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THE LANDSCAPE OF MICROINSURANCE IN AFRICA

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EXECUTIVE SUMMARY

This paper provides a detailed picture of the landscape of microinsurance activities in Africa. It is based on a study that was conducted in 2009 (using 2008 year-end data) by the International Labour Organization's Microinsurance Innovation Facility and the MicroInsurance Centre in collaboration with the African Insurance Organization, the Fédération des Sociétés d'Assurances de Droit National Africaines, the ILO's STEP Programme and the Concertation, an association of health mutual stakeholders in Africa.

MARKET OPPORTUNITY AND DEMAND

Approximately 1 billion people live in Africa, of which an estimated 60% live below USD 2 per day. These low-income households are particularly vulnerable to risks. Illness, death, natural disasters, damage to property, and accidents all can have devastating effects on livelihoods without a buffer to mitigate the financial impact.

The informal mechanisms developed by the poor – rotating savings and credit associations, depleting savings, informal borrowing, selling assets, taking children out of school - offer short-term protection at long-term costs, preventing escape from poverty. Furthermore, most individuals in Africa cannot count on government safety nets to mitigate risks. Failure of informal schemes and government-led programs opens a significant window of opportunity for microinsurance.

Microinsurance is not an appropriate product for the destitute (the poorest group of 200 million), but instead serves the needs of the working poor and the vulnerable non-poor. These two segments constitute a **microinsurance market of approximately 700 million people**. The annual income of this group is approximately 500 billion USD (World Bank, 2007). Assuming a potential for insurance expenditure levels of 5% of GDP (Sigma 3, 2009 figure for South Africa), the value of the market for microinsurance in Africa is approximately **25 billion USD**. One can further estimate the market for a few generic microinsurance products: 560 million lives for health insurance, 300 million lives for life products, 75 million lives for credit life, 65 million policies for agriculture and 100 million policies for property.

CURRENT OUTREACH

The current outreach of microinsurance in Africa falls far short of these figures. The landscaping survey found that 14.7 million lives were covered by microinsurance, accounting for around 257 million USD in received premiums. This indicates that only **2.6% of the target population currently uses microinsurance products**, or, the **current value of gross premiums received from the microinsurance market in Africa is only 1% of its potential value**. The majority of providers surveyed recognize this potential: over 70% partially or fully agreed that the number of microinsurance policies in their national market will grow over 10% in the next year, and around 40% agreed partially or fully that the market penetration will double in the next 5 years.

Life insurance products dominate the African microinsurance landscape. Of their estimated potential market size, credit life products cover close to 9.5%, and other life products cover about 3.2%. Health products, those which are often cited as the most in need, only cover about 0.3% of the low-income population, with property and agriculture covering significantly fewer in numbers, but about 0.2% and 0.1% respectively of their potential markets. These figures clearly demonstrate that there is great potential for microinsurance expansion and growth in Africa.

PROVIDERS

A wide variety of providers constitute the current microinsurance market in Africa. The survey identified 134 schemes run by regulated insurers, 386 health mutuals or community-based schemes and 24 insurance programs managed by other risk carriers. The vast majority of the health mutuals are found in West and Central Africa. The geographical spread of regulated insurers is more consistent, though they are slightly more prevalent in West and East Africa. In terms of premiums received, regulated insurers dominate the microinsurance market, representing 88% of premiums received in 2008.

Mutuals/community-based organizations and MFIs appear as the most significant delivery channels, but there is a substantial effort to broaden the range of delivery channel types. Particularly in South Africa and Kenya, there are experiments with alternative channels such as retailers or mobile phone providers. Massification of microinsurance will require improved penetration through MFIs, as well as expansion through other potentially untested delivery channels.

CHALLENGES

Survey respondents were asked several questions regarding the limitations to microinsurance expansion in their markets. On the demand side, respondents felt that expansion was hindered most by potential clients' lack of understanding about insurance (80%) and their limited ability to pay premiums (72%). On the supply side, hindering factors were a lack of information technology (78%), high administrative costs (71%), and a lack of qualified personnel (73%).

Examining the responses by insurer type, health mutuals report that difficulties arise from a lack of technology, management and staff capacity, clients' ability to pay premiums, and access to reinsurance. Commercial insurers' issues centre on reducing administrative costs through technology, as well as scepticism about market demand. In more mature markets, risk carriers see a predominant need for consumer education to facilitate sales and general understanding of insurance concepts.

FUTURE IMPLICATIONS

Though there is significant microinsurance activity in certain regions, the majority of the African continent remains a vast and untapped market. It is possible to reach hundreds of millions of low-income people in Africa with microinsurance, but the growth of the industry will require solid foundations. A diversity of providers, informed clients who understand the value of microinsurance, innovative distribution channels, improved efficiency and human resource management are all critical components to success – and not all can be achieved by providers' efforts alone. Donors and governments must support these efforts, creating a coordinated movement to provide tools that will help low-income Africans manage risks and lead safer, more stable lives.

1 > INTRODUCTION

In various forms, microinsurance has been available to some low-income people in Africa for a number of years. Cooperative Insurers have serviced a market that spans the income ranges since the 1970s. In the 1980s, community-based health insurance schemes, especially in West Africa, followed the Bamako Initiative. In the mid-1990s, commercial insurers began to enter the market, offering specialized microinsurance products. Informal microinsurance has been available for decades in a range of forms, from "tontines" in West Africa or "friend in need" groups in East Africa to burial societies in South Africa. Over the last ten years, insurance has developed into a widely recognized financial intervention to help Africa's low-income populations to manage their financial risks.

To facilitate broader high-quality expansion, it is helpful to develop a quantitative knowledge of the landscape of microinsurance in Africa. This paper presents and discusses findings of a study conducted in 2009 by the International Labour Organization's (ILO's) Microinsurance Innovation Facility and the MicroInsurance Centre in collaboration with the African Insurance Organization, the Fédération des Sociétés d'Assurances de Droit National Africaines (FANAF), the ILO's STEP Programme and the Concertation, an association of health mutual stakeholders in Africa. Based on 2008 year-end data, this study expands and updates previous work to provide a detailed picture of microinsurance activities in Africa.[1]

This paper defines microinsurance as an insurance product that is accessible to low-income households.[2] Mandatory health mutual schemes for the formal sector (no option to opt-out) are not taken into account. Also excluded are historical and emerging national social security schemes, which may be an important source of financial risk management for low-income people, especially for health. Such social security schemes cover over 5 million people in both Ghana and Rwanda. In addition, South Africa, Tunisia, Libya and Egypt, among others, provide some social security for health and disability risks; these systems were also excluded from the sample.

Starting in mid-2009, the first phase of the study included a request for basic data through an on-line survey tool, to which 262 risk carriers, delivery channels, and support organizations responded. Those institutions that covered more than 5,000 lives were asked to provide more detailed information through a phone interview. With the help of several key informants and extensive contacting efforts, the majority of significant organizations were identified and included in the study. Furthermore, a number of secondary sources on microinsurance was used to cross-check and verify the accuracy and completeness of the data collected. Although there are probably some microinsurance schemes that have not provided information, the resulting data were compared to other partial studies and no major gaps were identified except for Mali (which should have more health mutual schemes) and Nigeria (with more activities in life insurance than reflected in our data).

After collecting the data, a thorough data-cleaning effort resulted in the removal of erroneous and redundant information. The resulting dataset includes 176 respondents for the on-line survey reporting on

[1] Several efforts have been made to quantify microinsurance and its components in parts of Africa. The MicroInsurance Centre's 2007 "Landscape of Microinsurance in the World's 100 Poorest Countries" (Roth et al 2007) has thus far been the most extensive. Based on 2005 data, this study found that just over 0.3%, or 3.5 million low-income people in Africa were accessing microinsurance in the eighteen countries out of forty-one that were considered for the study (South Africa was not included in the study).

[2] To give a bit more guidance to respondents, we used the most common definition of poverty to define microinsurance: "an insurance product accessible either by price or delivery channel to people earning less than approximately USD 2 per day". It is to be noted that this definition was used to make it easier for organizations to classify their own activities as either micro- or non microinsurance. However, because of the inclusion of the word 'approximately' in the definition, we also include schemes that target those that are not poor but still vulnerable to poverty.

544 schemes and 51 organizations reporting via telephone in detail on 74 microinsurance products. More than half of the organizations are in West Africa. Central, South and East Africa accounted for 15% of responses respectively, whereas fewer than 5% of responses came from North Africa. Approximately 35% of the respondents are commercial insurers, 30% are mutual- and community based insurance schemes, around 20% are MFI's and banks, and 10% are NGO's.

The remainder of this paper is organized as follows: the next two sections discuss risk management needs of low-income households, market opportunity and demand; section 4 provides an overview of an enabling environment for microinsurance, sections 5 to 9 present key findings of the survey, focusing on outreach, insurers, products, delivery channels, financial performance and profitability; the last section presents key conclusions.

2 > RISK MANAGEMENT NEEDS OF LOW-INCOME HOUSEHOLDS

Low-income households are vulnerable to risks, a fact that is widely recognized as one of key drivers of underdevelopment (World Bank 2001). In Africa, a continent with many infectious diseases, limited infrastructure, largely agrarian populations and fragile economies, low-income people are exposed to a multitude of risks that keep them in, or push them back into, poverty. Illness, death, natural disasters, damage to and loss of property, and accidents all can have devastating effects on livelihoods without a buffer to help people mitigate the financial impact of these events.

Through the ages, households and communities in Africa have developed a range of strategies to deal with these risks, such as rotating savings and credit associations, burial societies, depleting savings, informal borrowing from friends and relatives, selling assets, and taking children out of school. There is a growing understanding that the informal mechanisms developed by the poor offer short-term protection at long-term costs – preventing any escape from poverty (Morduch 1999). This observation is further substantiated by Cohen and Sebstad (2005) in their review of risk-management needs in East Africa: *'Self insurance is used by most people but is rarely able to meet the full cost 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 poor people, reliant on variable incomes, the full costs of even the smallest shocks may prove too much.'*

Furthermore, as opposed to people in developed countries, most individuals in Africa cannot count on government safety nets to successfully mitigate significant portions of their risks. Despite emergence of potentially effective government schemes in a few African countries, outreach is still very low (ILO 2008, Leppert 2009) and it is unlikely that those schemes would provide effective protection in the medium term. Failure of informal schemes and government-led programs opens a significant window of opportunity for microinsurance to decrease low-income households' vulnerability to risks and help smooth their way out of poverty.

Insurable risks that can be tackled by microinsurance can be classified into four main categories: health, life, agriculture, property (Figure 1).

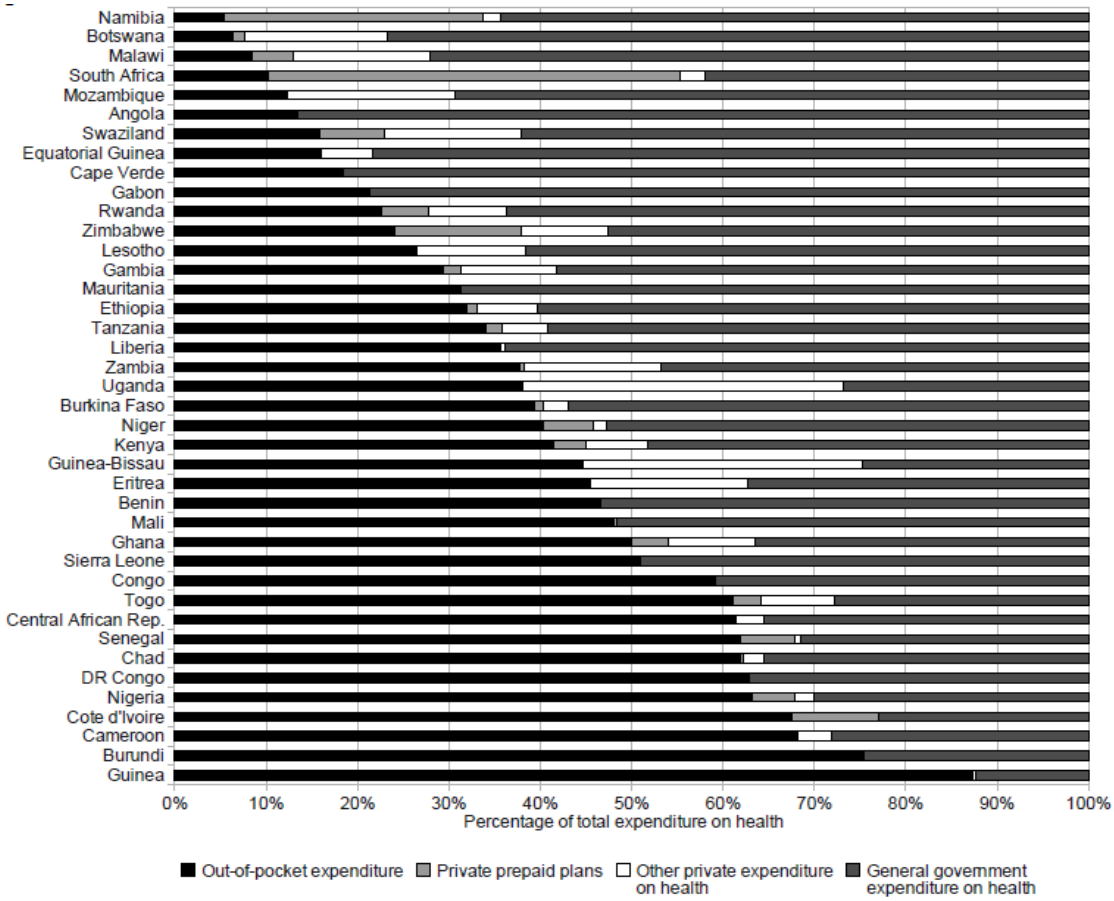
Figure 1: Insurable risks and insurance products

	Risks	Insurance products
HEALTH	Illness, hospitalization, out-patient consultations, medicines	Comprehensive (in-patient and out-patient), in-patient only, targeted benefits (i.e. maternity)
LIFE	Accident, death, total or partial disability, loss of income due to disability/death	Credit life (only outstanding loan), credit life plus (additional benefits, lives), term life, funeral, endowment, personal accident/disability
AGRICULTURE	Drought, flood and other perils impacting agriculture production; livestock disease and death	Indemnity-based crop or livestock insurance, index insurance (rainfall, prices, average area yield)
PROPERTY	Fire, loss of or damage to property/housing, theft	Home (building and contents), business assets and stock, car/motor, specific covers (i.e. fire)

Africa is plagued by disease. Malaria alone kills more than 1 million people each year (Snow et al 2005), and leaves many more sick and unable to work, yielding massive reductions in productivity. Although in some African countries healthcare coverage is financed publicly, many people still do not have access to basic medical services and medication. This is partly because the medical infrastructure is not fully developed, and partly because people do not have adequate financial resources to access the available

medical care. As is clearly demonstrated in Figure 2, medical care requires significant out-of-pocket payments which put pressure on the households' financial resources. Therefore, there is a clear need for affordable health insurance products in Africa.

Figure 2: Sources of health care financing in Africa



Source: Leppert (2009) based on WHO data from 2008.

Death or disability of a family member, especially the breadwinner, has many financial repercussions. In many communities, for example, the costs related to funerals are significant. Interestingly, this differs across different cultures from almost no cost in some areas in Burkina Faso[3] to ruinous amounts in East and South Africa (Roth 2000, Dercon et al 2006). The situation is even more complicated when the household loses an income source, which results in several months of searching for alternative sources and often leads simply to acceptance of a lower income level. Life insurance products can effectively transfer those risks. Additionally, some long-term life insurance products also function as a savings instrument, which is usually an added value for low-income populations looking for a safe place to systematically accumulate small savings.

Sixty per cent of Africans work primarily in the agricultural sector. Depending to a large degree on the weather and the health of their livestock, many farmers face great fluctuations in their income. As a result, some farmers engage in less risky agricultural practices, such as the growing of crops which are less sensitive to weather changes or the growing of many different crops in order to spread the risk of one crop failing. These strategies, although useful from the perspective of the vulnerable farmer, often come with lower average productivity, limiting the farmer's ability to generate reserves for the next crisis. This

[3] Personal conversation with Soumaila Sorgho, Director of UAB Vie in Burkina Faso, August 2008.

tendency keeps farmers locked into a poverty cycle. Weather is the main uncertainty in agriculture: as hardship caused by adverse weather conditions such as droughts and floods often strikes an entire community at once, traditional community-level risk management strategies might fail to adequately protect farmers. Elbers, Gunning and Kinsey (2006) estimate that livestock accumulation amongst Zimbabwean farmers without insurance is reduced by almost 50% as a result of adverse weather; around two thirds of this reduction can be attributed to the farmers' anticipation of the weather risk. Appropriate risk management tools can bring about a change in people's behaviour, leading to more productivity and less poverty. All in all, there is a clear need for insurance products to pool the risks on a larger scale in order to efficiently cope with the inherent uncertainty of agricultural life.

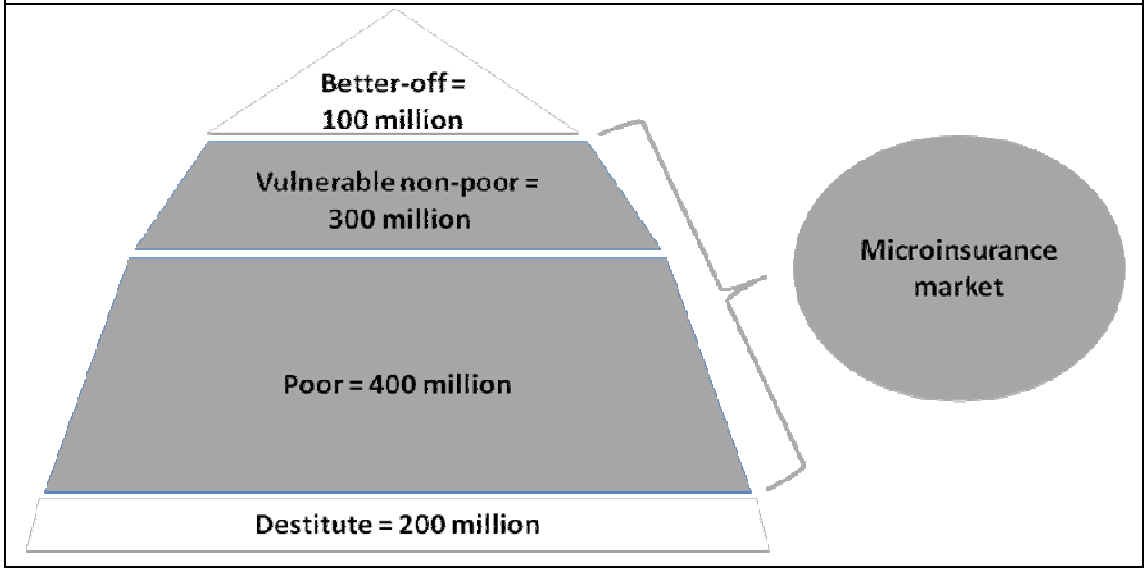
Europeans started to insure themselves after the great fire of London in 1666. Similarly, for most low-income households in Africa, the serious risk of damage and loss to valuable assets such as houses and cattle creates a demand for appropriate risk management tools. Pooling enables households to cope with the risk of property damage and loss, which is especially important for a large number of microentrepreneurs whose business assets are not protected. Although some property loss and damage risks may be managed on a community level or simply deferred in time, insurance offers a clear advantage for risks that may strike the entire community at once, such as a fire or an earthquake.

