represented between two-thirds and three-quarters of the total risk premium, or claims costs, of their comprehensive cover. Clearly, obtaining care at an earlier stage of an illness, as doctors report that Microcare clients do, will help to hold down in-patient costs. However, outpatient costs are often reasonably bearable by this market. Where poor people report the greatest difficulty is with hospitalisation costs which are frequently beyond the regular means of low-income households. Thus, a hospitalisation-only policy could reduce the cost of cover to as little as one-quarter to one-third of the cost of these comprehensive policies. This would have an important positive impact on both the potential for sustainability for the institution, and access for the low-income market in an area that is critical. Sometimes the answer is not microinsurance at all, and institutions should be considering savings or credit products to help their members or clients manage their risk affordably.

Community-Based Insurance or Emergency Credit?

CIDR members settled on two health risk management options to offer to their groups. The first is a community-based insurance programme with risk pooling, and the other is an emergency credit facility. Both are linked to a local hospital and cover in-patient care only.

The insurance program requires a recurrent annual *premium* payment at the beginning of each year. The emergency health care credit programme requires all members to contribute a set value of *capital*, equivalent to the first year premium. This forms the capitalisation for the loan fund. All funds are held at the partner hospital, which provides treatment when someone from the group requires in-patient care. Charges are paid directly from the accumulated fund. At subsequent annual renewal periods, members of credit groups simply pay a small fee to cover the minimal operating expenses.

The loan is repaid to the group with no set repayment dates except that full amount must be repaid within three months of hospitalisation. These groups charge no interest. With the insurance program, there is no repayment to the group.

In the first year, all groups were insurance based. In the second year, most were insurance based, and by the third year, all CIDR groups chose the credit option over the community-based insurance option. They found it cheaper overall, and noted that it satisfied their needs better. Several members noted that the three months repayment period allows them a chance to accumulate funds in a more effective manner (away from the desperation of the moment when someone is hospitalised), and that is what they find most helpful.

In helping low-income people manage risk, insurance is not always the answer.

The Clients’ Institutional Options

For most clients of microfinance institutions, self-insurance is the main risk management tool and comes into play following a shock. However, self-insurance strategies depend on individual resources available. As a result, they deplete assets and divert income and other resources that might otherwise be invested in productive, income generating activities. It may be the option of necessity, but it is difficult to argue that it would necessarily be the option of choice if other alternatives were available. It may cover the minor costs, but rarely covers the big expenses.

For those lucky enough to be able to use MFI resources as a coping mechanism, the typical pattern observed in self-insuring is to take loans first, and then savings to repay the loans when all else fails. In the absence of emergency loans, this works only when the loan cycle happens to be in harmony with the crisis.

Repeated shocks, combined with depleted reserves, exacerbate a household's wherewithal to cope. Productive assets and inventory are sold at great discounts to pay the debts, and the family is left with no base from which to get back out of poverty. The cost is high and long-term. Many become stuck in the poverty trap.

Well established and always evolving, welfare associations are perceived to serve their members reasonably well. However, typically they are for fairly specific, pre-defined events so are limited in what they cover. However, they do experience incidences of fraud and misappropriation of funds. They are vulnerable to the classic insurance problems of moral hazard and adverse or anti-selection. In addition, using these groups to gain access to the cash required for large expenses involves high transaction costs. Beyond the direct transaction costs, are the time costs of reciprocal behaviours implicit in accessing from welfare groups, commitments to family and friends, and the time lost from self-employment. Understanding how these organisations could lower transaction costs might provide additional insights that could be utilised in the design of more appropriate microinsurance products that could, in turn, provide another institutional option for this sector of the economy.

Implications for Microinsurance

There are many gaps that need to be addressed as the industry moves towards delivering appropriate microinsurance products on any scale. Where access is limited to microcredit clients, microinsurance reaches only a narrow band of the low-income market. Where the existence of quality health care resources is minimal, the potential for microinsurance is limited. The effective cost of insurance is still not well understood. There is much distrust of the insurance sector among the poor, mostly out of ignorance – thus significant client education is required.

