



Improving Access to Health for Rural Populations:

A Study of CRS' Health Microinsurance Pilot in Benin

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REPORT

Abstract: CRS' health microinsurance (HMI) pilot was launched in Atacora, Benin on March 1, 2012. This study was commissioned to better understand the HMI program rollout, including client demand and experiences, strengths and weaknesses, and ideas about how to integrate the HMI into Benin's universal health insurance program (RAMU). The research used qualitative methods to hold focus group discussions and interviews with members of 14 SILC groups. The groups were selected from 33 participating groups, using a stratified random sample to ensure representation of the participating health service providers. The findings show that there is a strong demand for HMI at the SILC level, and that users observe benefits of decreased costs; increased access to health care; decreased worries related to health; improved ability to follow treatment; and increased group solidarity. The greatest challenge is with the level of healthcare provider, where nurses are required to complete additional and uncompensated administrative work, and therefore are not motivated to support the HMI product. Other challenges found were first, a low level of commitment from the insurance company (NSIA), manifest in a hesitation to dedicate human and financial resources necessary to support the administrative components of the product, and second, obstacles created by a lack of trust between the SILC groups, NSIA, and the healthcare providers.

Table of Acronyms

ANAM	Agence Nationale de l'Assurance Maladie
ASCA	Accumulated Savings and Credit Association
CRS	Catholic Relief Services
DNPS	Direction Nationale de la Protection Sanitaire
FBR	Financement Basé sur les Résultats
F CFA	Francs de la Communauté Financière Africaine
FGD	Focus Group Discussions
GoB	Government of Benin
HMI	Health Microinsurance
HMO	Health Mutual Organization
LC	Learning Conversation
NGO	Non-Governmental Organization
NSIA	Nouvelle Société Interafricaine d'Assurance
RAMU	Régime d'Assurance Maladie Universelle
SILC	Savings and Internal Lending Communities
USD	United States Dollar

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EXECUTIVE SUMMARY

Since 1992, CRS has provided microfinance services to rural and unbanked populations in Benin. In 2006, CRS adopted the Savings and Internal Lending Communities methodology,

known as SILC. SILC groups become independent or “mature” after one cycle, after which they no longer receive external support. In addition to a loan fund, they have a social insurance fund, known as the “social fund.” Members regularly contribute to the social fund and can access it in a time of need. The social fund is used for unexpected health costs, including transport to health centers, consultations, and medications. However, the social fund grant is rarely sufficient to cover all costs. As such, SILC members borrow from the group, friends or neighbors to pay the difference.

To better manage their health costs, SILC members in the Atacora region of northern Benin considered joining health mutuals; however, they reportedly felt unwelcome at the regional health mutuals, which were far away and lacked the solidarity of SILC groups. The SILC groups therefore asked Caritas Natitingou and CRS to transform their savings groups into health mutuals. Since health mutuals can take many years to form and become independent, CRS proposed to look at alternative that led to the SILC groups partnering the Nouvelle Société Interafricaine d'Assurance – Bénin, a private insurance company, to create a health microinsurance product.

Subscription to the product is voluntary and individual, with a monthly premium collected bi-annually (February and July 2012). Primary membership is limited to SILC members and costs 290 F CFA (\$0.54) per person, per month, or 3,480 F CFA (\$6.52) per person, per year. The insurance covers 70% of costs at participating local health centers, including products sold at those health centers' pharmacies. The 30% copay covers the difference and is paid at the time of service. The insurance includes a life insurance rider for death and permanent disability.

Given that this is a new process for CRS, Caritas and the SILC members CRS decided to conduct this study to better understand if the insurance product is meeting client demand, how demand for HMI is changing, the perceived benefits and downsides of HMI, and the current strengths and weaknesses related to general functioning of HMI in its early stages. As such, this study looked at the initial challenges, possible solutions, and how it might be linked to the Government of Benin's Régime d'Assurance Maladie Universelle.

The study, which was conducted from July 4 through 14, 2012 in Chabicouma and Kotopounga “arrondissements,” used a qualitative methodology. Due to the limited size of the sample these findings cannot be extrapolated or generalized to other SILC groups, or to other health microinsurance programs. A sample of 16 SILC was randomly selected, stratified by the health center frequented; e.g., 7 from St. Joseph's Heath Center, 7 from Boderima and Kotopounga Health Centers, and 2 groups from Yarikou Health Center. Two groups could not be interviewed due to logistical conflicts. Data was collected from SILC groups via focus group discussions (n=19) and qualitative individual interviews with SILC members (n=6). Fourteen interviews were conducted with subscribers and 11 with non-subscribers.

The study found that while significantly fewer SILC members enrolled in the insurance product than CRS originally projected, feedback about the product was generally positive. Subscribers reported decreased health costs, improved access to healthcare, a decrease in worries, a decrease in surprise costs, an improved ability to follow prescribed treatments, and increased group solidarity. Most respondents (subscribers and non-subscribers) reported that they would like to join or renew their subscription. Non-subscribers stated that the cost per member and logistical obstacles were the major factors preventing subscription, while subscribers stated that others declined to join HMI because of a lack of understanding and a lack of trust.