Microinsurance products for health and agriculture seem to have the greatest potential to improve people's quality of life, as these risks are listed to be most troublesome by low-income people in Uganda, Kenya, Tanzania, Nigeria, Ethiopia and Zambia (Cohen and Sebstad 2005, CCI 2007, Tadesse and Victor 2009, Hougaard et al 2009). However, it is important to note that at the end of the day all mentioned risks put financial pressure on households in a similar way. When these risks actualize, households are forced to raise a lump sum of money within a short period. Therefore, any insurance product that provides fair value and rapidly addresses the above risks improves the risk-management options of low-income households. Moreover, limiting uncertainty among insured individuals should incite them to get involved in higher-risk business activities, potentially yielding higher returns and unleashing their productive potential. Both behaviour change and effective risk transfer constitute the core role microinsurance can play in development. This simple concept gets more complicated when we consider the target group in question: a population with limited capacities to pay, low levels of education and sceptical attitudes towards formal insurance. These factors affect demand for microinsurance and are discussed in the next section.

3 > MARKET OPPORTUNITY AND DEMAND

Approximately 1 billion people live in Africa, of which an estimated 60% live below USD 2 per day[4] , and are thus classified as poor. Microinsurance is not appropriate to serve the needs of the destitute, the poorest group of 200 million who cannot afford to pay for market-priced products[5]. Microinsurance caters to the risk-management needs of the working poor and those non-poor who are still vulnerable to sliding down into poverty. As shown in Figure 3, those two segments constitute a **microinsurance market of approximately 700 million people**[6]. The annual income of this group is equivalent to approximately 500 billion USD (World Bank, 2007)[7]. Assuming a potential for insurance expenditure levels of 5% of GDP (Sigma 3, 2009 figure for South Africa), the value of the market for microinsurance in Africa is equivalent to an approximate **25 billion USD**. One can further estimate the market for a few generic microinsurance products: 560 million lives for health insurance, 300 million lives for life products, 75 million lives for credit life, 65 million policies for agriculture and 100 million policies for property.[8]

Figure 3: Microinsurance market in Africa



These figures stand in bleak contrast to the current outreach of microinsurance in Africa. In total, 14.7 million lives were found to be covered by microinsurance, accounting for around 257 million USD in received premiums. Based on the above-noted estimates, this indicates that only **2.6% of the target population currently uses microinsurance products**, or, the **current value of gross premiums received from the microinsurance market in Africa is only 1% of its potential value**. Even when relaxing these assumptions, there remains a very large market to be served. According to our landscaping survey, this potential is also recognized by the majority of providers; over 70% partially or fully agreed with the statement that the number of microinsurance policies in their national market will grow over 10% in the next year. Furthermore,

[4] Percentage of population below 2USD/day calculated by population below 2USD/day divided by total population (UN 2005).
[5] Based on World Bank 2007 World Development Indicators; as the income share of the lowest income quintile in Africa is around 5%, with average annual GDP/capita of 671USD, this implies an average daily budget of around 0.5USD/day for the average person in the bottom quintile. We assume these people are too poor to buy unsubsidized microinsurance products.
[6] It is estimated that the African population will double by 2050, implying an even bigger potential future market for microinsurance (UN ESA 2008).
[7] Based on World Bank 2007 World Development Indicators, the income share of the 2nd – 4th income quintile is around 45%, and african GDP is around 1,150 billion USD (UNDP). This gives an income of around 500 billion USD for the target market for microinsurance products.
[8] Total market sizes are specified differently for various product groups. Credit life = share of poor households (below USD 2) having credit needs (assuming 50%); Life = share of poor population (below USD 2) aged 15-64; Health = poor population (below USD 2); Agriculture = share of poor households (below USD 2) living in rural areas; Property = poor households (below USD 2).

around 40% agreed partially or fully with the statement that the market penetration will double in the next 5 years.

With such a wide open market for risk-management tools leading to potential opportunities for providers, why are there still so few people in Africa with microinsurance? Key factors in the dynamics of demand for microinsurance in Africa include:

- Insurance literacy and the perception of insurance
- Capacity to pay
- The match between what people see as needed and what is offered
- Simplicity of products and the way they are presented
- The effectiveness of traditional alternative risk management strategies
- Trust in the provider, and
- The development of related value chains and infrastructure.

Several demand studies have been carried out in Africa to identify specific risk management gaps among the low-income markets. It is important to recognize that a gap in risk management coverage does not equate to a demand for microinsurance. Until people see that microinsurance is a valuable solution, its growth will be limited.

Figure 4 shows that among Africa's low-income groups, a large share of household resources is allocated to the basic necessities of life, and an available **budget for insurance is limited**. However, the benefits of insurance do allow for households reallocating budget items to finance insurance premiums. For example, part of health expenditures could possibly be allocated to health insurance as to minimize the risk of catastrophic expenses, while not increasing the total budget spent on health. Over 70% of providers agreed fully or partially with the statement that low capacity to pay on the side of the consumers is impairing demand for microinsurance.

Figure 4: Distribution of expenditure in Africa by product and income tier

Income tier:	Poorest	Middle	Richest	Total
Food	53	44.2	35.4	**47.1**
Housing	9.2	9.1	9.8	**9.4**
Water	1.6	1.5	1.4	**1.6**
Energy	6.1	5.8	5.4	**5.9**
Households goods	10	10.5	11.3	**10.4**
Health	4.3	4.8	5.2	**4.5**
Transportation	4.4	8	11.5	**6.5**
ICT	0.5	1.4	2.8	**1.2**
Education	2.2	3.1	3.1	**2.8**
Other	8.6	11.5	14.1	**10.6**
Total	100	100	100	**100**

Source: Guesalaga and Marshall (2008)

Furthermore, it is to be noted that microinsurance does not exist in a vacuum. Over time, low-income households have developed a wide range of **alternative risk management strategies**, such as burial societies, rotating savings and credit associations (ROSCA's), and informal borrowing. These strategies, which are deep rooted in many African societies, will not be disregarded overnight, and indeed should not be, as they tend to have important social and community functions. As such, demand for microinsurance is

affected by the way microinsurance ties into and fills the gaps in these informal safety nets. Important lessons can be gleaned from these informal structures and sometimes they may even be used to link the community with formal insurance coverage.

In addition, **customers' understanding** of the value of insurance has shown to affect demand. A study by Chankova (2008) shows how education level of the household head is positively correlated with uptake of health insurance in West Africa. Studies by McCord (2001) and Chankova (2008) indicate that insurance literacy, a customer's understanding of the workings and potential benefits of insurance, is an important determinant of demand. For example, customers that do not understand insurance are frequently reported to request the return of their premiums at the end of an insurance term if they did not "use" the insurance (Cohen and Sebstad, 2005). Such misunderstandings are part of the reason for low renewal rates in microinsurance. Close to 80% of providers agreed fully or partially with the statement that limited understanding of the benefits of insurance on the side of the consumers is impairing demand.

Recent research in the field of **behavioural economics** is presenting a growing body of evidence for irrational behaviour in demand for insurance. Starting at the level of household finances, people tend to have problems with self-control regarding expenditures, and use irrational mental accounting strategies. Bundorf and Pauly (2006) show that many people who do not have health insurance actually have sufficient budget to pay the premium, but do not do so because they had already allocated this budget to another expense. Furthermore, people tend to make errors in estimating risks, especially for infrequent events such as earthquakes, which are not part of the everyday human experience. For potential microinsurance clients with budgetary constraints, this perception can make it difficult to justify paying for insurance. Also, people are more likely to buy insurance for a certain risk if the risk has recently actualized. For example, after the 1989 Loma Prieta earthquake in California, many local homeowners decided to purchase earthquake insurance **afterwards** because they claimed to be "worried that an earthquake will destroy my house or cause major damage in the future" (Palm, 1995).

An underlying cause for such irrational behaviour is a certain degree of **inability or reluctance to collect and process information needed to make a rational insurance purchase decision** (Kunreuther, 2006). For many potential microinsurance clients, the long walk to the nearest village to obtain information about microinsurance, and the corresponding opportunity cost of valuable time working on the farm, can limit people's understanding of the benefits of microinsurance. Furthermore, low levels of education, both in reading and mathematics, prevent people from effectively evaluating available information.. Particularly in Africa, conveying the value of microinsurance to potential customers is a big challenge, and the above-mentioned behavioural factors need to be taken into account for the design, marketing and education on microinsurance products.

Trust has also been identified as an important determinant of demand for microinsurance (Radermacher et al 2006). As the insurance product's value is contingent on the insurer paying claims, African consumers, especially those who have hitherto not been included in the formal financial system, require a significant level of trust in the insurance company to be convinced to buy or renew a microinsurance policy. In addition, the development of legal systems to protect customers' interests has been shown to affect customers trust (Schneider 2005).

Aside from the above-mentioned micro-level determinants of demand for microinsurance, some **macro-level factors** play a significant role as well. In particular, for agriculture and health products, dysfunctional value chains are another reason why people do not buy insurance. If a farmer does not have good access to input or output markets, the potential benefit of insurance to expand production is close to zero. When it comes to the value of health microinsurance, it is striking to note that in the Democratic Republic of Congo,

there is only one physician per 10 000 people, while there are 40 in Switzerland. The same holds true for the health care infrastructure: in Chad there are four hospital beds per 10 000 people, whereas in France there are 73 (WHO 2009). With such gaps in infrastructure, it is hard to offer valuable products and convince people to spend their money on insurance. In addition, macro-level infrastructure also plays a role in enabling providers to activate latent demand for microinsurance in Africa. For example, availability of infrastructure for marketing and sales campaigns allows providers to convince customers to buy their products. Without good roads and/or media channels, it becomes very expensive for insurance providers to inform potential customers, especially those in rural areas, about the value of microinsurance, and latent demand is less easily activated. Furthermore, the availability of appropriate delivery channels that reduce administration costs, such as MFIs and cooperatives, is important in making microinsurance cheap enough for demand to be activated.

Finally, **cultural and religious values** affect demand for microinsurance in Africa. Tadesse and Victor (2009) found that Ethiopian farmers expressed a feeling of determinism and reliance on God. When people believe that their fortunes are in God's hands, they might not realize how insurance can help them take control of their lives. As such, demand for microinsurance is likely to be affected by religious sentiments that are present in many parts of Africa. For the Islamic countries in West and North Africa, the *takaful* insurance laws add another dimension to the influence of culture and religion on demand: commercial insurance is traditionally forbidden under Islam. The low number of microinsurance schemes that our survey identified in North Africa may be a result of these laws.

Some of the aforementioned factors cannot be addressed by individual insurers; however, some of those challenges are within their control. Educating consumers, building trust and simplifying products are definitely key strategies to activate demand for microinsurance in the short term. **Investing in consumer education** will help potential clients develop a clearer understanding of the benefits of insurance and make better choices, therefore increasing demand for valuable microinsurance products (Sebstad 2005, Chankova 2008). A recent study supported by the Microinsurance Innovation Facility and the Microinsurance Network (Dror et al, forthcoming) indicates that in Africa there are currently around 50 consumer education projects on risk management and insurance. This figure reflects the sector's recognition of the importance of helping potential clients understand the value of microinsurance. Box 1 below outlines what it takes to design a good consumer education program, drawing on the work of one of the world leaders in microfinancial education, Microfinance Opportunities.

Subsequently, there is the importance of **developing trust**. When providers maintain close contact with communities and reliable claim settling procedures, potential clients become more comfortable with buying microinsurance and existing clients are more likely to renew their policies.

Finally, **simplicity of the microinsurance product** is essential (Churchill, 2006). Especially amongst potential consumers in Africa with little education and limited understanding of the workings of insurance, it is important to offer products that are easy to understand and easy to use.

Box 1: Designing effective consumer education on microinsurance

By Monique Cohen, President, Microfinance Opportunities[9]

Introducing microinsurance to the poor requires coming to grips with their lack of understanding about insurance concepts and products. Successfully interesting the poor in microinsurance requires leveraging this basic knowledge to help them understand how microinsurance can benefit them and their families. While achieving this level of understanding is a major hurdle to uptake and persistence with the product, it is one that can be addressed with

[9] For more information go to www.microfinanceopportunities.org

consumer education. Consumer education is defined as building knowledge and skills and changing attitudes and behaviours to help people to make better decisions regarding the use and management of money.

The central goal of insurance education is to improve risk management behaviour. It should also help to increase the uptake and persistence of valuable microinsurance products. It seeks to provide current and future policyholders with the tools to help them assess the value of insurance for themselves and their families. It can also help people to overcome their widespread lack of trust of insurance providers and their products.

Consumer education can be delivered through a range of delivery channels and extends from mechanisms aimed at broad outreach involving public campaigns using mass media to more focused initiatives such as comics, brochures, and posters, and to personal counselling and classroom style workshops. Experience has shown that there is no one way to deliver insurance education but rather a set of options depending on the specific objective, who is driving the agenda, their available resources, as well as the target audience.

There is growing evidence that the most desirable consumer education package is one that includes both classroom training and national-level awareness campaigns/publicity focused on what insurance is and its value proposition for the consumer. Microfinance Opportunities and the Association of Kenyan Insurers propose implementing a strategy that primarily involves awareness raising using radio. Part education and part awareness-raising, comics occupy a middle ground. Well-liked by their readers, they are a cost effective marketing strategy for insurance providers. But we must not forget that there are many potential policyholders with low literacy, so comics also have their limits. The emerging evidence also demonstrates a need for on-going insurance education for insurance agents working with low-income populations.

Designing behaviour-change education for insurance that overcomes these challenges starts with an understanding of how the low-income household currently manages risk and how insurance could improve on these practices. Promoting the uptake of insurance also requires recognition that low-income households will use formal financial instruments in combination with informal financial services, at least initially. Microinsurance rarely displaces existing risk management mechanisms entirely.

While microinsurance may be a new financial service for low-income households, pooled risk is often not a foreign concept. In many countries, low-income populations informally pool funds to manage economic shocks. The parallels between informal and formal practices of pooling provide a basis for discussing what an insurance policy is and the meaning of key insurance terms.

As we consider the alternatives for delivering insurance education to the low-income market in developing countries, the issues of market outreach, impact and budget should not be ignored.

Many wishing to enter this market appear reluctant to provide adequate resources to cover market research for product development or insurance education. Yet, in the absence of such investments, the growth of the market will remain constrained. Products that are priced right, where their attributes match household cash flow and respond to poor people's needs, are rarely the norm in the microinsurance space. Neither is quality insurance education. The demand is for more than the limited transfer of knowledge exhibited in much of the printed material distributed under the label of "financial literacy". The bottom of the pyramid is not a cheap and easy market to penetrate with a product that people initially view with distrust. Relevant education is needed for consumers to perceive insurance positively and make informed decisions.

Insurance education should build financial capabilities, placing this education in the context of real-world choices. The expectation is that if people are provided with the information to better help them manage risk and reduce their vulnerability, they will consider innovative and affordable insurance programs as part of their household financial portfolios.

4 > CREATING AN ENABLING ENVIRONMENT FOR MICROINSURANCE

By Martina Wiedmaier-Pfister[10]

Across the globe, many governments – particularly finance ministries, financial sector regulators and insurance supervisors – have recognized that expanding the insurance sector to include broader population segments can spur economic development and welfare.

The creation of a financial sector characterised by competition, market efficiency and outreach is on the development agenda of numerous governments in Africa. Enabling policies and regulations, along with effective supervision, facilitate the growth of private-sector involvement and enhance the distribution and quality of microinsurance.

The enabling environment can be defined as "the set of conditions that promote a sustainable trajectory of market development" (Porteous, 2006). These conditions include all factors that impact the operation of the market in a country, including the regulatory environment, infrastructure, and availability of information. The term is often used to refer specifically to a *facilitative regulatory framework*. To be enabling, regulation should be characterized by sufficient openness to encourage innovation (while still managing risk) and should provide operators with the necessary certainty that there will not be arbitrary or negative changes to the regulatory framework (Porteous, 2006).

Some global trends in the private sector, such as liberalization, growth in the volume of credit clients, and new developments in distribution and payment systems, also help to serve the poor by contributing to the growth of microinsurance.

Microinsurance market development has been impacted by the public sector as well. The role of governments in insurance provision has undergone a fundamental change in the past decade. For years, governments were direct providers of insurance in many developing and emerging market countries. Changes in the political environment and prevailing ideology, however, brought about a trend toward liberalization in the early 1990s. With the microfinance revolution of the late 1990s also came greater awareness of the need for financial inclusion as a public policy goal.

Governments increasingly regard market-led microinsurance as a serious option for making insurance markets more inclusive and extending their reach to low-income households. In many countries, areas such as health coverage for the destitute and agricultural insurance or pensions for the elderly poor are still covered by the government through social assistance (such as cash transfers), direct public provision (public healthcare) or subsidized insurance schemes where the market does not reach (often the case with agricultural insurance). Yet even in these areas, private-public partnerships or public models based on private management and smart subsidies[11] could offer promising opportunities.
The new paradigm is based on a shift towards the government serving as a facilitator of market development, including a clear development mandate for the insurance supervisor based on his role as a facilitator of financial access. At the same time, regulators are also realizing that facilitation alone may not

[10] This chapter has been written by Martina Wiedmaier-Pfister, a consultant to German Technical Cooperation (GTZ) and the German Ministry for Economic Cooperation and Development (BMZ) and the Access to Insurance Initiative. With comments from Michael McCord, Microinsurance Centre; and Christine Hougaard and Doubell Chamberlain, Centre for Financial Regulation and Inclusion.

[11] A smart subsidy can be defined as a one-off public trigger that seeks to catalyze market provision and therefore does not crowd out the market. Alternatively, the term can also refer to the design of a subsidy and the process through which it is implemented to present the best possible solution in the particular context.

suffice and that an active balance of stability/soundness and market development will ensure consumer protection and inclusion. Stakeholders from both the private and public sectors confirm that good policy solutions are significant in helping to spur and sustain growth while at the same time protecting consumers.