Still, despite the challenges, microinsurance has a role to play in providing the poor with enhanced risk management options. The demand, not just the need, for microinsurance is high. Responding with flexible and appropriate products and services is an enormous challenge. The demand analysis points to product design elements worthy of consideration. They include:

- Separate out the different risk elements of health or life/funeral/loan insurance.
- Provide differentiated products able to meet different needs.
- Time premium payments to match income flows.
- Assess the range of formal and informal insurance options to gain a better understanding of effective demand.
- De-link microinsurance from microcredit, and premium payments from loan disbursements.
- Focus on protective mechanisms for property loss rather than *ex post* insurance.
- Learn from the advantages and disadvantages of reciprocity and social obligation in informal group-based insurance mechanisms.¹¹

To cope with death, the poor will benefit if the major costs can be separated out and constraints removed:

- Life insurance should cover the needs of the household as they see fit.
- Life insurance should be available to the poor even when they choose not to take a loan.
- Credit life insurance should cover the balance on the deceased's outstanding loan to relieve the bereaved of any financial contracts with the MFI.
- Loan and life insurance, currently offered together, should be split up. This may be more complex for the insurer, but it would offer customers a choice that may correspond better to effective demand.
- Funeral insurance should cover the costs associated with the burial rites. This should be designed within the context of traditional practices.

¹¹ These traditions provided the basis for solidarity group lending.

- If the lessons of microcredit are to be heeded, the group dynamics of the welfare associations might provide a basis for collecting premiums and making claims that can lower transaction costs for the supplier and the consumer. Insuring the group rather than the individual is easier and cheaper.
- Cover for widowhood should be explored as a separate insurance policy, or a rider might be included in a general life insurance policy for male spouses to ensure that jointly owned assets are protected for the women.

Framing any discussion of health insurance for the poor is the high level of unpredictability of health shocks together with the limited household cash flow of most poor people. While the potential for health insurance is clear, health insurance needs to be supported by accessible, quality health services. Six specific component areas of coverage identified in the study are:

- Outpatient services which cover visits to a range of health service providers.
- Hospitalisation.
- Long-term illness and related care as a result of HIV/AIDS, TB and other chronic illnesses and sickness relating to old age.
- Transport to cover the costs incurred by both the sick person and their caretaker who accompanies them to a health service provider.
- Medications.
- Preventive measures such as insecticide-treated mosquito nets.

Health microinsurance is not likely to meet all the costs related to all these components with a premium reasonable to this market. Teasing out those costs that can be supported in other ways seems an important first step in assessing the options. Other possibilities that might be considered include linking informal insurance associations with formal insurance providers as well as with other services, to enhance not replace current informal measures. Emergency loans, small amounts of money that can be disbursed quickly and repaid over a relatively short period, have an important role and draw on skills that MFIs already possess.

The protection of assets would seem an obvious market for microinsurance. The demand is high and the objects to be covered are primarily productive assets, equipment, or buildings. At the same time, the problems of moral hazard and fraud suggest that the risks to the insurer are extremely high. Until the many stumbling blocks are overcome, perhaps the emphasis should be on precautionary strategies and campaigns to protect assets ahead of time -- locks, keys, burglar bars, smoke alarms, association-paid security guards, anti-crime campaigns (theft and arson), fire extinguishers, and fire prevention education might have a greater pay off.

There is also a critical role for selected non-financial services that will increase the success of any microinsurance initiative. One of the recurring impediments to introducing microinsurance in East Africa is people's limited comprehension of the concepts of insurance. To counter this, it is clear that insurance education targeted at both the front line staff with responsibility for selling the microinsurance products and facilitating the initial basic servicing of claims, and the potential individual policyholders is needed. This is key to raising the acceptance and therefore success of a viable microinsurance programme for the poor. This will likely require efforts of the insurance commissions, insurance companies, and other external forces.

Lastly, it is important to recognise the role of the state. It will continue to provide social protection services to the poor, particularly with respect to health insurance. For many, hospitalisation in a government facility is their only option. However, these were reported as being corrupt, providing poor quality care, and frequently lacking drugs.¹² National health policies should be understood before introducing private microinsurance. The equity of user-fee policies should be assessed, as should the affordability and accessibility of services for the poor. An evaluation of the gaps in the market and the complementarities will suggest where the greatest opportunities exist for microinsurance to extend service provision and quality care to those currently un-served or under-served. The state also has a role to play in the protection of homes, businesses, and other assets from theft, vandalism, and fire through systems that enforce the rule of

¹² The CHP case is an effort by the World Bank and the Government of Tanzania to mitigate these problems, and in fact their members report a significant improvement in the availability of drugs at the district medical facilities.

law and promote safe communities. Regulatory systems that set building codes to reduce the risk of fires and public safety systems that provide fire and other emergency services are other areas where the state has a role to play.