CRS and Caritas staff noted that while there is a strong demand from SILC groups there are a number of challenges that need to be addressed before the product can be sustainable. The greatest challenge identified by Caritas was planning, in terms of setting dates for subscription and renewal with the communities. Healthcare providers expressed that the product, so far, presents an added administrative burden for them, with little or no short-term benefit. They expressed that they lack the capacity to serve additional clients and reported logistical challenges in terms of salary and claim reimbursements from NSIA. Nonetheless, they expressed that they are willing to work with CRS and NSIA to make the product work.

While NSIA indicated that the product has the potential to be greatly profitable in the future, they were still reluctant to invest financial resources before seeing proof of concept. They expressed mixed opinions about the financing structure, particularly the profitability of the life insurance rider. NSIA expressed approval of CRS' work and the hope that CRS will remain involved for at least two more years. Government officials expressed their approval of the pilot project and curiosity about whether it will be successful or not.

CONCLUSIONS AND RECOMMENDATIONS

This research and analysis demonstrates that health microinsurance through a private insurance company is a unique opportunity with significant potential benefits for all relevant parties. The client base, the insurance company, the healthcare providers, and the Government of Benin, stand to make significant gains if it is successful. The fundamental factors necessary for success are present. At the SILC level there is demand and they are able to make the premium payments. At the health center level, they have committed to the pilot program as they stand to gain more clients, more income, and can provide a more proactive approach to preventative healthcare. For NSIA, they can make a substantial profit, while providing a valued service. As such the following recommendations are provided to ensure the long-term success of this pilot, with a particular focus on building trust between all stakeholders:

Global Recommendations

- (1) Prioritize the experiences of the first clients as others are observing before joining.
- (2) Promote trust by being transparent, predictable, and proactive in all decisions:

- Share findings and insights with all partners, as quickly as possible; and
- Provide a formal forum for feedback; e.g. a quarterly stakeholders meeting.

1.1. Recommendations for CRS & Caritas

- (3) Think outside the project box to find ways to build capacities and interest of NSIA, the healthcare providers, and the clients.
- (4) Work with NSIA to develop strategy to improve NSIA's ability to serve rural populations:
 - Leverage relationships to convince the superiors at NSIA to prioritize HMI;
 - Remain involved in the pilot until it is self-sustainable but start a transfer of responsibilities to NSIA immediately;
 - Foster the relationship between NSIA and target communities by identifying an NSIA employee to be the face of HMI in rural communities *and* at NSIA headquarters; and
- (5) Motivate the healthcare providers to provide higher quality service:
 - Consider a prize to honor the health center that welcomes and treats the most patients;
 - Consider working with the Government of Benin to adopt NSIA's HMI into RAMU; and
 - Consider adding a capacity building component for participating healthcare providers.
- (6) Strengthen sensitizations and learning conversation session to:
 - Reinforce the notion that health insurance does not necessarily decrease overall health costs, but that it does improve subscribers' ability to manage healthcare costs;
 - Encourage clients to use facilities for a range of services; and
 - Develop additional learning conversation sessions to address challenges as they arise.

1.2. Recommendations for NSIA

- (7) Invest in the necessary financial and human resources to successfully manage the project.
- (8) Strengthen the relationship between NSIA and the client base to develop trust:
 - Establish a method of direct contact between NSIA and client populations; and
 - Consider holding a sensitization campaign about NSIA with local populations:
- (9) Strengthen the relationship between NSIA and the healthcare providers to develop trust:
 - Contact healthcare providers regularly and provide them with a dedicated contact person at NSIA who they can call with any questions or concerns;
 - Consider re-working and simplifying the administrative documents; and
 - Consult healthcare providers in the process of developing the new documents.
- (10) Establish and publicize a schedule for policy renewal dates, well in advance:
 - Make these dates public; and
 - Stick to the scheduled day and scheduled time.
- (11) Publicize the terms and conditions as much as possible:
 - Include costs, services available, accepted drugs, life insurance payout, etc.;
 - Distribute informational packets to healthcare centers and SILC groups; and

- Laminate one copy for each healthcare center and request it be kept in a place where visitors and healthcare providers can easily reference it.

1.3. For Future Research

- (12) Examine how mobile technology could help with logistical challenges:
 - SMS platforms for healthcare providers to send receipts digitally to NSIA;
 - Mobile money to send reimbursements to healthcare providers; and
 - Enable clients to sign up directly from Natitingou via mobile phones.
- (13) Examine how this product can be integrated into RAMU.