In a growing number of African countries, the call for a policy approach that enables the supply of privately-led risk-management for low-income segments has been pushed by increasing private sector engagement. Recognizing this, some jurisdictions have taken on a market development role in addition to their classic consumer protection role. Though some recent growth can be attributed to specialized regulatory frameworks, it must be noted that much of this growth has occurred without the benefits and protections of government policy.

Figure 5: Country approaches towards a national enabling policy and regulatory environment for microinsurance market development in Africa

Country	Policy and Regulatory Approach	Process and Outcome
Egypt	National and regional sensitization workshops	National workshops conducted; regional workshop in December
Ethiopia	Sector diagnostic including microinsurance strategy	National Microinsurance Strategy with all stakeholders including sector-wide dialogue and capacity building events
Ghana	Public-private financial capability campaign Microinsurance regulation	Awareness campaign supported by National Insurance Commission, Insurance Association and other private and public actors Dialogue workshop and trainings with and for industry Policy Paper on a dedicated regulatory framework for microinsurance under way
South Africa	Financial inclusion policy Microinsurance regulation	Discussion Paper setting out microinsurance market context, suggested regulatory definition of MI and suggested parameters for dedicated microinsurance regulatory framework This paper fed into a public consultation process that will inform the redrafting and refining of the regulatory framework, resulting in microinsurance legislation
Uganda	Sector diagnostic	National dialogue conducted
Zambia	Microinsurance strategy	National Microinsurance strategy process underway, Designed and implemented by a committee of industry and government stakeholders. This process stimulates sector-wide dialogue and will include capacity-building events as well as specific microinsurance development projects including regulatory reform.
CIMA code in West Africa	Sensitization of member jurisdictions in terms of a future regulatory framework	Participation in regional workshops (Senegal)

Source: Author's own collection

What emerges very clearly from this table is that country diagnostics and dialogue sessions are important steps to understand the market dynamics and inform regulatory design. Though policy and regulatory approaches are only found in a small number of African countries, and only in early stages (with the exception of South Africa), there is clearly a movement towards proactive steps.

With growing markets and new players, sound regulatory responses to protect microinsurance consumers that allow valuable and innovative growth are of utmost importance in market development. It is a task

where public and private actors need to work hand-in-hand, with the insurance supervisor playing a leading role.

Currently, some African governments, such as those of Ethiopia, Egypt, Ghana, Kenya, Nigeria, Uganda, South Africa and Zambia, are in the process of considering special policies and regulatory frameworks to spur microinsurance market development. South Africa is the only one so far that has taken definite steps to develop a special policy approach that has helped to improve access to insurance. The overwhelming majority of governments have yet to take steps towards integrating the poor into the formal insurance sector. The lessons that have been learned in some of these countries are worth analyzing in more detail to help provide a framework under which policymakers and insurance regulators can design their country-specific approaches.

However, African governments can also learn from policy approaches at the global level. The most relevant **policy elements** are described below. Though they may be valid as individual solutions, they will be more effective when combined. Good policies and their implementation must accomplish the following goals:

1) Create awareness of the market and build regulatory and supervisory capacity. Policymakers, regulators and insurance supervisors need to:

- Be aware of the policy and regulatory barriers to microinsurance development;
- Understand the landscape of institutions offering microinsurance in their jurisdiction;
- Know their strategic options for facilitating the expansion of microinsurance;
- Provide or obtain a clear mandate for microinsurance regulation and supervision in light of the diverse authorities involved in insurance provision.

The capacity of insurance supervisors is critical, a fact that must be considered from the onset of policy development. In recognition of the huge capacity building gap, the International Association of Insurance Supervisors (IAIS), in cooperation with the partners organized in the Microinsurance Network as well as the Financial Stability Institute, have been developing training events in Africa and other locations. The IAIS has also partnered with four development agencies under the Access to Insurance Initiative.[12] Among its core strategies are country diagnostics and their synthesis, a more systematic national and regional capacity building for authorities, and international standards and best practice.

2) Formulate a financial inclusion policy which includes microinsurance along with the other poverty-oriented financial services (credit, savings, and payments). An increasing number of countries, such as Ethiopia, Ghana, South Africa and Uganda, have included microinsurance in their financial sectors or microfinance strategies. This is an important first step. However, most African countries still lack such a strategy, or the means to implement it. It is worth noting that the mere existence of such a strategy is just the beginning, and its implementation – based on a continuous dialogue with all stakeholders from the public and private sector – is a long-term task.

[12] The Access to Insurance Initiative is a global program designed to strengthen the capacity and understanding of insurance supervisors, to facilitate their role in expanding access to insurance markets for low-income clients, and to support the implementation of sound regulatory and supervisory frameworks consistent with international standards. It is a partnership bringing together funding organizations and sponsors with insurance supervisors, regulators and policymakers. The Initiative was launched at end October 2009 at the IAIS Annual Meeting in Rio. The founding sponsors are IAIS, CGAP, BMZ, Finmark Trust and the ILO; see www.access-to-insurance.org.

3) Develop regulation that facilitates microinsurance supply. In order to facilitate microinsurance supply, regulators must understand both the barriers and the opportunities. It will then be possible to make effective adjustments that leverage the opportunities for microinsurance expansion while protecting consumers. Some of the common regulatory barriers that may hinder broad-based and cost-effective provision of microinsurance include:

- Entry barriers: Requirements in insurance laws and regulations (e.g. high capital requirements or high requirements for key management) prevent unregulated microinsurers from getting a license and being supervised along with other formal insurance providers.
- Distribution barriers: Licensing requirements should allow a broad range of microinsurance intermediaries, and allow e-money and new technologies such as cell phone banking. Restrictions on agency commissions can disincentivize microinsurance salespeople in the low-income market.
- Product restrictions: Often, microinsurance products are written on the same basis, i.e. short-term risk and open group policies. In such cases, bans on composite products (e.g. where products are not allowed to combine life and non-life elements) may hamper service provision. Or, complex contract requirements impede the design of simple products.
- Weak consumer protection regulations or systems that are inadequate for low-income households hamper sound growth. Similarly, ill-designed consumer recourse mechanisms can undermine rather than promote consumer protection.
- Other regulation, such as know-your-customer rules, can impede the inclusion of poor people.

In Africa, some jurisdictions have undertaken country diagnostics to identify their regulatory and policy barriers. The Zambian insurance supervisory body is a lead agency of a sector-wide microinsurance strategy that brings key stakeholders together to streamline activities and advance the microinsurance agenda on all fronts. Basis on a country diagnostic and related workshops, the Ugandan Insurance Commission has identified regulatory obstacles such as commission capping and the prohibition of banks and MFIs to channel microinsurance.

4) Manage consumer education and protection as a public-private task.
The Ghanaian National Insurance Commission envisages developing consumer information modalities tailored to the needs of low-income households. In Kenya, a public-private financial education programme is underway.[13] The Making Finance Work for Africa Partnership has a working group that focuses on financial education. These are first promising steps. However, specific approaches that focus on insurance for the poor are still lacking. Africa-wide, no best practices have yet been developed and the challenge remains to create innovative, effective models.

5) Create a supportive and non-distorting incentive structure. Fiscal incentives for both the consumer and the supplier can improve microinsurance outreach to the low-income populations. Care should be taken, however, that incentives (e.g., tax concessions or more explicit subsidies) do not crowd out or distort market provision.

6) Explore public-private partnerships to foster expansion of health and agriculture microinsurance products. As discussed later in this paper, both health and agriculture microinsurance products are complex and can deliver more value if private and NGO players leverage existing infrastructure and value chains.

In summary, a complex set of context, market and policy, legal and regulatory factors drive microinsurance development. The market can develop faster if actors operate in an enabling environment in which the

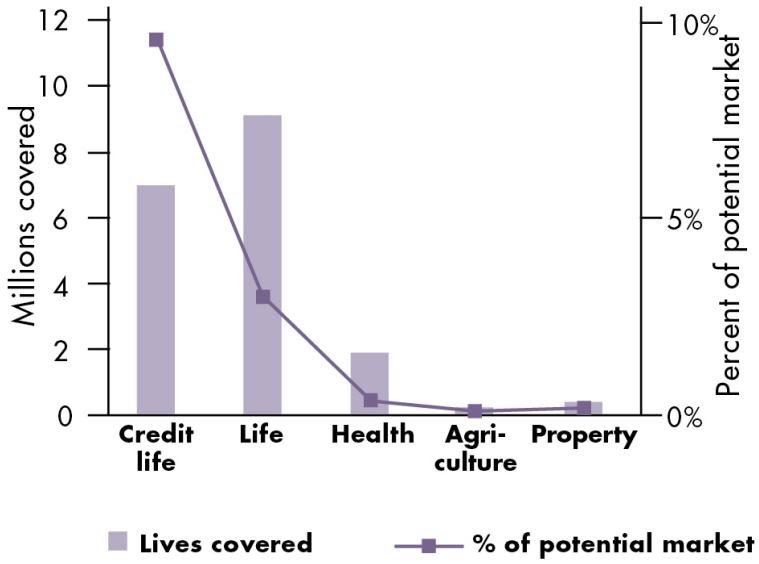
[13] Financial Education Partnership for Kenya: http://www.fepkenya.org/ .

state, and especially the insurance supervisor, is a key player. Governments have a far-reaching role in formulating a coherent plan for microinsurance (which may include a special regulatory dispensation) that is sensitive to the specific local context while also reflecting lessons from the international community. Though there is still a long road ahead, this realisation is increasingly taking place in Africa.

5 > CURRENT OUTREACH

Our study of microinsurance in Africa identified 14.7 million people in 32 countries, or about 2.6% of the population living under USD 2 per day, who were covered by microinsurance products. Of these, South Africa alone, where funeral insurance is pervasive throughout even the poorest areas, represents 8.2 million, or almost 56% of the total. Also, of the total 14.7 million, 10.3 million are covered by products other than credit life. The total microinsurance premiums received in 2008 amount to about USD 257 million, out of which 88% was collected by regulated insurers (see more in the next section).

Figure 6: Outreach and penetration rate by product[14]



It is clear that Africa remains dominated by life insurance products, as seen in Figure 6. Of their estimated potential market size, credit life products cover close to 9.5%, and other life products cover about 3.2%.[15] Health products, those which are often cited as the most in need, only cover about 0.3% of the low-income population, with property and agriculture covering significantly fewer in numbers, but about 0.2% and 0.1% respectively of their potential markets. There is still great potential for microinsurance expansion and growth in Africa. One finds a range of available products in some countries, such as Kenya, Namibia, Senegal and Cameroon, while other settings are dominated by one specific product line. See the Annex for more information on specific countries, including outreach by product and a list of providers that have agreed to share information with the public.

[14] Note that the number of people covered by product does not match the total number covered due to microinsurance programs offering multiple products to the same clients.

[15] Penetration rate = current outreach divided by total market size calculated as follows for specific risk areas:
Credit life = share of poor households (below USD 2) having credit needs (assuming 50%); Life = share of poor population (below USD 2) aged 15-64; Health = poor population (below USD 2); Agriculture = share of poor households (below USD 2) living in rural areas; Property = poor households (below USD 2).

Figure 7: Outreach of microinsurance in Africa

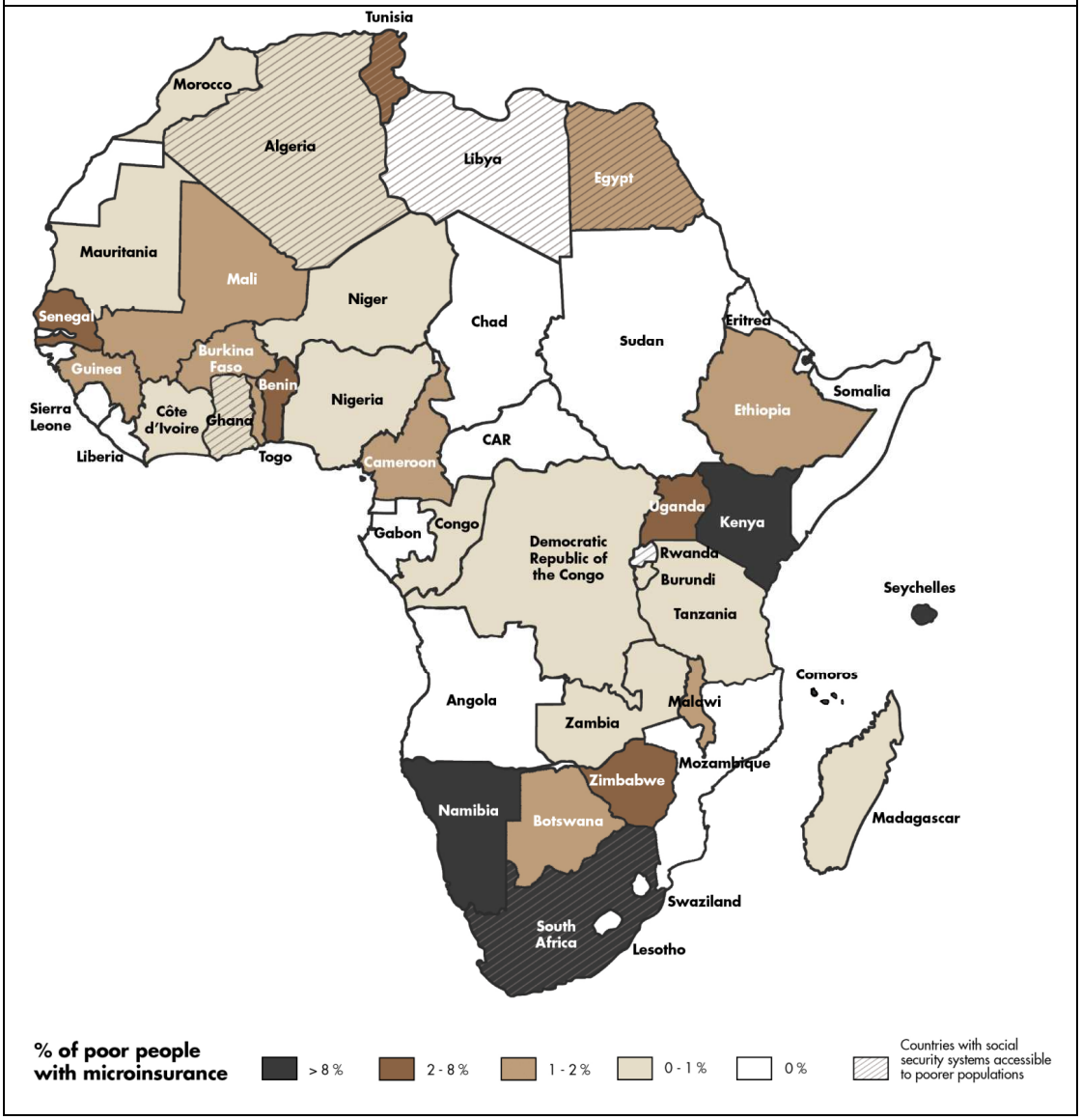
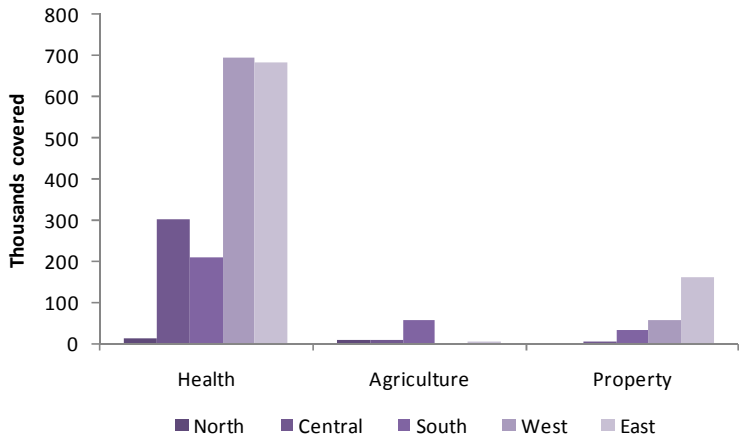


Figure 7 shows that Southern and Eastern Africa dominate the microinsurance landscape with 8.8 million and 4 million lives covered, respectively. This leaves only 1.9 million covered in Central, North, and West Africa. This disparity can be partly explained by the strength of life microinsurance in South Africa, as well as the engagement of commercial insurers in microinsurance in the East and South. However, except for North Africa, the regions are more similar in their offering of health microinsurance, as illustrated in Figure 8, which looks specifically at the non-life products. The strength of health microinsurance in Senegal, Benin, Mali, Cameroon and Guinea is directly related to health mutuals, while in Kenya and Uganda it is driven by a mix of community-based schemes and commercial providers. Prior landscape studies showed a significant void of microinsurance in the North. This clear gap continues to be reflected in the results of this study, which might be explained by better social security systems in the North.

Figure 8: Outreach of non-life products by sub-region



As mentioned earlier, we have not included historical and emerging national social security schemes in our analysis. However, they may be an important source of financial risk-management for low-income people, especially for health and disability. Therefore, such schemes can reduce the need for microinsurance and limit the demand for its development and expansion. As the map (Figure 7) shows, there are a few countries in Africa with social security systems that are accessible to poorer populations. In those countries, governments find ways to expand access to social protection (mostly disability or health benefits) beyond the formal sector. In Rwanda and Ghana, national health insurance schemes were expanded to the informal sector through pre-existing community-based schemes. Initial results in Ghana are remarkable, as presented below in Box 2, providing evidence that extending health coverage to low-income populations can be done effectively by national governments through linkages with informal structures or different sorts of public-private partnerships. There were 3.2 million low-income households covered in Ghana at the end of 2008 – more than all other surveyed countries combined.

Microinsurance is on the rise. A comparison to the 2005 landscaping study indicates that the number of lives covered increased by 82% in three years.[16] The growth rate is confirmed by our survey data that allows us to compare outreach in 2007 and 2008 showing that half of the schemes were growing at a rate higher than 30% per year. These high growth rates stand in stark contrast with the insurance sector in developed countries, which has expressed much lower and even negative growth rates in some countries (Sigma 3, 2009). The growth rates are higher for agriculture products, reflecting the recent burst of index insurance pilots in Africa. Interestingly, there are no significant differences between various insurer types and delivery models with regard to their growth rates. Finally, it should be noted that our figures do not give a clear indication of the renewal rates. Although the total number of beneficiaries of microinsurance has risen, there is reason to believe that low renewal rates are restricting the potential growth.