Conclusions

There is a clear demand for providing microinsurance services to help the poor better manage risk both *ex ante* and *ex post*. Microinsurance can help poor people better manage risk and avoid falling back down the poverty ladder when faced with shocks. From the interviews with current or potential microinsurance clients, health care providers, insurers, and intermediaries like MFIs, it has become clear that microinsurance is a key in the process of poverty alleviation. Simply offering credit or savings is not enough to help the poor maintain the gains they have earned. It is time to respond to the expressed demands of the market and develop products that will help them better manage risk.

Responding to these demands with appropriate microinsurance products and services will take time and will be a tough challenge, but one that is well worth addressing. However, these must be addressed by institutions that are strong and professionally managing their own risk. A simple desire to help the poor is not nearly sufficient to manage an insurance business. The total risk must be assessed and whatever tools are offered, in whatever method, they must reduce the overall risk to client, intermediary, health care provider, and insurer. It *does little good* for CHaP to offer a product that will undoubtedly damage all the good works of their larger organisation. It *does not help* for MediPlus to collect premiums and then find themselves bankrupt and unable to care for their insured clients, leaving them even more vulnerable. It *does not help* for Poverty Africa to offer their product with so few controls and no reserves that they cannot pay the doctors that care for their members.

There is tremendous opportunity in the low-income markets of these countries where formal insurers cover the top five to ten percent of the population, leaving the rest to fend for themselves. The institutions studied are trying to service this market and are learning important lessons along the way, and most do try to apply the lessons as they move forward. These cases show us that realising these opportunities will take much effort, as well as the implementation of lessons learned and those yet to be learned.

These institutions provide many lessons for developing similar programmes. An overriding lesson that is reiterated in different ways in almost every case is that to develop an insurance business, an institution needs to have the expertise and risk management tools of an insurance company. Indeed, a company should be a formal insurer to take health insurance risk. Insurance companies are specialists in this complex business, have access to reserves and reinsurance, and are overseen by insurance supervisors. Non-insurers put their own business at significant risk, and they risk the capital and confidence of their clients. Non-insurers should identify an insurance partner, or not offer insurance.

Some other key lessons include:

1. *Management and Governance*

- ✓ To make microinsurance programmes successful, management capacity in insurance *is* necessary in the institution that manages the insurance risk.
- ✓ Because microinsurance is a complex business and management and staff of MFIs have weak capacity in microinsurance company management, it is highly preferable for them to stay away from taking any health insurance risk. If they cannot be dissuaded from insuring directly, it is imperative that their boards be strengthened regardless of the model being implemented. The requirements of insuring health successfully are much more than most institutions can manage. Even most regulated insurance companies refrain from offering health cover.

2. *Microinsurance Products*

- ✓ Emergency loans with disbursements made directly to the health care facility can be appropriate and sometimes preferred over insurance.

- ✓ Follow a systematic product development process when developing these products¹³. When this is done, issues are caught early and cause fewer problems to the institution.
 - ✓ Lack of quality health care providers has a limiting effect on the potential for microinsurance outreach.
3. *Operations and Accounting*
- ✓ Pricing of microinsurance products must improve. If they are to be successful, microinsurers must work with professionally derived premiums.
 - ✓ Underwriting needs to be simple and efficient for the low-income market, complex requirements simply confuse potential clients and the staff that try to sell it.
 - ✓ Microinsurers need accurate accounting and timely access to management data including specific utilisation data for health plans.
4. *Marketing*
- ✓ Strong and innovative marketing management is a critical ingredient in creating an effective commissioned marketing team.
 - ✓ Marketing requires a strong component of market training to get potential clients to understand insurance and how it works. This may be one of the most important lessons.
 - ✓ Employers of low-income employees have proven a very good market with efficient access.
5. *Risk Management*
- ✓ The closer the microinsurer's staff are to the health care facility, the easier it is to manage controls adequately.
 - ✓ The partner that carries the risk should be well capitalised and willing and able to lose some money while the product is growing.
 - ✓ A review of the total risk of the system – insured, intermediaries, providers, insurers, and others – must reflect a reduced overall risk for any product that is being considered. This results from placing the risk where it is most effectively managed.
6. *Provider/Insurer/Intermediary Relations*
- ✓ MFIs have been weak partners in microinsurance. Microfinance institutions must become more committed and involved in terms of staff incentives and support products if they are seriously interested in getting health microinsurance to their clients.
 - ✓ Construct formal agreements with partners so that everyone is clear about their role.
 - ✓ Conduct due diligence exercises on partners. These programmes can go very wrong, and a good institution should not become embroiled in problems because of a partner's issues.
 - ✓ Coordinate external health information outreach programmes with microinsurance.