[16] Based on end 2005 data, the 'Landscape of Microinsurance in the World's 100 Poorest Countries' identified that 3.5 million low-income people in Africa were accessing microinsurance in eighteen countries. South Africa was not counted in that study. If we exclude South Africa from our study, this leaves 6.4 million covered at the end of 2008. This reflects more than an 80% increase over the 2006-2008 period. It should be noted here that there are differences in the dataset for the 2005 study and our dataset; the new dataset includes more schemes, in more countries. However, based on extrapolations from growth rates within our dataset (between 2007 and 2008) an annual growth rate of 30% implies that our estimate of 82% growth over 3 years might even be on the low side, even when accounting for differences in the datasets.

Box 2: Expanding national health coverage through health mutuals in Ghana

By Veronika Wodsak, ILO's Social Security Department

Since independence, Ghana has struggled to improve the quality and accessibility of health services to its citizens. Earlier reforms resulted in inequity and deteriorating health outcomes. This led to the birth of many grassroots community-based initiatives helping low-income households manage the health risks. The passage of the Ghana National Health Insurance Act in 2003 marked a milestone for extension of social health protection in Ghana. The Act extends the mandatory scheme for formal sector employees to the informal sector by building on the strengths of the community-based initiative, structuring them as mutual health organizations.

The pre-existing health mutuals were regrouped at the district level within new District Wide Mutual Health Insurance Schemes (DWMHIS). The government provided funds for each district to establish a DWMHIS and as of December 2008, 145 DWMHIS were registered with the National Health Insurance Authority (NHIA). The new scheme is regulated by the NHIA which is responsible for registering, licensing and regulating the health insurance schemes and for the accreditation and monitoring of the providers. The NHIA also oversees the operations of the National Health Insurance Fund which provides subsidies to licensed DWMHIS. The DWMHIS register and collect contributions and registration fees from informal sector members.

All health insurance schemes under the NHIA must provide the same benefit package (covering comprehensive inpatient and outpatient services, including certain dental and optical services) at accredited private and public facilities and adhere to the range of contribution levels and tariff structure for reimbursement as set by the NHIA board.

The scheme is financed through a combination of contributions from formal sector employees, a tax levy and private contributions from the new informal sector members. Those contributions are set by the district schemes within the range prescribed by the NHIA. Currently, schemes charge 12-15 GHS (8-10 USD) per year. Additionally, all informal sector members must pay registration fees of 4-5 GHS. For the sake of comparison, cost for one outpatient consultation is about 18 GHS (13 USD).

Since its introduction, the NHIA reports, as of December 2008, the coverage rate is estimated at about 48% of the population. Membership data is not always available, but it is estimated that roughly 30% of the scheme members are informal sector contributors, which translates roughly to 3.2 million low-income people covered. This enrolment is due to linking the scheme to pre-existing health mutuals, which facilitated involvement of local communities in planning and implementation of the scheme.

This scheme also includes pregnant women, an adjustment introduced in July 2007. The scheme already covered a recorded number of 432,728 pregnant women by December 2008, roughly 3% of total membership. With increasing coverage, health services utilization has also grown, averaging two visits per head per year for insured persons (compared to the national level estimated at 0.5 visits).

Challenges remain for the scheme. For example, a recent change in the reimbursement mechanism – shifting to Diagnostic Related Groups even for inpatient and outpatient treatments – is costly to administer and seems to have created incentives for over-prescription and fraudulent claims from some providers. Claims management, and especially the claims-vetting capacity of the DWMHIS and NHIA are very weak and a huge backlog of claims has been accumulating, leading to delayed payments of providers. Providers are getting frustrated with the system, complain to insured patients, address them as "non-paying" patients, and are reluctant to treat those insured under the scheme because of the delays in processing claims. In recognition of these challenges, the NHIA is strengthening information systems as well as plans to shift claims management to the central level. Some DWMHIS do not greet those changes with enthusiasm as they may distort the balance of responsibilities between district and national levels and jeopardize the programme which was set up based on the strengths of community-based schemes coupled with the advantages of national insurance schemes.

6 > INSURERS

"Insurers" are defined here as institutions that manage insurance risk. These include:

- Regulated insurers - commercial, cooperative, and mutual insurance companies that are regulated by the Insurance Act or other government regulations
- Health mutuals and community-based microinsurance programs
- Microfinance institutions (MFIs), non-governmental organizations (NGOs), hospitals and others that manage the risk of their own "insurance" programs.

The surveyors identified 134 schemes run by regulated insurers, 386 health mutuals or community-based schemes and 24 insurance programs managed by other risk carriers. The vast majority of the health mutuals are found in West and Central Africa. The geographical spread of regulated insurers is more consistent, though they are slightly more prevalent in West and East Africa (Figure 9). While most of the schemes are based in Central and West Africa, the programs in South and East Africa insure many more low-income people, as reflected in the much higher microinsurance outreach of regulated insurers in those two sub-regions (Figure 10). The large outreach of "other risk carriers" in East Africa is mostly accounted for by three Credit and Savings institutions in Ethiopia providing more than one million clients with credit life insurance.

Figure 9: Number of schemes by sub-region

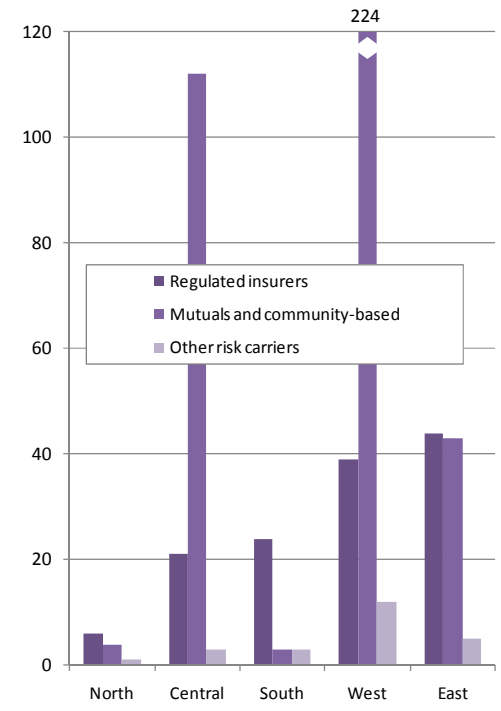


Figure 10: Outreach by sub-region

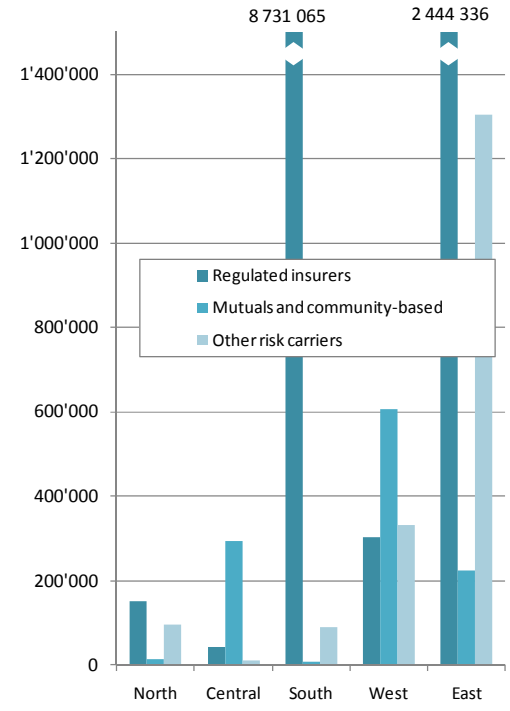
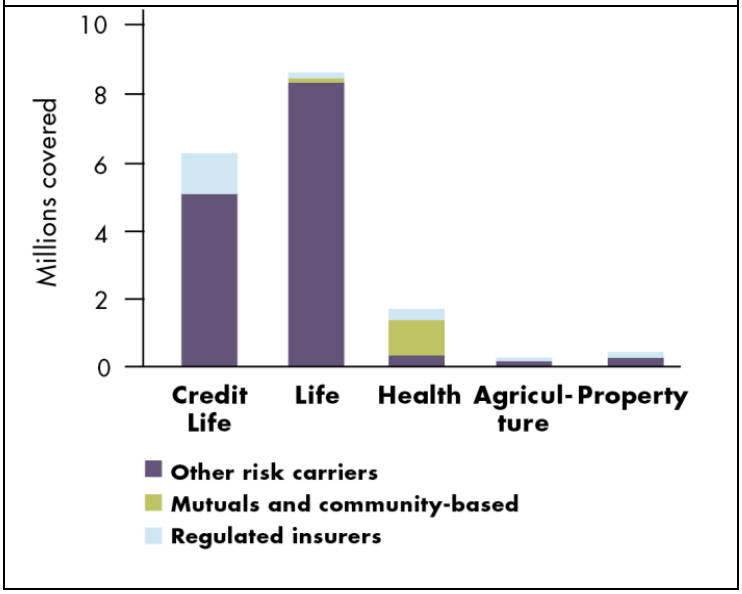
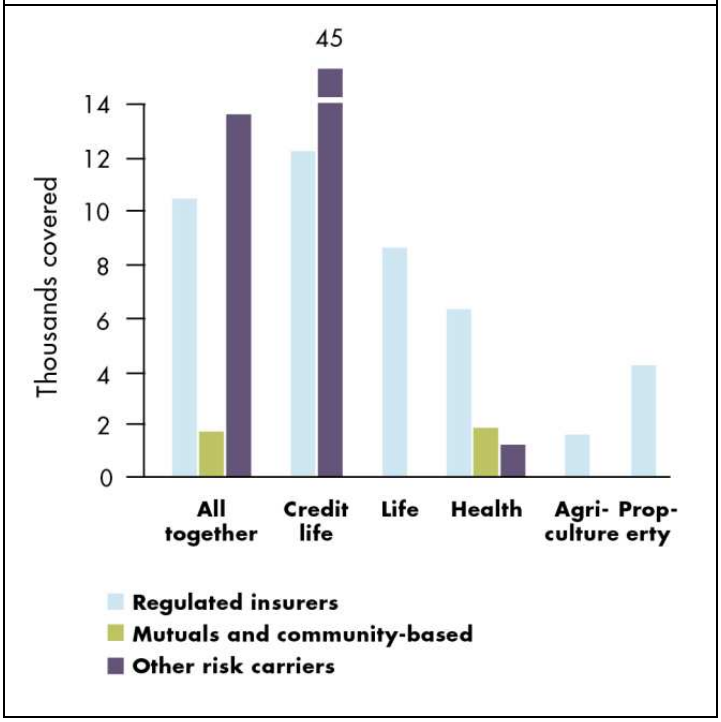


Figure 11: Outreach by product and insurer type



This huge geographical discrepancy between number of schemes and lives covered is partly due to the fact that regulated insurers tend to focus on life products, which allows them to reach larger numbers. Figure 11 provides data on lives covered by product and insurer type. It is clear that regulated insurers dominate the life landscape other than about 1.5 million receiving credit life insurance primarily from their MFI. Health mutuals have been focusing almost entirely on health care financing, though the total volume of health insurance remains limited, with 1.2 million covered by health mutuals and 0.7 million covered by regulated insurers and other risk carriers.

Figure 12: Median insured per scheme by insurer type



The geographical discrepancy is also related to institutional factors. Community-based schemes and health mutuals tend to have a relatively low ratio of insureds per scheme. Commercial insurers tend to strive towards maximizing the number of insureds covered because they usually have greater capacity to manage the large numbers. Generally, as observed in Figure 12, which presents median values of the number of insured per scheme, regulated insurers manage large volumes of insureds in both life and health, less so with agriculture and property. This might suggest that in a business where high volumes are critical, regulated insurers may have an advantage due to their ability to generate more insureds per scheme. This seems to be the case with health insurance, where risk pools of regulated insurers are significantly larger than those of mutual organizations. Interestingly, some large MFIs take advantage of their size and carry the credit life risk themselves, therefore lowering the administrative costs.

The significant difference in volumes by product and insurer type is not strongly linked to the maturity of schemes. Half the schemes have been in existence for less than 5 years and there are no significant differences in maturity by risk carrier type and sub-region. The difference is more likely related to the

relative ease of delivering life and especially credit life microinsurance and the particular focus of the different insurer types. There also appears to be a high turnover of schemes, typical for a young industry.

Microinsurance schemes are not only experiencing growth, expansion, and new entrants across the continent. In an effort to follow up on specific risk carriers that were identified in earlier studies, there were many that could not be located, and are presumed closed.

In terms of premiums received, regulated insurers dominate the microinsurance market. Eighty-eight per cent of all the premiums identified as received in 2008 were to regulated insurers (Figure 13). Mutuals and community-based schemes, which offer much cheaper products, collected only 3% of all the premiums identified. Figure 13 compares microinsurance premiums to all insurance premiums collected in different sub-regions. It seems there is no direct link, and it is hard to defend a hypothesis that microinsurance market development is determined by overall development of insurance markets in Africa. It appears as though microinsurance is still in its early stages. Therefore, its past development has depended more on efforts of isolated champions rather than being a result of enabling environment and infrastructure.

Figure 13: Premiums received in 2008 by insurer type and sub-region (all figures in millions USD)

Sub-region	Regulated insurers	Mutuals and community-based	Other risk carriers	Total	Share by sub-region	Insurance total premiums[17]
North	2.9	0.03	0.5	**3.4**	1%	5,792
Central	0.9	1.6	0.04	**2.5**	1%	459
South	182.6	0.09	0.1	**182.9**	71%	43,178
West	4.4	3.6	10	**18**	7%	3,095
East	36.1	1.6	13	**50.6**	20%	1,204
Total	**226.9**	**6.92**	**23.64**	**257.4**	100%	50,633
Share by type of insurer	88%	3%	9%	100%		

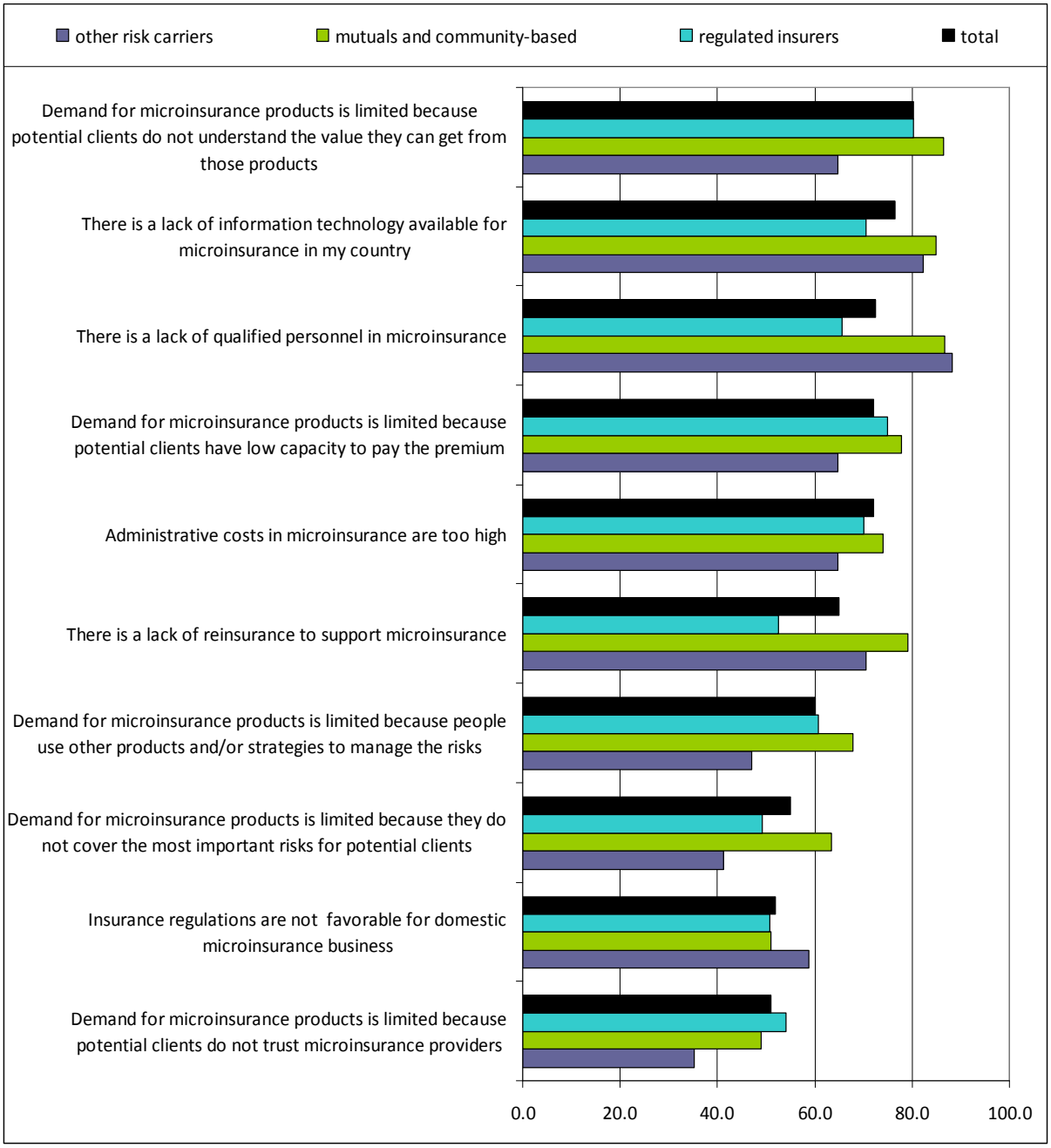
In the study, respondents were asked several questions to help assess their perceptions of the microinsurance markets in which they were active. As shown in Figure 14, the responses suggested that expansion is most significantly hindered by:

- On the demand side: potential clients' lack of understanding about insurance (80%) and limited ability of potential clients to pay premiums (72%)
- On the supply side: a lack of information technology for microinsurance (78%), administrative costs being too high (71%), and a lack of qualified microinsurance personnel (73%).

Looking at the issues through the lens of institutional type, some trends appear. Health mutuals report that their difficulties arise substantially from a lack of technology (many are not computerized), management and staff capacity (often selected from the local area without expertise), member capacity to pay premiums, and access to reinsurance (since they are not legal insurers). This is in line with the evolution of health mutuals outlined in Box 3, below. Commercial insurers suggest that their issues centre on reducing administrative costs through technology, as well as scepticism about market demand. The survey did not address distribution, but it seems to be a major challenge for regulated insurers, as explained in Section 8. Finally, in more mature markets, risk carriers see a predominant need for consumer education to help facilitate sales and general understanding of insurance concepts.

[17] Swiss Re (2008), AIO (2006), FANAF (2007).

Figure 14: Challenges by type of provider



Box 3: Development of mutual health funds in Africa

By Olivier Louis Dit Guerin, ILO's STEP Africa Program

In the last two decades, mutual health funds have undergone significant development in sub-Saharan Africa. The development of the African mutual benefit movement, which emerged during the course of the 1980s, is now considered to be in its fourth phase.

The first generation of mutual health funds developed with the primary objective of improving access to health care based on mutual assistance and solidarity. This first movement includes small schemes, generally known as "community mutual funds", which still account for the largest number of mutual health funds. These funds are small in size (under 1000 beneficiaries) and their scope of action is limited (frequently confined to primary health care). They are similar in their operation to traditional organizations such as *tontines*. Starting from the assumption that target populations have a low capacity to pay, they offer very low contributions (250 CFA francs/month/beneficiary (or 0.55 USD) on average in West and Central Africa) and are financially fragile. Strict compliance with mutual benefit principles, which envisage that the members of a scheme "*are responsible for its management directly or through elected representatives*," and the need to contain management costs have often resulted in assigning the management function to members with a low educational level. Although considered a potential strength of mutual benefit funds, these self-management principles have turned out to be a weakness, resulting in schemes that are poorly set up and badly managed. Nevertheless, community mutual funds continue to offer a first level of response to the financial risks related to illness where no other system exists.

The second generation consisted of mutual funds backed up by significant networks, particularly micro-finance institutions, resulting in higher human resource capacities and volumes.

The third generation emerged with the adoption of more effective technical management and the use of tools such as small-scale computerized management programmes and improved practices for concluding agreements with care suppliers. These schemes continue to be based on mutual benefit values, but with significant effort devoted to their technical management and systems, enabling greater financial viability. Contributions are higher (400 to 600 CFA francs/month/beneficiary or 0.90 to 1.30 USD) and coverage extends to secondary health care.

The last generation emerged during the course of the 2000s and benefited from the experience of those that preceded it. Mutual funds are continuing the efforts to improve their technical management and employ staff who work alongside elected administrators, thereby maintaining the principal characteristic of mutual funds: the duality between homespun governance and professional management. Moreover, they do not hesitate to increase contribution levels (between 800 and over 1000 CFA francs/month/beneficiary or 1.80 to over 2.20 USD) with a view to covering the costs of better quality management and extending their health care coverage (most frequently covering both primary and secondary care). These mutual funds generally target homogenous socio-economic groups (mutual organizations of craft-workers, transporters, etc.) and have several thousand beneficiaries. Although still very recent, they are demonstrating ever-more clearly that the capacity to pay contributions is not the only limitation on membership – willingness to pay for a microinsurance product is just as dependent on trust, the quality of the product and its management. It should, however, be emphasized that these mutual funds do not cover the poorest population categories, and recruit their members from persons in the informal economy with average to high income levels.

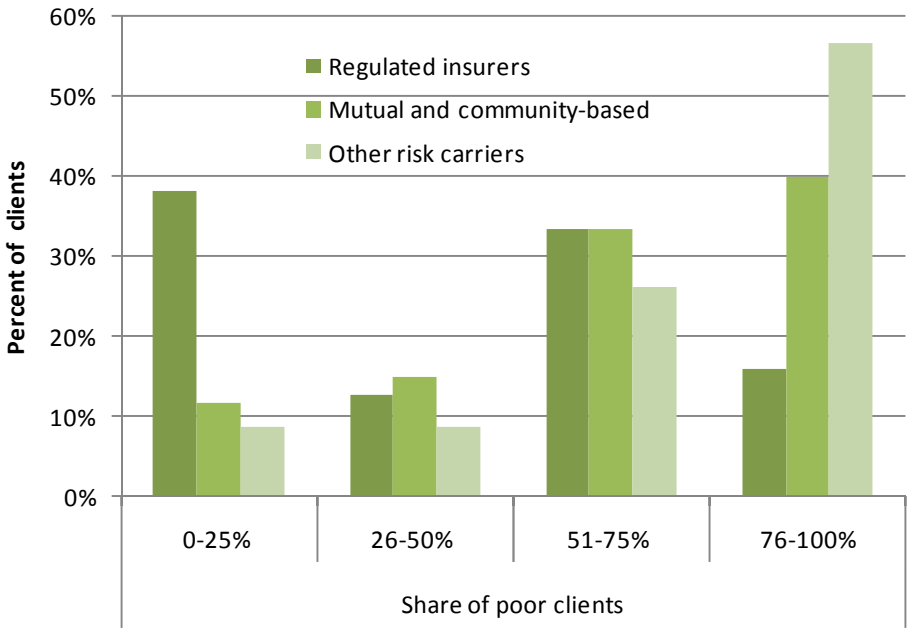
The current growth of mutual health funds, which have become more professional, shows that populations are ready to contribute for a product that they consider to be of good quality. However, the capacity to pay in the informal economy remains limited. The question that therefore arises in relation to mutual health funds is no longer, "How can we reduce contributions as much as possible?", but rather, "How can we finance a good level of contributions?" The answer appears to lie in social transfers that finance all or part of the poorest members' contributions, a strategy that has already been attempted by certain mutual funds (such as the Social Security Mutual Fund in Benin). Furthermore, certain countries (Rwanda, Ghana, Burkina Faso) are endeavouring to exploit the

expertise acquired by mutual health funds and other microinsurance health schemes, adapting certain insurance functions to the specific characteristics of the informal economy. Accordingly, mutual funds are no longer considered isolated actors in national policies. They are now included in a more global architecture of social protection for health, which also includes insurance schemes for the informal sector and technical and financial passageways between the various mechanisms.

Therefore, the next generation of mutual health funds in Africa should incorporate mutual funds in coherent national social protection policies for health, based on national (or even international) solidarity.

Since microinsurance is geared to serve the needs of the bankable poor and those who are vulnerable to poverty, it is useful to use the percentage of poor clients (below USD 2 per day) as a proxy indicator to depict market segments served by different institutional types. As indicated in Figure 15, health mutuals and other risk carriers (such as MFIs and NGOs) tend to focus on predominantly poor markets, (though, as shown in Box 3, even the mutuals are moving up market). Indeed, of the other risk carriers identified, 70% of them have a client/member base composed mostly of poor people. This finding suggests that it is important to support the development of various models if the intention is to expand microinsurance across the low-income market. Some institutional types may be better at focusing on poorer target groups while others might be more effective in the slightly less poor markets.

Figure 15: Depth of outreach by insurer type



7 > PRODUCTS

African microinsurers offer a wide variety of microinsurance products. Although life insurance is clearly predominant, efforts to provide other products are an important response to market demands, and create demonstrations from which other insurers can learn. These learning opportunities may eventually translate into higher overall sales and a richer, more varied spectrum of product offerings across the microinsurance marketplace.

A total of 9.1 million people were identified as having life cover. Funeral and personal accident insurance, both covering about 6.2 million people, are the predominant life policies. Personal accident is a common inexpensive add-on by insurers, and the relatively high funeral cover numbers are related to cultural issues in South Africa. Indeed, Swiss Re (Sigma3 2009) reports South Africa as having the third highest life insurance penetration in the world. Even though the Swiss Re data for South Africa include pensions and savings, which are excluded in most countries, the South African case still shows that cultural factors play an important role in insurance market development.

Term life policies (covering 4.8 million lives) are relatively inexpensive and easy to manage, and are thus popularly offered in many African countries. Endowment policies (0.8 million lives) are less available as their longer-term nature requires greater complexity in management and greater risk for the policyholder. In practice, insurers commonly experience a high lapse rate with such products across the globe, as low-income policyholders find it difficult to maintain long-term regular premium payments. However, low-income people tend to have a combination of an illiquidity preference and long-term financial goals (Ashraf et al, 2006) which should generate interest in such products provided that they become further aligned with their expectations.

The specific microinsurance product that touches the most people in Africa – 7 million – is credit life insurance, which is commonly a required purchase with microcredit and other borrowing. It is indeed the simplest product to offer, it is easy to require borrowers to purchase it, and it can be very profitable, especially since borrowers are often not aware that they have purchased insurance with their loan. Anecdotally, those insured with simple credit life cover suggest that the product is not for them, but rather for the lender. As illustrated in Box 4, insurers are recognizing this issue, and at least 25% of those covered by credit life now enjoy an expanded product with additional benefits that accrue to their surviving family as well as property covers (i.e. fire) for their business assets.

Box 4 : Credit life insurance: beyond the basics

By Marc Nabeth, CGSI Consulting

Loan insurance is the most widespread product in the microinsurance sector in Africa. It is also probably the most problematic. Its problems lie not in its complexity – it is a simple product to design and implement – but in its social and economic impact on the borrower, which is questioned by many.

Many MFIs to introduce credit life insurance schemes for borrowers in an effort to reduce risk. Charges for such cover range from 0.8 to 8 per cent of the loan principle. In the event of death or disability, the insurer reimburses the balance of the loan payments to the credit institution. However, experience has long shown that this type of insurance tends to be of greater benefit to the credit institution than a protection to those who are insured, allowing insurers and MFIs to achieve significant profit margins. The product's contribution to the positive dissemination of insurance is questionable, as it is often compulsory and MFI mortality tends to be rather limited. Additionally, due to poorly trained agents and the lack of clear communication with the population, clients are often unaware that they are covered. Therefore, a question arises for insurers and MFIs: what insurance products can benefit clients, reduce risk and support portfolio expansion?

Loan insurance needs to be seen as much more complex than a mere guarantee fund. There are a number of important

aspects to be considered:

- Should the coverage be limited to the duration of the loan? Microcredits are sometimes not continuous during the same year. Longer coverage for insured persons would make it possible to avoid gaps in coverage, and would be less costly than renewal while at the same time reducing the risk of negative selection.

- Should coverage be confined to the borrower, who may also be unable to pay the loan back due to the death or costly hospital treatment of a member of the family? If an MFI does decide to extend insurance to the family members of the borrower, the concept of "family" needs to be defined. Many Africans support and depend upon large extended families – where should the MFI draw the line? How can the concept of the family be defined when the terms 'mother' and 'father' are commonly used in Africa to denote protectors in a popular market or migration area?

- The transparent management of loan insurance requires the MFI to establish clear procedures for coverage and the payment of claims. Families affected by a loss need to receive benefits rapidly, but without the insurer becoming a blind and naïve payer. But how are insured persons to be identified in countries where birth and death certificates do not exist? Furthermore, for invalidity guarantees, it is important to determine scales of invalidity that are acceptable to both insurers and the population. How, for example, can it be explained to a client who has lost an arm that his coverage does not include an injury of less than 30 percent?

The list is clearly not exhaustive. These are just a few of the questions that need to be considered by any insurer or MFI wishing to develop microinsurance that adds real value for clients. Certain insurers and MFIs are leading the way, demonstrating that loan insurance has to go beyond the mere amount of the loan. Effective loan insurance should incorporate additional guarantees identified by the target populations, clear and precise procedures, training, practical marketing and communication measures, and the rapid, transparent and effective compensation of losses.

Health products cover at least 1.9 million people, out of which 1.3 million enjoy comprehensive packages covering both in-patient and out-patient treatments, mostly delivered by health mutuals and a few specialized commercial players. About 0.6 million people take advantage of in-patient-only covers (i.e. hospitalization), which are mostly delivered by regulated insurers. This type of coverage represents a new arena for commercial insurers to get involved in microinsurance. The in-patient products are relatively easy to deliver, as moral hazard and fraud are less of an issue, especially in urban areas where the private and public health care provider networks are accessible and relatively well-managed. Administration costs can be trimmed when partners have good information systems or when there is an option to involve a third-party administrator. Lastly, 0.9 million people have access to products with targeted benefits, such as the maternity coverage and schoolchildren products developed by CIDR and delivered by the UMSGF in Guinea and the Réseau Alliance Santé in Benin (Box 5).

Box 5: Targeted benefits

Health mutual schemes have traditionally offered comprehensive health insurance packages covering both primary care and in-patient treatments in public hospitals. In a quest for sustainability, many health mutuals have reduced member benefits by introducing certain exclusions, which in turn resulted in lower member value, therefore causing problems with take-up and renewals.

To overcome those challenges, CIDR (Centre International de Recherche et de Développement), a French NGO active in the field of health microinsurance in Africa, developed two new health insurance products with targeted benefits: maternity cover and the schoolchildren product, delivered by two health mutual networks (Réseau Alliance Santé in Benin since 2005 and UMSGF in Guinea since 2009). Both products are mandatory, therefore can be offered at low prices due to limited adverse selection and low administrative costs. The maternity cover is to be taken at the village level, with all inhabitants paying a limited premium (USD 0.4/person/year) to cover pregnant women in the village. The schoolchildren product is mandatory at the school level, once both school management and representative parents agree to include the insurance fees (USD 0.4/person/year) in the annual school registration fee. By complementing the

more traditional family package, these products improve member benefits, hopefully driving sales of the core product and increasing sustainability of partner health mutuals. It is too early to judge whether those objectives will be met, but first results are encouraging. In Guinea, after one year, the maternity benefits cover 1,000 women and the schoolchildren product has reached 1,800 pupils.

Both products were developed based on extensive market research conducted in both countries, and were specifically designed to meet key risk-management needs of remote rural populations. Besides increasing the financial viability of the mutuals, they have the potential to yield significant development impact – improving rural delivery conditions and health-seeking behaviours of pregnant women as well as enabling schools to respond quickly to health shocks and accidents at school when parents are far away or difficult to reach.

In the agriculture insurance category, the study found less than 80,000 people covered by livestock, crop and various agriculture-related index products. On a continent with such a need for agriculture risk management, this tiny result dramatizes the need to find better tools for farmers.

Recent developments in index microinsurance products offer a tentative potential for managing the financial shocks of agriculture losses. Index-linked insurance products eliminate the need to individually verify claims, reduce transaction costs and make it easier to offer products and services in rural communities and in frontier regions. MicroEnsure has been pilot testing index products in various African countries, which allowed them to consolidate valuable lessons (Box 6). Despite growing enthusiasm over index insurance, it is important to remember that these products are still being tested and generally have limited uptake, which is proved by our survey showing that only 13,000 African farmers were covered by index insurance in 2008. There remains a debate about the real potential for index cover in microinsurance.

Box 6: Microensure's experience with index insurance on the ground

By Shadreck Mapfumo, Vice President, Agricultural Insurance, MicroEnsure

MicroEnsure and the World Bank Commodity Risk Management Group in Africa started the first weather index crop insurance pilots in Malawi in the 2005–2006 growing season. This scheme is still

successful, with high take-up rates from the farmers. In 2009, approximately 8,000 weather index insurance policies were sold to farmers in Africa, and a number of new pilots were launched in Rwanda, Tanzania, and outside of Africa. There are plans to launch drought insurance in Ghana that will cover rice, cocoa, and maize. Detailed assessments of the potential for weather index insurance in Uganda and Kenya are well under way.

Weather index crop insurance is not a panacea. There are multiple challenges that must be met before it can be deployed, and even then care must be taken to ensure it will do the job it was designed to do: protect the poor. For example, there must be a sustainable value chain for cash crops. Crop microinsurance works best within existing supply chain mechanisms and needs sufficiently developed infrastructures.

Index insurance requires considerable on-going management and stakeholder input. In different countries, or even different regions of the same country, agronomic conditions vary widely and careful adaptation is needed. Typically, 30 years of historic weather data is a prerequisite for designing a weather index product.

An adequate weather infrastructure must be in place with sufficient operational weather stations for pilots and for future expansion. The use of remote sensing (satellite) data sources might help overcome the limited availability of weather stations.

A significant consideration for weather index insurance is known as "basis risk", the risk that the experience in the farmer's field is quite different from the weather index. For example, a farmer may experience a drought in his field, but a nearby weather station may have higher rainfall. A duty of care is taken to minimize this risk in the product design for the farmers.

Every crop insurance programme requires well-capitalized risk carriers who have a clear understanding of the market and the insurance program. Often, this means involving large international reinsurers, as local insurance companies do not have the capacity or specific expertise required for this innovative instrument.

Client education is, and will continue to be, a major challenge for crop microinsurance in the developing world. MicroEnsure has introduced easily understandable comic books as a client education tool, and holds regular agricultural learning sessions for farmers.

Fewer than 0.3 million Africans were found to access non-agriculture-related property insurance. Business property cover stands out in this group, but still represents only 140,000 policyholders. The business property covers are usually bundled with credit life products. There are few examples of voluntary property insurance policies for home assets. Hollard Insurance in South Africa pioneered such products for the low-income market. Their efforts, summarized in Box 7, clearly illustrate the key challenges facing these products.

Box 7: Hollard's venture into property insurance for low-income households

Building on its vast experience in delivering life products to the low-income market, the Hollard Insurance Group has recently developed a voluntary property insurance product for the poor in South Africa. Depending on the delivery channel, the product offers coverage for low-income homeowners

for building (USD 6,500-13,000), contents against natural disasters and fire (USD 1,300-6,600), contents against theft (USD 2,000) as well as liability and SASRIA covers for an affordable monthly premium of USD 8-13. An extension of the product to cover the large number of Home-Based Businesses is on its way. As the first sales started in October 2009, it is still too early to evaluate this experience. However, the Hollard example highlights key challenges in offering voluntary short-term products to the low-income market that might be useful for other pioneers in this field.

Identifying the right intermediaries to reach out to target clients is key, as insurance companies have a questionable reputation in the low-income market. Hollard works through partnerships with retailers, air-time sellers, MFIs that are trusted by the low-income market. Moreover, in the South African environment, insurance premiums are collected almost exclusively via debit orders, which involve high transaction costs and rely on bank accounts that are still not widely used by the poor. Hollard's challenge was to find a distribution channel through which low-income clients could pay their premiums in cash, have flexibility regarding monthly payment dates, make lump sum payments if they are seasonal workers or make partial payments during difficult financial times.

An important challenge for property insurance is underwriting and assessing claims. Dwelling conditions do not allow easy identification of property, so Hollard plans to use mobile phones and GPS technology. Low-ticket policies can not cover the cost of regular claims assessors, either for pre-inspection or claims assessment, which cost about USD 250 per claim. Hollard uses its black economic empowerment (BEE) contractors to go out and assess claims, cutting costs by almost 90%. The assessors visit a customer's home, take photos and write a short report to be submitted to Hollard. What is more, the BEE assessors will also be involved in some pre-inspection which will help to gather more data on client profiles.

Last but not least, introducing a new voluntary product into a market that has had very little experience and exposure to our industry means that alternative marketing strategies and consumer education efforts need to be developed.