These institutions are blazing trails in a new realm. Their experiences help us all to carve out a better, more efficient, and more effective methods on the way to achieving the lofty goal of improving access to high-quality health care for low-income families.

¹³ The *MicroSave* website www.MicroSave.net has useful resources to support such a process.

Next Steps

Some next steps in the further exploration of what might make microinsurance successful:

- ❑ The conclusions of this synthesis point to the importance of linking a market analysis of the potential customers' preferences, as well as their existing insurance landscapes, with institutional assessments. It is important to understand better the linkages between the demand and supply side in creating, marketing, and servicing products.
- ❑ The lessons learned here have come about through an assessment of the present and historical activities of the institutions. Those interested in microinsurance need to take these data and data from other sources to begin to develop a framework or matrix to help develop a better understanding, in advance, of the potential for success of a microinsurance product and implementation structure.
- ❑ A preferred model of microinsurance delivery is the partnership model that uses formal sector insurers with other groups that serve low-income populations to form an efficient distribution channel. MFIs are one example of this type of intermediary. The cases in this study showed that this model requires a more serious intervention on the part of the MFI in terms of training staff, using incentive schemes and staff objectives, and developing symbiotic products. More work is needed to understand better how to integrate these into the MFI environment.
- ❑ These cases and this demand work have provided important insight into the demand for and supply of microinsurance in East Africa. These studies should be considered as new studies are completed so that a pool of accumulated knowledge is created, rather than simply independent studies. This could help to develop more quickly a better global knowledge of best practices in this field.

Table 1: Respondents Insurance/Risk Management Landscape and Perceived Effectiveness

Insurance/ risk management mechanisms	Risk	Ex ante or Ex post	Terms and Conditions	Effectiveness		
				Coverage	Accessibility	Timeliness
SELF-INSURANCE <i>Low-Stress Coping Strategies</i>						
MFI	Death Sickness Fire	Ex post		<ul style="list-style-type: none"> • Advantageous primarily when person has access to multiple loans from MFIs. • Savings accounts often too small. • Few MFIs offer short-term emergency loans. 	<ul style="list-style-type: none"> • Function of whether savings account is mandatory or voluntary. 	<ul style="list-style-type: none"> • Depends on place in loan cycle - unavailable if between loans. • Depends on type of savings account.
ASCAs, ROSCA	Fire Sickness	Ex ante		<ul style="list-style-type: none"> • Loans and savings services vary by ASCA and ROSCA. 	<ul style="list-style-type: none"> • ASCAs collateral requirements can be an obstacle. • ROSCAs may not offer large enough payouts. • ASCAs can be good for emergencies. 	<ul style="list-style-type: none"> • Depends on place in rotational cycle • ASCAs can be timely
Change behaviours ¹⁴	Death Sickness Fire	Ex ante		<ul style="list-style-type: none"> • Depends on quality and supply of existing health and utilities infrastructure. • Cheaper schools may have lower standards. 	Services may be available in urban and peri-urban areas but scarce in rural areas.	
Writing a will	Death	Ex ante	Requires multiple persons to hold copies of the will.	<ul style="list-style-type: none"> • Limited to available owned assets 	<ul style="list-style-type: none"> • Illiteracy and few legal support services limit the ability of women to write wills and exercise their rights. • Harassment from in-laws and cost makes a will difficult to enforce. 	<ul style="list-style-type: none"> • Cumbersome legal processes.

¹⁴ Seek early medical treatment; keep out of trouble; maintain good business relationships, turn off electrical appliances; buy fire extinguisher; hire security guard. Also includes use of condoms and mosquito nets.