There are more and more examples of composite products, which boost the value proposition by covering multiple risks. The most frequent combination is, as previously mentioned, credit life plus, where outstanding loan balance benefit is often bundled with any combination of personal accident policies for other household members, funeral cover benefiting borrower's family, and/or business asset cover. The other popular bundled product is a hospitalization cover with additional riders in the form of funeral policy or term life product. The Bima Ya Jamii product offered jointly by the Cooperative Insurance Company and the National Health Insurance Fund in Kenya is a good example of such a composite product (Box 8). There are strong arguments for designing composite products given limited capabilities of low-income households

to understand insurance concepts and decide on the optimal risk-management tools. However, one needs to be conscious of the drawbacks of composite products. Quite often, at least in developed countries, those products include so-called 'window dressing' benefits, additional riders for which the client needs to pay but which are not a high priority for him or her. Low-income markets are more sensitive to these issues because the client's capacity to pay is limited. Therefore, to achieve development goals, microinsurance products need to be carefully designed to respond to a specific set of the most important risk-management needs.

Box 8: Bima ya Jamii: a composite product in Kenya

By Charles Mutua, Swedish Cooperative Centre

In the Eastern Africa region, previous attempts to provide microinsurance products to the low-income market have not been successful due to the lack of trust and understanding of the market segment, unaffordable prices, unconducive regulatory frameworks and poor delivery mechanisms. Having learnt from these experiences, the Cooperative Insurance Company (CIC), with a help from the Swedish Cooperative Centre (SCC) and the National Health Insurance Fund (NHIF), have launched Bima ya Jamii (Insurance for the Family) – a comprehensive insurance solution for low-income families in Kenya.

The product is composite in design and covers the policy holder, his/her spouse and all dependent children. Coverage includes **hospitalization costs**, **compensation for loss of income**, **disability benefits**, **accidental death compensation** and **funeral expense** coverage. The annual premium for this insurance policy is KSH 3,650 per year (approx. 50 USD) or KSH 10 per day per family. The policy is non-discriminatory (regardless of age, even available to people above 68), non-exclusive (covers all illnesses and pre-existing conditions) and has no limit to the number of children covered.

CIC is responsible for marketing and covers personal accident, loss of income and funeral expenses. NHIF provides inpatient medical coverage for its members and groups at over 200 hospitals in Kenya. Launched mid-2008, the product covered 15,000 lives in its first year, mostly to members of rural savings and credit cooperatives and clients of MFIs.

Although the response from the general public has mostly been very positive, the product has experienced delays in reaching the targets for the number of policyholders. The start-up process and the amount of groundwork needed to ensure the quality of the product delivery was more extensive than anticipated.

To overcome limited understanding and low renewals, an important component of the project is educating the target population about risk management and insurance. Given the high rate of illiteracy among the target group, SCC-employs an adult self-training methodology called study circle, which has been extensively promoted by SCC in its development support programmes in many countries. The study circles are a community propelled, owned and managed mechanism of adult learning, enhancing cooperation in sharing common problems as well as access to new information and technology. It is composed of small groups of people who meet consecutively for an agreed period and carry out planned studies under the leadership of an accepted leader. The aim of the material is to create better informed consumers of microinsurance. In this way, the partners hope to improve the low renewal rates, which are largely caused by a lack of consumer understanding of the potential value of insurance.

The dramatic preference of regulated insurers to offer life products may also suggest a reluctance to intervene in health and other microinsurance products. The clear lack of health cover, even when health

care is typically noted as the highest risk management priority for low-income families, is likely a factor of several issues that will have to be addressed if this gap is to be bridged:

- How can we propose valuable products while maintaining affordability of the premiums? In-patient only coverage may not be attractive enough to address the demand, but comprehensive coverage may be too expensive if no subsidies (governmental or donor funded) are considered.
- How can we limit operational costs? Health insurance requires additional skills to manage relationships with health care providers, precautions to control for adverse selection, and administrative work to process claims, which are more frequent than in other types of insurance.
- How can we create an attractive product when access and quality of care is limited?
- How can we effectively price products in the absence of risk data?

If microinsurance is to prove effective as a risk management strategy for low-income households in Africa, risk carriers will need to better reflect the demands of the market in their product offerings while still ensuring viability.

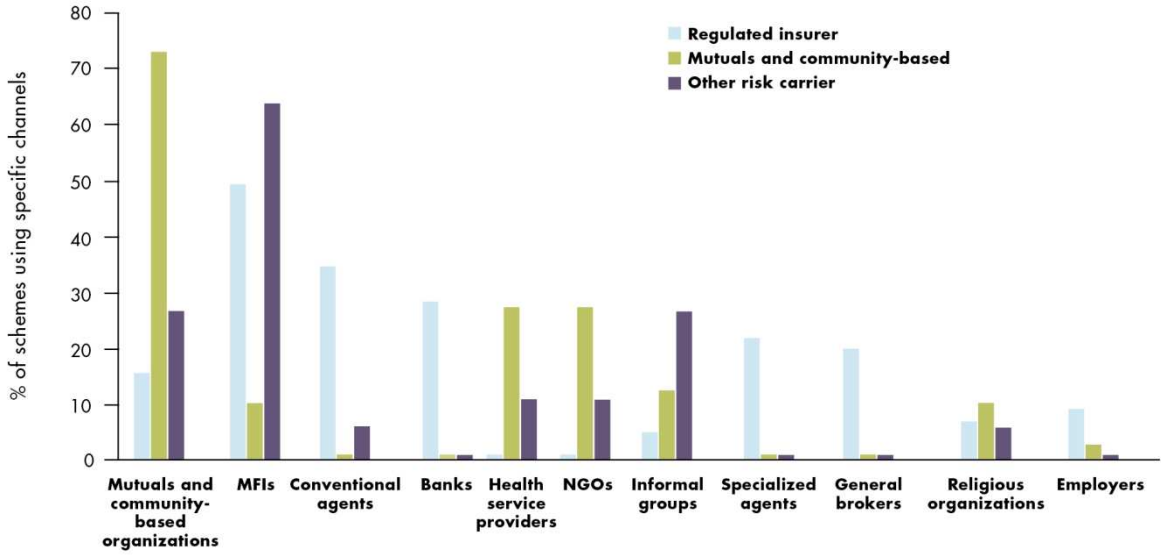
8 > DELIVERY CHANNELS

In the study, microinsurers were queried about their perceptions of the market and what they saw as challenges to massification. Figure 14 on Challenges in Microinsurance in Section 6 shows the responses of the more than 160 microinsurers. The top four limitations noted were all somehow related to microinsurance delivery: lack of customer understanding of the value of microinsurance, lack of technology, high administrative costs, and lack of qualified personnel. Fundamentally, microinsurance costs must be as low as possible, and delivery is a key cost driver. Improving technology and access to it, as well as finding and developing efficient delivery channels, are critical to reducing administrative costs.

Concern about these four key issues is reflected in the category of lowest agreement on the Challenges Table. Only 38% of respondents agreed that microinsurance would experience growth by more than 100% in the next 5 years. This limited confidence in major growth from a nascent "industry" likely reflects problems of delivery. Microinsurers across the continent seem to recognize that effective delivery is a major limiting factor to their massive growth.

Arguably the greatest challenge for microinsurance is getting market-demanded products efficiently and effectively to the clients, and providing good quality service for those products. Insurers in Africa use a variety of delivery channels in an effort to address these challenges, as shown in Figure 16. Mutuals/community-based organizations and MFIs appear as the most significant delivery channels.

Figure 16: Delivery channels used by insurer type[18]



There is a substantial effort to test and broaden the range of delivery channel types used. Particularly in South Africa and Kenya, there are more experiments with alternative channels such as retailers or mobile phone providers.

About one-third of the regulated insurers in Africa use conventional agents to get microinsurance products to the market. Twenty per cent use a network of specialized agents that are specially trained, managed, and remunerated for their microinsurance activities. One example of this specialized agent network is UAB Vie in Burkina Faso, who offers a life and disability product to low-income entrepreneurs (Box 9).

[18] Percentages do not add to 100% as insurers often use multiple channels.

Box 9: Serving urban microentrepreneurs through UAB's specialized agent network

UAB Vie, a well-established insurance company in Burkina Faso, delivers its microinsurance product through its own agent network. The product, *Cauri d´or*, offers life and disability cover to 14,500 informal sector entrepreneurs, such as those selling goods at market stalls in urban areas. Its current success depends mostly on mirroring methods used by traditional *tontiniers* (*susu* collectors). *Tontiniers* offer informal contractual, daily savings schemes that local people know very well. Similarly, with *Cauri d´or*, clients´ contributions are collected every day and are as low as 150 CFA (0.35 USD). Terms vary from 1 month to 5 years and insurance premiums are low, at 100 CFA per month (about 0.24 USD). The benefit is twice the value of the contracted capital (with a cap of 200,000 CFA, or about 460 USD, for both life and disability). Client value seems to be higher compared to the savings collections offered by traditional *tontiniers*. UAB adds the insurance cover, client savings are much safer, and the economic value of savings is higher with UAB despite insurance costs. After one year, daily savings of 150 CFA results in average account balances of 53,400 CFA with UAB and 52,200 CFA with *tontiniers*. The only advantage of *tontiniers* is that they can give advances on savings at any moment but UAB plans to develop the overdraft facility.

Because of bad initial experiences using community-based organizations to deliver the product, UAB Vie tested a direct sales approach using their own agent network. UAB has more than 40 agents, mostly young undergraduate professionals, who promote the product, initiate enrolment and collect

100-250 contributions per day. It seems as though their strategy – recruitment, 1-month training and performance-based incentives – works, as UAB enjoys a low turnover rate (1-2 agents per year). Their agents work in the field every day and are recruited from local communities, which helps UAB establish client trust, one of the main entry barriers for commercial insurers in low-income markets. An additional advantage of having their own agent network is that UAB can implement and control their own marketing and sales strategies, an issue that is often a bottleneck when relying on an external delivery channel. However, having their own agent network leaves UAB with security issues and the costs of controlling fraud and running manual daily collections. These high operational costs have kept the company from breaking even financially. However, the use of new technologies (equipping clients with smart cards and collectors with computer terminals) should improve the administration of the product, help overcome the challenges, and allow UAB to expand its operations country-wide.

The UAB case highlights several issues with microinsurance delivery:

- Developing and managing one's own agent network provides better control over delivery, but at a cost
- Technological solutions may help improve efficiency
- Employing local people as agents helps build trust and allows commercial insurers to enter low-income markets

Recognizing the efficiencies that can be achieved by working through established financial institutions, a significant portion of the microinsurance market identified in our survey is still sold through MFIs. Because MFIs already provide financial products to this market, they potentially have systems for cash management and client training and supervision, risk data on their clients, the trust of local people, and the capacity to offer group products. In theory, MFIs are the perfect delivery channels for microinsurance.

However, the high reliance on MFIs is likely to be a limiting factor for the massive expansion of microinsurance. The MIX Market (www.mixmarket.org) reports only 7.3 million microfinance borrowers in Africa,[19] yet the potential microinsurance market for Africa should be in excess of 300 million persons for life products and 500 million for health.

[19] Much of the microfinance activity in Africa is not reported to the MIX, so the actual number of microfinance borrowers may number closer to twice that reported.

MFIs will only satisfy a relatively small part of the potential demand for microinsurance. In addition to their limited outreach, they tend to offer a limited range of products. Typically, MFIs offer only products that have a direct quantifiable return to their bottom line, such as portfolio protection or credit life through commissions or high fees. There has been limited recognition of the indirect benefits of having more financially stable clients due to health microinsurance or spousal coverage. Additionally, many MFIs offer products to borrowers only, excluding family members and the institution's savers. Massification of microinsurance will require improved penetration through MFIs (see Box 10), as well as expansion through other potentially untested delivery channels.

Box 10: Key considerations in creating successful partnerships between insurers and MFIs

- *Does the MFI have a large market?*
  Having a large market facilitates the ability to negotiate for better products.
- *Does the MFI see added value to its core products from the sale of microinsurance?*
  This will make them more interested in offering a variety of products.
- *Does the MFI actively represent its clients in product and service discussions?*
  When the client's demands are well represented, the sale of products is much more likely.
- *Are there effective systems and technology to make processes efficient?*
  Efficiency is important for all parties.
- *Is the insurer flexible in terms of products and processes?*
  Successful microinsurance requires not only reduced premiums and lower coverage, but significantly redesigned products and processes.
- *Is there an effective effort to educate the market beyond one-on-one or small group training sessions?*
  The more receptive the market is to the products, the more effective the front line staff of the delivery channel will be in selling the product.
- *Is there a strong and clear agreement between the MFI and the insurer?*
  It is important that the roles and responsibilities are clear in the relationship.
- *Are there possibilities to offer group based and mandatory products?*
  Volumes grow faster with these products, but premiums are lower and sales are limited to linkages with other microfinance products.

Potential alternative delivery channels can be divided into two groups: active and passive.[20] Active channels are those in which the staff of the delivery channel actively solicits microinsurance business, like the specialty agents of UAB. Passive channels are those that make no particular effort to sell microinsurance policies, such as retailers that may sell a microinsurance card, like a cell phone top-up card. It is likely that passive channels will become increasingly important to microinsurance massification.

Some of the characteristics of passive channels include:

- Voluntary purchase initiated by a client and based on the recognition of their need for insurance.
- Simplified products and documentation that improve efficiency for both client and insurer.
- Innovative packaging providing a tangible evidence of insurance, such as the Hollard Insurance's "insurance starter packs" sold by Pep stores in South Africa.

[20] The discussion of passive delivery channels is drawn from Anja Smith and Doubell Chamberlain, "The frontier of microinsurance distribution in Africa: emergence of passive channels". The Centre for Financial Regulation and Inclusion, 2009.

- Clever use of communication technology, such as using call centres and SMS to communicate with and service clients.
- Absence of face-to-face advice or disclosure processes backed up by extensive market conduct regulation.
- Scale through targeting large client concentrations, such as clients of retailers.
- Efficient transaction platform where the sales channel is also the payment channel, such as with premiums being paid on utility bills.

Three main types of passive channels have been observed thus far:

- Retailer networks, including supermarkets and clothing store chains, that are leveraging their extensive networks, brand strength and customer loyalty by also offering insurance products to their customers. For example, Shoprite, the South African supermarket chain, sells the insurance products of various insurers.
- Retail payment system networks partnering with formal and informal vendors. In South Africa, there are an increasing number of retail payment system networks offering clients prepaid electricity, airtime, and other electronic fund transfer services via a network of vendors. One example of this is the partnership between Hollard, the South African insurer, and Take it Eezi, a network of vendors with access to a central retail payment system.
- Cell phone networks/airtime distributors. Insurance products are being packaged in the form of scratch cards sold via airtime distributors (that often also link into a network of formal and informal vendors). One scheme in Kenya addresses product activation and premium payment[21] via a short message service (SMS), with the premium deducted from available airtime[22].

Passive channels can dramatically reduce costs and expand access. However, expecting low-income people to actively seek out microinsurance without any face-to-face explanation of the product may not lead to high sales. Traditional insurance is said to be "sold and not bought". In most countries in Africa, this idea is even more accurate for microinsurance. Thus, the success of passive channels will require a major effort in broad consumer education, strong marketing, and a hybrid model where some face-to-face interaction is used for making sales. Following this initial effort, subsequent communications and transactions might be conducted through passive channels. Ongoing experiments in South Africa and Kenya will provide more information on what can be expected of passive channels.

In Africa, it is also likely that each microinsurer will need to develop and manage a range of delivery models servicing different populations. Old Mutual in South Africa uses different models in rural areas than in urban areas, as shown in Box 11.

Box 11: Tailoring Old Mutual's delivery approaches to specific markets

Old Mutual, a large South African insurer, aims to deliver a broad spectrum of financial services that are not only sustainable, but also provide real value to low-income clients. Old Mutual's delivery approaches differ between rural and urban spaces. In the rural areas, engagement models leverage the unique structures of traditional culture (stokvels, village structures, traditional leadership). In urban sites, more emphasis is placed on customised solutions for both individuals and special interest groups. The group currently has 45 tied agents, seven managers and supervisors, and 70,000 low-income policy holders. The agent networks work with 1,000 burial societies, stokvels and funeral parlours, each with a membership of 50 to 100 members.

When discussing innovations in microinsurance delivery, it is worth showcasing the *Imbizo* programme. A new initiative of

[21] This is a personal accident product where a one-time premium is paid for cover for a set period, after which the client will have to purchase another product to continue cover.

[22] The use of airtime as currency raises questions about of countries' positions on e-money regulation.

Old Mutual and its sister companies Nedbank and Mutual & Federal, the *Imbizo* programme will deliver a full spectrum of financial services (a one-stop shop) using a community-based approach. The model links agents with community workers who facilitate sales, client servicing, and product refinement to meet local needs. Education on financial services and basic business skills is considered paramount in the transformation of low-income communities into viable consumer markets, so the model also includes a major consumer education effort using the "On the Money" package.

It is possible to reach hundreds of millions of low-income people in Africa with microinsurance. Successful delivery of such massive volumes of microinsurance in Africa will require:

- S.U.A.V.E. products which are Simple, Understood, Accessible, Valued, and Efficient;[23]
- Major efforts at market education to facilitate both passive and active sales;
- A broad range of delivery channels;
- A clear understanding of the benefits that microinsurance offers to vendors (including appropriate incentives for agents);
- An appropriate balance between face-to-face and electronic interventions;
- Regulatory structures that enforce strong market conduct rules while facilitating a range of delivery models;
- Further research and quantification of the costs and effectiveness of various microinsurance delivery mechanisms.

[23] Michael J. McCord, presentation at 4th Annual Microinsurance Conference, Cartagena, Colombia. November 2008.

9 > IN PURSUIT OF PROFITABILITY

Solid financial performance is crucial to the success of the microinsurance industry. In order to offer valuable products, microinsurance needs to build its roots on viable business models, either by developing market mechanisms or by involving long-term subsidies. The survey gathered financial data on 50 schemes in Africa through follow-up phone interviews. Due to the limited sample size, financial performance could only be analyzed for three products: comprehensive health package (N=22), bundled in-patient and funeral cover (N=5), and credit life (N=24). Findings of the analysis are not surprising. Most of the credit life products are profitable, while health products face difficulties in achieving profitability even though some benefit from direct subsidies.

The average claim ratio[24] in 2008 for **comprehensive health products** in the sample, delivered mostly by West African mutuals, is 74 per cent (median 70 per cent). This figure means that, on average, 74 per cent of premiums earned are used to pay claims and 26 per cent remains to cover operational costs and surplus. In health microinsurance, operational costs are high due to the complexity of the product's processes, and 26 per cent of premium incurred may not be enough to cover them. To contain costs, mutuals often use voluntary workers for the administrative tasks of the scheme.

Even though half of the mutuals proposing comprehensive health coverage have a claims ratio of less than 70 per cent, only 35 per cent declare being very or somewhat profitable,[25] which demonstrates the fragility of those schemes. Considering the limited outreach per mutual (see Section 6), financial viability of health mutuals comes into question. In addition, reinsurance mechanisms are almost nonexistent for comprehensive health products (except for guarantee fund mechanisms in some networks), and catastrophic events can have a significant impact on the sustainability of these schemes.

One of the reasons for the low profitability of mutuals is their low premiums. The average monthly premium registered by mutuals is USD 0.33 per person, ranging from USD 0.033 to 0.66. This premium level is a result of mutuals' commitment to serve low-income people within their capacities to pay – however, it makes the schemes financially vulnerable. Without much profit margin, mutuals struggle to add operational costs into the premium, and administrative costs are often borne by volunteers.

The survey identified that bundled **in-patient and funeral covers** are becoming quite a popular new entry point for commercial and cooperative insurers. Even though the sample for financial analysis is limited to just five examples of such products, it is interesting to note that these products seem to be much more viable than comprehensive health products. Their average claims ratio is 44 per cent (median 50 per cent), and 80 per cent of institutions report that these products are profitable. Three of the five products identified benefit from reinsurance. The average monthly premium registered for the five products is USD 0.93 per person. This composite product, proposing a restricted package with a higher premium level, seems to enable institutions to progress to profitability. Indeed, processes for in-patient coverage are simpler than for comprehensive health products. As the risk covered is a low-frequency one, claim costs are reduced and fraud and adverse selection can be more easily controlled, enabling the institution to contain operational costs.

[24] The claim ratio calculated considers only the ratio of claims paid / premium earned, and does not consider claim reserves. Therefore, the ratio presented has to be taken as an estimation of the correct loss ratio, under the assumption that all institutions have stabilized their activities.

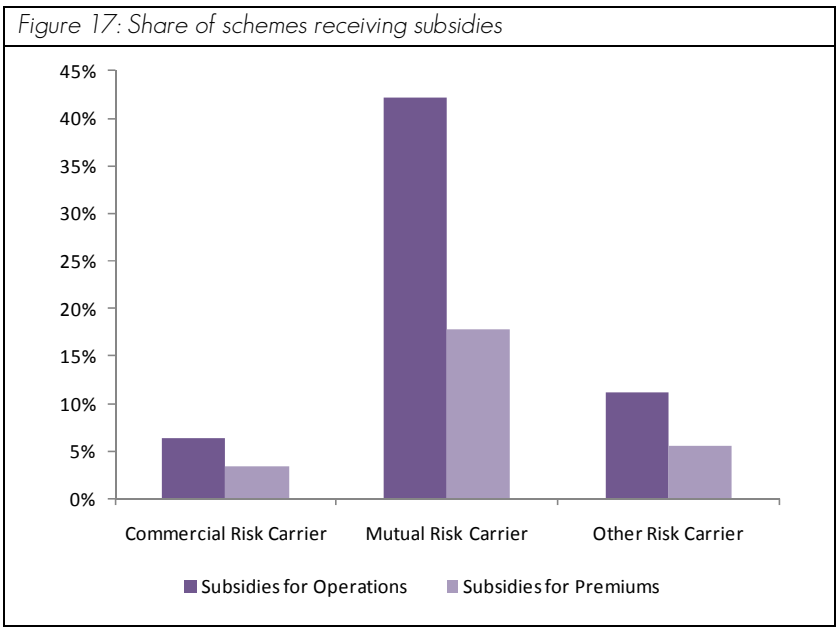
[25] Qualitative perception of profitability was asked during the survey. The respondents had to claim if their product was: very profitable, somewhat profitable, not really profitable, not profitable at all.

Credit life products appear to be the most profitable ones. The results are similar whether the organization provides a 'pure' credit life or offers some additional benefits (additional lives covered, property cover for business assets, etc.). The average claim ratio captured in our dataset is 32 per cent (median 30 per cent). Of the institutions offering this product, 83 per cent reported that their activity was profitable, a figure that is consistent across zones or types of risk carriers. This finding is not surprising. Credit life is usually sold on a mandatory basis, drastically reducing operational costs. As the risk premium is low, it is easier to add operational margin to the premium and keep it affordable to clients. As mentioned earlier, part of the reason for the higher profitability is the fact that many clients are not aware that they covered, resulting in much lower claims and higher profit margins.

As profitability is a challenge for some products that target poorer groups, the question of **subsidies** naturally arises: do low-income people have to support the total cost of the premium to benefit from a decent coverage, or should the government or external donors cover part of the cost? This question is especially relevant for products such as health or agriculture, where governments in developed countries have traditionally played a subsidizing role. Interestingly, 24 per cent of all survey respondents reported having benefited from explicit subsidies in 2008.

As Figure 17 shows, donors who are active in the field of microinsurance mainly support mutuals or microfinance institutions. Few of them subsidize premiums directly; instead, they subsidize operations. On one hand, there is more and more awareness about the dark side of subsidies, which are rarely lasting but crowd out certain valuable market-based services, leaving the poor without any medium-term solution. On the other hand, a long-term government commitment for basic health and agriculture products is necessary to extend the safety net for the poorest groups. Moreover, other donors have important roles to play in microinsurance: abolishing entry barriers, covering investment costs, creating enabling environments, and stimulating transparency and innovation.

Figure 17: Share of schemes receiving subsidies



Profitability is a key challenge for microinsurance: stakeholders agree that serving the low-income market is both a social commitment and a tremendous opportunity for risk carriers to find new markets. But in order to convince players to actively enter this new area, the profitability of the sector must be proven. The findings from the survey show that microinsurance can be profitable, mainly in cases where simple processes and infrequent risk minimize administrative costs, enabling lower premiums, such as credit life products and in-patient health covers. Reducing operating costs by finding efficiencies remains one of the key challenges

for microinsurers on their way to profitability. In this respect, information technologies open up new opportunities, as shown in Box 12. All in all, microinsurance is still a young industry and needs more volume and innovation to profitably sustain its growth.

Box 12: Technology for Microinsurance in Africa

By Eric Gerelle, IBEX Project Services

When considering technology's potential role in African microinsurance, it is worthwhile to consider how it has evolved in the continent over the past decade. The Global Information Technology Report 2008/2009 (Dutta & Mia, 2009) notes that, despite some positive trends, sub-Saharan Africa continues to lag behind the rest of the world. Only two African economies rank in the top half of the Networked Readiness Index, while 18 rank below 100th place. This deficiency may have a positive advantage, as Africa could potentially leapfrog obsolete phases of technology, which would otherwise have required an evolutionary process. The rapid emergence of mobile banking and remittance solutions across Africa over the past five years shows that this technological leapfrogging is indeed possible, and that the continent has become very attentive to the potential of information and communication technologies (ICT) as a tool for development.

Faced with this potential, we must consider technology's optimal role in microinsurance. Or, more generally, we must consider how the insurance industry can best leverage information technology to develop itself and the African continent.

There are many challenges in applying technology to financial services for the unbanked. Mobile phones work well for remittances because the transaction cost is small relative to the amount being transferred. Mobile banking and remittance services are supply-driven initiatives and are often based on proprietary or inflexible communications protocols that lock the client into the service provider. While this system benefits financial companies by providing a captive client base, this should not be the only objective of mobile technology.

From the demand side, the objective is to provide the poor with access to much-needed financial and risk management services. Microinsurance, because of its emphasis on savings and premium collection, has greater promise for the long-term application of technology to assist the poor than remittance services.

The main challenge in applying mobile technology to microinsurance is the size of the transactions. Because the amounts of money involved in each microinsurance transaction can be very small, the primary role of technology must be to reduce transaction costs. This challenge is best illustrated with an example. Let us take the case of UAB Vie, presented in Box 9, which provides an innovative mixed savings and life insurance product in Burkina Faso called *Cauri d'Or*. The clients have an insurance contract in which they must save a minimum (150 CFA USD 0.3) per working day for the period of the contract. UAB Vie sales agents collect savings on a daily basis from clients who typically sell produce in markets and who would otherwise have no access to financial services. In this case, the role of technology would be to improve overall security and transparency, reduce transaction costs and allow the program to scale up significantly.

The practical question is how to use technology to support microinsurance in the most cost-effective way. It is tempting to focus on using technology to support the money collection part of the *Cauri d'Or* process. Rather than first automating the front-end, however, the priority should be to set up a back-end ICT infrastructure to manage the overall program.

As noted in Gerelle and Berende (2008), one ICT solution would be a platform providing Internet access to an African Microinsurance Software Service (AMSS). Application developers would install their software on the common platform, granting access to insurance companies. The infrastructure, licence and software maintenance costs would be shared by several insurers, each operating autonomously and securely with provisions to protect the privacy of their customer data. From an operational perspective, the platform would be managed across Africa at a regional level, with servers in each country. The AMSS platform would be built around appropriate data and workflow standards, allowing many different types of microinsurance applications to use the same ICT platform. Once in place, the AMSS platform would open up the efficient application of mobile technology to lower the transaction costs associated with collecting small premiums. The AMSS platform would provide a stored value account for each client. Since each cell phone transaction contributes to the administrative overhead, there needs to be a way to minimize this cost. As opposed to remittances, which are cost-optimized on a single transaction basis, the AMSS platform would allow applications running on the agent's phone to store many individual transactions and send them to the server as a batch, thus lowering the

communications costs. The AMSS platform would also link to mobile payment platforms so that mobile remittance services, debit cards and other banking services would become available to the microinsurance clients when needed.

The future of technology in microinsurance lies in bypassing obsolete ICT models and leapfrogging directly to the Internet. Using the latest mobile applications to access innovations like shared software as service platforms will reduce operational costs and make microinsurance more financially viable.

10 > CONCLUSIONS

Lack of access to good risk-management tools leaves low-income households in Africa highly vulnerable. National social security systems are absent in most African countries, and informal mechanisms that people use to deal with risks offer limited protection. As a result, at least 700 million people in Africa frequently slide down into poverty or get locked in poverty traps, forced to invest in low-risk, low-return productive activities.

Failure of existing mechanisms presents a huge opportunity for microinsurance to decrease the vulnerability to risks of low-income households, unleash their productive potential and smooth their way out of poverty. Market-based approaches make it possible to deploy microinsurance in a quick and responsive way, filling the gap over the medium-term until governments extend comprehensive safety nets to low-income households.

Microinsurance is growing and expanding throughout Africa. This study finds that over 14 million low-income people in Africa were covered by microinsurance at the end of 2008, accounting for around USD 257 million in received premiums. This amount reflects more than an 80 per cent increase over the last three years, which is substantial growth by any standard.

Even with such growth, there are clearly significant gaps, as this figure still only indicates coverage by less than three per cent of the low-income population in Africa. Substantial parts of the continent remain almost barren of microinsurance. Health, agriculture and property covers, all significantly in need by the low-income market, are evident as a mere fraction of life insurance coverage. Those that are providing health products have difficulty reaching large volumes, and providing quality services to their clients. Credit life, a low-value product for the low-income market, dominates the landscape.

There is a striking abundance of models delivering microinsurance in Africa: commercial and cooperative insurers, health mutual and community-based schemes, MFIs self-carrying risk, health management organizations, and schemes linked to national social security. It is clear that each of these models has advantages; therefore, it is important to support the development of various models in order to expand microinsurance across the low-income market.

The microinsurance market in Africa is definitely attractive for private sector, which already covers more than half of the insureds in this market and collects almost 90 per cent of the premiums. The potential market value of USD 25 billion is compelling. Life, agriculture, weather index and property insurance products are in line with the competences and strategies of commercial insurers. The picture is slightly more complicated regarding health microinsurance: simple in-patient covers might be not perceived as valuable enough by low-income consumers to drive demand. Hybrid models, which leverage the comparative advantages of health mutuals (trust, depth of outreach), commercial insurers (efficiency) and national schemes (risk pooling, subsidies), should be further explored in health microinsurance.

It is critical to create an enabling environment that both protects consumers and allows providers to innovate and reach scale. With this new paradigm, government policies must strike a balance between regulation and market development. The South African experience merits a closer look and could potentially be adapted to other contexts, given its existing regulatory framework and current remarkable outreach.

Given the nature of insurance – clients paying for a future benefit – there is a need for a demand revolution before the microinsurance can reach significant scale. Low renewal rates demonstrate that lack of demand

significantly hampers growth. Some hindrances to growth cannot be directly influenced by insurers, such as availability of quality health services and low capacity to pay among the poorest. However, there are many factors that can be influenced by providers themselves in order to increase take up and renewals. Educating consumers, building trust and simplifying products are among key strategies that should be embraced.

We still need to learn how to make microinsurance a viable business. Increasing scale and risk pools will contribute to this end. Yet, there is still much that needs to be done on the supply side to increase client value and product profitability. Three factors seem to be instrumental in Africa:

- *Distribution* – consolidating current experiences with MFIs and other financial institutions as well as identifying other delivery channels that are trusted, can reach volumes, and have appropriate systems and incentives.
- *Efficiency* – using information and communication technologies to improve efficiency while simultaneously undertaking a more traditional mapping of business processes to identify gaps and trim the fat.
- *Human resources* – designing effective training and human resource management to translate intangible assets – insurance professionals with development lenses – into tangible results.

All in all, massive growth of microinsurance is contingent upon creating solid foundations. Enabling environments, a diversity of providers, a demand revolution, new distribution channels, improved efficiency and human resource management – not all can be done by providers themselves. Donors and governments must support the efforts of providers, creating a coordinated movement to provide tools that will help low-income Africans manage risks and lead safer, more stable lives.

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ANNEX: OUTREACH BY PRODUCT AND LIST OF PROVIDERS FOR SPECIFIC COUNTRIES

Country	Number of lives covered*						Penetration rate**					
	total	CL	L	H	A	P	total	CL	L	H	A	P
South Africa	8,227,387	3,800,000	6,841,387	100,000	56	9,005	40.4%	141.4%	51.1%	0.5%	0.0%	0.2%
Namibia	141,969	17,709	91,969	54,479	50,000		11.2%	10.6%	12.1%	4.3%	33.3%	0.0%
Seychelles	4,000		4,000			4,000	9.9%	0.0%	14.1%	0.0%	0.0%	52.3%
Kenya	1,102,317	780,725	112,147	483,555		90,000	8.1%	43.2%	1.5%	3.5%	0.0%	3.5%
Tunisia	95,000	95,000					7.3%	59.8%	0.0%	0.0%	0.0%	0.0%
Uganda	1,498,789	310,000	1,309,000	154,789		70,000	6.9%	10.8%	12.5%	0.7%	0.0%	1.7%
Senegal	346,764	91,423	0	266,351	0	0	4.9%	9.8%	0.0%	3.8%	0.0%	0.0%
Benin	170,081	57,250	1,700	118,081		245	2.7%	6.8%	0.1%	1.9%	0.0%	0.0%
Zimbabwe	211,000	1,000	210,000		1,870		2.4%	0.1%	4.3%	0.0%	0.2%	0.0%
Togo	81,757	78,464	2,250	1,293			1.9%	14.0%	0.1%	0.0%	0.0%	0.0%
Cameroon	177,718	33,225	15,005	133,897	10,000	87	1.9%	2.7%	0.3%	1.4%	1.3%	0.0%
Botswana	16,000	1,000	7,000	10,000	100	11,000	1.8%	0.9%	1.3%	1.1%	0.2%	6.7%
Comoros	9,000			9,000			1.7%	0.0%	0.0%	1.7%	0.0%	0.0%
Ethiopia	1,008,292	1,005,092			3,200		1.7%	12.7%	0.0%	0.0%	0.0%	0.0%
Guinea	136,146			136,146			1.7%	0.0%	0.0%	1.7%	0.0%	0.0%
Malawi	186,521	143,668	174,521	34,815	4,800	12,000	1.6%	9.3%	2.9%	0.3%	0.3%	0.5%
Burkina Faso	140,403	82,637	19,296	36,381		12,000	1.3%	5.8%	0.4%	0.3%	0.0%	0.6%
Mali	131,559	83,775		47,784			1.3%	6.1%	0.0%	0.5%	0.0%	0.0%
Egypt	142,100	142,100	19,000				1.1%	9.4%	0.2%	0.0%	0.0%	0.0%
Mauritania	12,681	100	130	12,681			0.9%	0.1%	0.0%	0.9%	0.0%	0.0%
Tanzania	335,022	157,006	194,822	29,992			0.9%	3.3%	1.0%	0.1%	0.0%	0.0%
Ghana	95,110	71,210	65,693	700	0	43,686	0.8%	4.5%	0.9%	0.0%	0.0%	2.0%
Republic of the Congo	21,146	2,599	18,698	18,547			0.7%	0.7%	1.2%	0.6%	0.0%	0.0%
Zambia	37,188	27,585	23,152				0.4%	2.2%	0.5%	0.0%	0.0%	0.0%
Côte d'Ivoire	30,644	5,000	350	25,394		100	0.4%	0.4%	0.0%	0.3%	0.0%	0.0%
Burundi	24,610	10,000	5,500	14,610			0.3%	1.1%	0.2%	0.2%	0.0%	0.0%
Democratic Republic of the Congo	150,335	1,000	500	150,335	1,500	100	0.3%	0.0%	0.0%	0.3%	0.0%	0.0%
Morocco	8,540				8,540		0.2%	0.0%	0.0%	0.0%	2.5%	0.0%
Nigeria	106,992	24,000	35,000	61,992			0.1%	0.2%	0.1%	0.1%	0.0%	0.0%
Niger	2,370			2,370			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Algeria	1,500	1,500					0.0%	0.2%	0.0%	0.0%	0.0%	0.0%
Madagascar	2,000	2,000					0.0%	0.1%	0.0%	0.0%	0.0%	0.0%

* Note that the number of people covered by product does not match the total number covered due to microinsurance programs offering multiple products to the same clients.

** Penetration rate = current outreach divided by total market size calculated as follows for specific risk areas: Credit life = share of poor households (below USD 2) having credit needs (assuming 50%); Life = share of poor population (below USD 2) aged 15-64; Health = poor population (below USD 2); Agriculture = share of poor households (below USD 2) living in rural areas; Property = poor households (below USD 2).

List of providers by country/product

The list below provides all organizations that responded and were included in the analysis. To avoid double counting they were organized by risk-carrier model , meaning that risk carriers were retained to represent the scheme in question. For example, if an MFI works with an insurer within a partner-agent model and both of them responded we have retained insurer to represent the scheme. But if an insurer has not responded the MFI was retained but under the category 'regulated insurer' as the risk is still carried by an insurer. Each of the risk-carriers below can run or represent multiple schemes and can have few product lines.