Insurance/ risk management mechanisms	Risk	Ex ante or Ex post	Terms and Conditions	Effectiveness		
				Coverage	Accessibility	Timeliness
SELF INSURANCE Medium-Stress Coping Strategies						
Loan from Money lender	Sickness Fire	Ex post		<ul style="list-style-type: none"> Amounts available vary. 	<ul style="list-style-type: none"> Interest rates high. 	<ul style="list-style-type: none"> Available when needed.
Sell family labour	Fire	Ex post		<ul style="list-style-type: none"> Depends on number of economically active people in household. 	<ul style="list-style-type: none"> Dependent on labour demand 	<ul style="list-style-type: none"> When migration required the time lag before remittances are received can be long.
SELF INSURANCE High-Stress Coping Strategies						
Savings and asset depletion ¹⁵	Death Sickness Fire	Ex ante Ex post	Many men do not want women to hold assets in their names.	<ul style="list-style-type: none"> Value of saleable assets often limited. Asset sale often at a fraction of real value due to immediate need. 	<ul style="list-style-type: none"> Savings institutions need to be accessible from client's home or work. Dependent on demand for saleable assets. 	<ul style="list-style-type: none"> Savings often not accessible when needed. Assets perceived as quick source of cash but may have to be sold below market price.
Deceased's children sent to relatives	Death	Ex post	Long-term family instability.			
INFORMAL GROUP-BASED INSURANCE						
Friends in Need groups ¹⁶	Death Fire Sickness	Ex ante	Membership requires regular payments.	<ul style="list-style-type: none"> Loans available from groups. Does not cover MFI debts. Covers ritual of funeral; rarely meets full cash needs. 	<ul style="list-style-type: none"> Source of support within immediate community so can be readily accessed. 	<ul style="list-style-type: none"> Readily available at time of shock.
Burial Societies	Death	Ex post	Reciprocity is key.	<ul style="list-style-type: none"> Subsidises main funeral costs.¹⁷ Multiple memberships often required to cover full costs. Loans available from some groups. Funds limited when group 	<ul style="list-style-type: none"> Locally based so can be readily accessed. 	<ul style="list-style-type: none"> Readily available at time of death.

¹⁵ Includes animals, land, housing, means of transport, and consumer durables.

¹⁶ Munno Mukabi; Bataka Mwezike; and burial and funeral societies.

¹⁷ Covers food, transport and coffin, and members contribute time to funeral preparation and sitting with body.

Insurance/ risk management mechanisms	Risk	Ex ante or Ex post	Terms and Conditions	Effectiveness		
				Coverage	Accessibility	Timeliness
				experiences many funerals.		
Financial support from family and friends	Death Sickness Fire	Ex post	Fear of providing credit to troubled person.	<ul style="list-style-type: none"> Works best when need is small (less than US\$10). Coverage weak for covariant shock. 		Often unable to help at time of shock.
Approaching local leaders and church group for help	Sickness	Ex post		Small amounts of money.	Often difficult to access.	
<i>Harambees</i> ¹⁸	Sickness Fire Theft	Ex post	Reciprocity is key.	<ul style="list-style-type: none"> Best suited for covering large expenses such as hospitalisation. Costly to organise and fund raiser may not meet target. 		<ul style="list-style-type: none"> Needs planning. Inappropriate for immediate emergencies.
FORMAL INSURANCE						
Life Insurance through MFI	Death	Ex ante	<ul style="list-style-type: none"> Can exclude certain illnesses. Intended to cover outstanding balance and other expenses. 	<ul style="list-style-type: none"> When fee is percentage of large loan, cost is perceived as excessive. Focus of coverage usually limited to loan repayment. 	<ul style="list-style-type: none"> May require complex paperwork, which is difficult for illiterate. Claim process can be burdensome. Mandatory cover offers simple access. 	<ul style="list-style-type: none"> Unavailable if individual or group is between loans.
Health Insurance	Health	Ex ante	Exclusions, drugs, testing and in/out-patient coverage, payment systems vary by policy	<ul style="list-style-type: none"> Depends on quality and supply of existing health and utilities infrastructure. Comprehensive health care remains unaffordable for many of the poor 	<ul style="list-style-type: none"> Proximity to health service provider is limiting factor. For some programmes access defined by use of MFI services. 	<ul style="list-style-type: none"> Transaction costs raised by drug unavailability, waiting time, especially with cover that relies on government facilities.
Property insurance through MFI	Fire	Ex ante	Verification of loss from fire is complex.	<ul style="list-style-type: none"> No experience in the region. 	<ul style="list-style-type: none"> May require complex paperwork for illiterate. 	<ul style="list-style-type: none"> Unavailable if between loans.

¹⁸ Kenya only.