Four respondents preferred to keep their data confidential, therefore the outreach figures for Uganda, Kenya and South Africa do not sum up to aggregate numbers for those three countries presented in the paper.

		Organization name	total lives covered	credit life	other life	health	agriculture	property
Algeria	mutuals and community-based	Caisse Nationale Mutualité Agricole	1'500	1'500	.	.	.	.
	Total	*1*	*1*	*1*				
Benin	mutuals and community-based	Centre Beninois pour le Developpement des Initiatives de Base	6'625	.	.	6'625	.	.
		Solidarite et developpement (SOLIDEV)	5'483	.	.	5'483	.	.
		RESEAU ALLIANCE SANTE	38'709	.	.	38'709	.	.
		mutuelle de santé de Cotonou	11'172	.	.	11'172	.	.
		Mutuelle de Sécurité Sociale du Bénin	8'000	.	.	8'000	.	.
		PROMUSAF- BENIN	10'916	.	.	10'916	.	.
		Mutuelle de Santé ALAFIA de Kétou	2'100	.	.	2'100	.	.
		Mutuelle de santé AZONDJEGBE d'Abomey	1'512	.	.	1'512	.	.
		MUSANT (Mutuelle de Sante pour Tous)	25'000	.	.	25'000	.	.
	regulated insurers	SAAR Benin / Agence Esperancia	700	.	500	700	.	150
		CHRYSALIDE INTERNATIONAL INSURANCE BROKERS	6'000	5'000	1'200	6'000	.	.
		LA GENERALE DES ASSURANCES DU BENIN (LA GAB sa)	.	.	.	.	.	.
		AFRICAINE VIE BENIN SA	7'000	7'000	.	.	.	.
	other risk carrier	VADID	460	250	.	460	.	95
		MUTUELLE DE SANTE DE GBANLIN	1'404	.	.	1'404	.	.
		VitalFinance	15'000	15'000	.	.	.	.
		FECECAM	30'000	30'000	.	.	.	.
	Total	*17*	*16*	*5*	*2*	*13*		*2*
Botswana	commercial risk carrier	Botswana Insurance Company	11'000	.	2'000	10'000	100	11'000

		Botswana Life	5'000	1'000	5'000	.	.	.
	Total	*2*	*2*	*1*	*2*	*1*	*1*	*1*
Burkina Faso	mutuals and community-based	ASSOCIATION MANEGDBZANGA	287	.	.	287	.	.
		Association pour le Developpement de la Region de Kaya	10'559	.	.	10'559	.	.
		Assurance Maladie a la Base Communautaire de Nouna	4'456	.	.	4'456	.	.
		MUTUELLE DE SANTE DE BOUAHOUN	1'119	.	.	1'119	.	.
		Mutuelle d'Epargne, de Credit & de Prevoyance "LAA FI SIRA KWIEOGO	130	130	.	.	.	.
		Mutuelle de Santé Urbaine Laafi-Baoré (MSU-LB)	965	.	.	965	.	.
		Mutuelle de santé du village de Sirghin	520	.	.	520	.	.
		Mutuelle Nationale de Santé des Etudiants du Burkina	1'500	.	.	1'500	.	.
		Association Songui Manegre Aide au Développement Endogène (ASMADE)	8'017	.	.	8'017	.	.
	other risk carrier	Federation des Caisses Populaires du Burkina	70'554	70'554	.	.	.	.
		PRODIA	11'700	11'700	.	.	.	.
	regulated insurers	GA-ASSURANCES VIE	12'000	.	700	700	.	12'000
		SONAR IARD	100	.	100	.	.	.
		UNION DES ASSURANCES DU BURKINA IARDT	8'258	.	8'258	8'258	.	.
		Union des Assurances du Burkina Vie	10'238	253	10'238	.	.	.
	Total	*15*	*15*	*4*	*4*	*10*		*1*
Burundi	regulated insurers	BURUNDI INSURANCE CORPORATION (BICOR SA)	10'000	10'000	5'500	.	.	.
	mutuals and community-based	ADISCO	14'610	.	.	14'610	.	.
	Total	*2*	*2*	*1*	*1*	*1*		
Cameroon	mutual risk carrier	ABIHO/CERDESS	584	.	.	584	.	.
		ASSOAL/MCSY(mutuelle communautaire de santé de yao	750	.	.	750	.	.
		ASSOCIATION POUR LA PROMOTION DU CAPITAL SOCIAL	2'000	.	.	2'000	.	.
		FONDS SPECIAL POUR LA PROMOTION DE LA SANTE DU LITTORAL	1'699	.	5	1'699	.	.
		Mutuelle de santé communautaire de Meskine	400	.	.	400	.	.
		MUTUELLE DE SANTE DE NYLON (MUSANY)	12'103	.	.	12'103	.	.
		North West Provincial Special Fund For Health	34'000			34'000		
		PROMO FEMMES	50	.	50	50	.	50

		SEGIDEV (Service de gestion de l'information pour	300	.	.	300	.	.
		Service d'Appui aux initiatives locales de developpement	55'237	.	.	55'237	.	.
		ARCAD	16'578	.	.	16'578	.	.
		Mutuelles de santé sans frontiere	1'250	.	.	1'250	.	.
	regulated insurers	AGF CAMEROUN ASSURANCES VIE	10'000	10'000	1'500	.	.	.
		Colina La Citoyenne Cameroun	6'000	.	1'500	6'000	.	.
		CREDIT DU SAHEL S.A.	10'000	10'000	.	.	.	.
		SAMIRIS S.A	2'000	.	2'000	2'000	.	.
		Societe ACTIVA VIE	13'225	13'225	8'408	.	.	37
	other risk carrier	Association EKAN MBOLO	700	.	700	700	.	.
		BSB Cameroon	842	.	842	246	.	.
		UNITED SAVINGS AND AGRICULTURAL CREDIT(USA CREDIT)	10'000	.	.	.	10'000	.
	Total	*20*	*20*	*4*	*9*	*16*	*2*	*3*
Comoros	mutuals and community-based	CIDR	9'000	.	.	9'000	.	.
	Total	*1*	*1*			*1*		
Congo Brazzaville	regulated insurers	ASSURANCES GENERALES DU CONGO -Vie	2'599	2'599	151	.	.	.
	mutual risk carrier	Mutuelle de la FETRAISEC (MUGEF)	18'547	.	18'547	18'547	.	.
	Total	*2*	*2*	*1*	*2*	*1*		
Côte dIvoire	regulated insurers	La Loyale VIE Assurance	3'000	3'000	.	.	.	.
		NSIA Vie CI	250	.	250	.	.	.
		Kescars Cote d'Ivoire	100	.	.	100	.	100
		AGF Cote d'Ivoire Assurances Vie	2'000	2'000	100	.	.	.
	mutuals and community-based	BUREAU IVOIRIEN DE L'INITIATIVE COMMUNAUTAIRE	12'000	.	.	12'000	.	.
		Mutuelle de Santé des Agents du Centre National de Recherche Agronomique	8'789	.	.	8'789	.	.
		Mutuelle Sociale des Agents de PALMAFRIQUE	4'245	.	.	4'245	.	.
		Centre Médico-social Nimatoullah	110	.	.	110	.	.
		Mutuelles des Fonctionnaires et des agents de l'Etat	.	.	.	.	.	.
	other risk carrier	Fondation Dr Javad Nourbakhsh	150	.	.	150	.	.
	Total	*10*	*9*	*2*	*2*	*6*		*1*
Democratic	mutuals and community-based	GROUPE D'APPUI A LA LUTTE CONTRE L'EXODE RURAL ET	5'000	1'000	500	5'000	1'500	100

Republic of the Congo		L'IMMIGRATION (GALERI/ONG)						
		Programme national de promotion des mutuelles de santé/Ministère de la santé publique/RDC	31'335	.	.	31'335	.	.
		CDI Bwamanda	114'000	.	.	114'000	.	.
	Total	*3*	*3*	*1*	*1*	*3*	*1*	*1*
Egypt	regulated insurers	Alexandria Business Association (ABA)	123'100	123'100	.	.	.	.
		FMF	19'000	19'000	19'000	.	.	.
	Total	*2*	*2*	*2*	*1*			
Ethiopia	other risk carrier	Addis credit and saving institution	87'000	87'000	.	.	.	.
		Amhara Credit and Saving Institution(ACSI)	500'000	500'000	.	.	.	.
		Gasha Micro Financing S. Co	4'092	4'092	.	.	.	.
		Oromia Credit and savings Share Company [OCSSCO]	414'000	414'000	.	.	.	.
	regulated insurers	NYALA INSURANCE S.C.	3'200	.	.	.	3'200	.
	Total	*5*	*5*	*4*			*1*	
Ghana	regulated insurers	StarLife	3'000	200	3'000	.	.	.
		Mumuadu Rural Bank ltd	15'007	15'007	.	.	.	.
		QUALITY INSURANCE COMPANY LIMITED, GHANA	400	.	.	.	.	400
		Sinapi Aba Trust	54'603	54'603	41'293	.	.	43'286
		Unique Life Assurance Company	1'400	1'400	1'400	.	.	.
		ELAC	20'000	.	20'000	.	.	.
	mutuals and community-based	Initiative Development Ghana	700			700		
	Total	*7*	*7*	*5*	*5*	*1*	*1*	*3*
Guinea	mutuals and community-based	PSS:GTZ	112'800	.	.	112'800	.	.
		Union des Mutuelles de santé de Guinée Forestiere	23'346	.	.	23'346	.	.
	Total	*2*	*2*			*2*		
Kenya	regulated insurers	BRITISH-AMERICAN INSURANCE COMPANY (K) LTD	550'000	550'000	65'000	65'000	.	.
		CIC Insurance Company	170'725	170'725	42'055	42'055	.	.
		Kenya Orient Insurance Limited	5'092	.	5'092	.	.	.
		AAR	1'500	.	.	1'500	.	.
	other risk carrier	Jamii Bora Kenya ltd	300'000	60'000	.	300'000	.	90'000
	mutuals and community-based	KENYA COMMUNITY BASED HEALTH FINANCING	75'000	.	.	75'000	.	.

		ASSOCIATION						
	Total	*6*	*6*	*3*	*3*	*5*		*1*
Madagascar	other risk carrier	SIPEM	2'000	2'000	.	.	.	.
	Total	*1*	*1*	*1*				
Malawi	regulated insurers	CUMO MICROFINANCE LIMITED	34'815	34'815	34'815	34'815	.	.
		OPPORTUNITY INTERNATIONAL BANK	34'000	34'000	22'000	.	4'800	12'000
		FINCA	29'706	14'853	29'706	.	.	.
	other risk carrier	MALAWI UNION OF SAVINGS AND CREDIT COOPERATIVES	88'000	60'000	88'000	.	.	.
	Total	*4*	*4*	*4*	*4*	*1*	*1*	*1*
Mali	other risk carrier	Reseau des Caisses d'Epargne et de Credit du Mali	10'613	10'613	.	.	.	.
		Kafo Jiginew	71'162	71'162	.	.	.	.
	regulated insurers	Societe Nouvelle d'Assurance Vie	2'000	2'000	.	.	.	.
	mutuals and community-based	Mutuelle de Santé Régionale de Sikasso(MUSARS)	2'419	.	.	2'419	.	.
		Assurance Maladie Volontaire	42'000	.	.	42'000	.	.
		"Union Technique de la Mutualité Malienne Unité O	3'365	.	.	3'365	.	.
	Total	*6*	*6*	*3*		*3*		
Marocco	regulated insurers	La Société Centrale de Réassurance (SCR)	8'540	.	.	.	8'540	.
	Total	*1*	*1*				*1*	
Mauritania	mutuals and community-based	Caritas Mauritanie	3'809	.	.	3'809	.	.
		Mutuelle Communautaire de Santé de Dar Naim	7'795	.	.	7'795	.	.
		Mutuelle de Sante de Kaedi	1'077	100	130	1'077	.	.
	Total	*3*	*3*	*1*	*1*	*3*		
Namibia	regulated insurers	Prosperity Insurance Limited	50'000	.	.	40'000	50'000	.
		Trustco Group Holdings Limited	91'969	17'709	91'969	14'479	.	.
	Total	*2*	*2*	*1*	*1*	*2*	*1*	
Niger	mutuals and community-based	ONG AFUA	2'370	.	.	2'370	.	.
	Total	*1*	*1*			*1*		
Nigeria	regulated insurers	ADIC Insurance Ltd	.	.	.	.	.	.
		AIICO GENERAL INSURANCE COMPANY LIMITED	.	.	.	.	.	.
		MUTUAL BENEFITS ASSURANCE PLC	25'000	2'000	25'000	.	.	.

		SPRING LIFE ASSURANCE PLC	12'000	12'000	.	12'000	.	.
		Unic	10'000	10'000	.	.	.	.
		INDUSTRIAL AND GENERAL INSURANCE PLC	10'000	.	10'000	.	.	.
	other risk carrier	Hygeia Community Health Plan	49'992	.	.	49'992	.	.
	Total	*7*	*5*	*3*	*2*	*2*		
Senegal	mutuals and community-based	Anesaroudine	20	.	.	20	.	.
		Association Intermondes	7'743	.	.	7'743	.	.
		BOKK FAJ	3'600	.	.	3'600	.	.
		Mutuelle Mame Cheikh Anta	150	.	.	150	.	.
		Mutuelle Sociale TransVie	1'293	.	.	1'293	.	.
		Cadre d'Etudes et des Partage des Initiatives Communautaires	12'000	.	.	12'000	.	.
		ENDSS SOLIDARITE	450	450	.	450	.	.
		MUTUELLE DE SANTE DU S U D E S	4'901	.	.	4'901	.	.
		WER WERLE PROFEMU	1'418	.	.	1'418	.	.
		ASADEP	4'654	.	.	4'654	.	.
		Mutuelle de Santé Communautaire de Foundiougne	3'618	.	.	3'618	.	.
		Gainde Fatma	828	.	.	828	.	.
		MUTUELLE DE SANTE HOUDA	400	.	.	400	.	.
		Mutuelle de Santé des Artisans et Ouvriers MUSAO	8'000	.	.	8'000	.	.
		UMUSARK	14'014	.	.	14'014	.	.
		Coordination regionale des mutuelles de sante de Diourbel	21'800	.	.	21'800	.	.
		Mutuelle de santé de Niakhar	5'902	.	.	5'902	.	.
		Mutuelle des Volontaires et Contractuels de L'Education	165'000	.	.	165'000	.	.
	regulated insurers	PLANET GUARANTEE	20'000	20'000				
	other risk carrier	PAMECAS	70'973	70'973	.	10'560	.	.
	Total	*23*	*22*	*3*	*1*	*22*	*1*	*1*
Seychelles	regulated insurers	SACOS INSURANCE CO. LTD	4'000	.	4'000	.	.	4'000
	Total	*1*	*1*		*1*			*1*
South Africa	regulated insurers	Hollard	1'600'000	1'600'000	720'000	.	.	.
		ABSA	1'000'000	200'000	1'000'000	.	.	.
		Absa Insurance Company	8'733	.	8'733	.	.	650
		Centriq	6'000	.	.	.	.	6'000

		Mutual & Federal Insurance Company Limited	2'654	.	2'654	.	56	2'355
		Old Mutual South Africa	100'000	.	100'000	.	.	.
		UnionLife	780'000	.	780'000	.	.	.
		GBA	150'000	.	150'000	.	.	.
		SANLAM DEVELOPING MARKETS LIMITED	2'400'000	.	2'400'000	.	.	.
	Total	*11*	*11*	*3*	*10*	*1*	*1*	*3*
Tanzania	mutuals and community-based	CIDR	9'792	.	9'792	9'792	.	.
		Tanzania Network of Community Health Funds (TNCHF)	20'200	.	.	20'200	.	.
	Regulated insurers	FINCA	185'030	37'006	185'030	.	.	.
	Total	*4*	*4*	*2*	*2*	*2*		
Togo	regulated insurers	GTAC2A-VIE	2'000	.	2'000	.	.	.
		MAFUCECTO	70'646	70'646	.	.	.	.
		MICROFUND	5'000	5'000	250	.	.	.
		MUTUELLE AKWABA	2'200	2'200	.	.	.	.
	mutuals and community-based	MUSA-CSTT	1'293	.	.	1'293	.	.
	other risk carrier	ASSOCIATION JEUNES ET DEVELLOPPEMENT (AS.J.D)	618	618	.	.	.	.
	Total	*6*	*6*	*4*	*2*	*1*		
Tunisia	other risk carrier	Enda Inter-Arabe	95'000	95'000	.	.	.	.
	Total	*1*	*1*	*1*				
Uganda	mutuals and community-based	HealthPartners	4'000	.	.	4'000	.	.
		Uganda Community Based Health Financing Association	100'000	.	.	100'000	.	.
	regulated insurers	Microcare Health Ltd	49'789	.	.	49'789	.	.
		UAP insurance Uganda Limited	30'000	15'000	2'000	1'000	.	30'000
		National Insurance Corporation Ltd	40'000	40'000	32'000	.	.	40'000
	Total	*6*	*6*	*3*	*3*	*4*		*2*
Zambia	regulated insurers	Madison life insurance co.	17'424	17'424	3'388	.	.	.
		FINCA	19'764	10'161	19'764	.	.	.
	Total	*2*	*2*	*2*	*2*			
Zimbabwe	other risk carrier	Collective Self Finance Scheme	1'000	1'000	.	.	.	.
	regulated insurers	TristarInsurance Company Limited	210'000	.	210'000	.	1'870	.
	Total	*2*	*2*	*1*	*1*		*1*	
Total		176	171	66	62	102	12	21

MICROINSURANCE INNOVATION FACILITY

Backed by a grant from the Bill & Melinda Gates Foundation, the ILO's Microinsurance Innovation Facility was established in 2008 to support the extension of insurance to millions of low-income people in the developing world, with the overall aim of reducing their vulnerability to risk.

The ultimate objective of the Facility is to encourage the development of microinsurance so that – by the end of 2012 –150 million low-income people will be able to make informed choices on how to manage risk and will have access to a wider range of insurance products that provide better value for money.

To achieve its goals, the Facility engages in four sets of activities:

- giving **grants** to institutions to devise and test innovative approaches to providing better insurance products to low-income women and men in developing countries
- supporting the development of **technical assistance** providers and encouraging the demand for such services
- supporting **research** on core issues related to insurance cover for low-income households
- **disseminating** information and lessons learned to key stakeholders

For more information, check the Facility's website (www.ilo.org/microinsurance) or contact us at microinsuranceresearch@ilo.org .

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