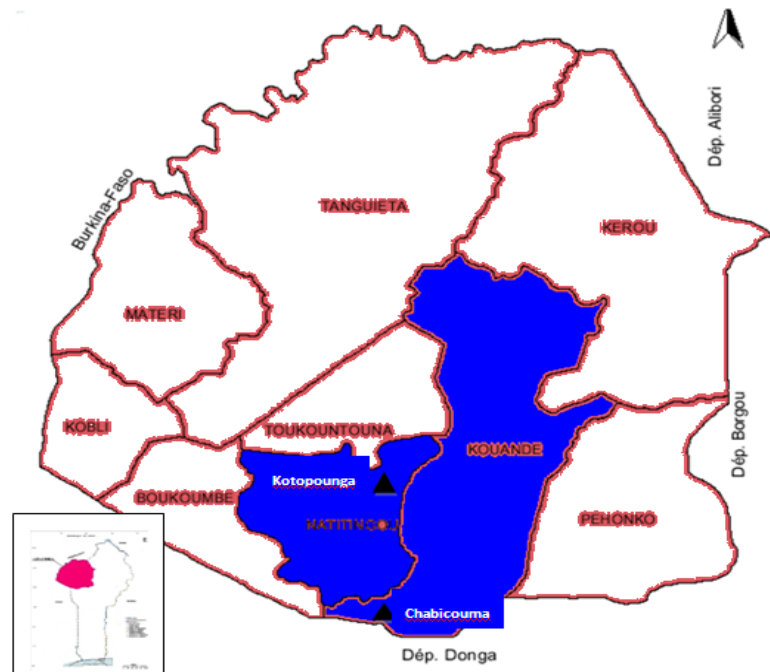
1. INTRODUCTION

Since 1992, CRS has provided microfinance services to rural and unbanked populations in Benin with the support of the implementing partner, Caritas Benin. In 2006, CRS adopted the Savings and Internal Lending Communities (SILC) methodology, based on an accumulated savings and credit association (ASCA) model, with an internally managed loan fund. SILC groups become independent or “mature” after one cycle (generally 12 months), at which time they no longer receive external support. There are currently over 765 functioning SILC groups in Benin.

In addition to a loan fund, SILC promotes the creation of a social insurance fund, known as the “social fund.” Members regularly contribute to the social fund and can access it in a time of need.¹ Although each group sets its own rules, the loan fund typically has a fixed interest rate and repayment period, while the social fund functions as an interest free grant.² Many groups use their social fund to help defray unexpected health costs, including transport to health centers, cost of consultations, and cost of medications. However, the

social fund grant is rarely sufficient to cover all costs. As such, SILC members often borrow from the group or from friends and neighbors to pay the difference (Sawyer, 2011). To better manage health costs, SILC members in the Atacora region of northern Benin (Figure 1) considered joining health mutuals, a form of community-based health insurance that is popular in Benin. SILC members; however, reportedly felt unwelcome at the regional health mutuals, which were far away and lacked the solidarity of SILC groups. The SILC groups asked Caritas Natitingou and CRS to transform their savings groups into health mutuals. Health mutuals take many years to form and become independent, and additionally, can fail due to internal shocks to the group. Instead, CRS proposed partnering with a private

Figure 1 Target communities in Natitingou and Kouandé



¹ For more information on SILC methodology, please see (Vanmeenen, 2010)

http://issuu.com/catholicreliefservices/docs/voices_from_africa?mode=window&backgroundColor=%23222222.

² Exceptions include groups that give interest free loans from the loan fund under specified circumstances; e.g., health emergencies.

insurance company, the Nouvelle Société Inter africaine d'Assurance-Bénin (NSIA)³ to formulate a health microinsurance (HMI)⁴ product to offer to mature SILC groups.

With the approval of the SILC groups and NSIA, CRS conducted a study on the health needs of the target populations in September 2010. The study concluded that on average, people get sick 1.33 times per year, and that malaria is the main cause of hospitalization, constituting 46% of illnesses in the study area. Severe respiratory infections and gastrointestinal illnesses followed at 12% and 10% respectively. According to government health statistics from 2007, hospital frequentation is less than 28% of capacity in the target area, with 51% of those interviewed stating that they have difficulty accessing health care because of costs. Table 1 describes the self-reported financial limitations of SILC members in relation to paying for healthcare costs.⁵ To mitigate these costs, people purchase medicines in the market, frequent traditional healers, and/or wait until it is absolutely necessary to seek formal medical care (Klein, 2007).

Table 1 Level of financial difficulty paying for health costs

Difficulty meeting costs of:	Respondents	Cumulative respondents
Greater than 1000 F CFA (\$1.87) ⁶	60	60/141
Greater than 2000 F CFA (\$3.75)	9	69/141
Greater than 5000 F CFA (\$9.37)	48	117/141
Greater than 10 000 F CFA (\$18.74)	24	141/141

Source: constructed from data collected in the field during CRS' microinsurance feasibility study in 2010.

The feasibility study found that 99% of the 141 people interviewed were interested in subscribing to a health microinsurance scheme, although 82% of those surveyed preferred that the premium remain below 1,000 F CFA (\$1.87) per month to cover the entire household. As discussed below, the premium of the current HMI product must be paid individually, so for an average household size of six people it costs 1,740 F CFA (\$3.26) per month.

Following the September 2010 study, NSIA decided that the initial study was not sufficient, and employed its in-house actuaries to conduct a second study. This resulted in a new and more expensive pricing structure. After negotiations, CRS and NSIA agreed on the price structure that is delineated in Table 2. SILC groups were made aware of the increase in the

³ New InterAfrican Insurance Company

⁴ For this paper, all references to HMI refer to the product developed by NSIA and promoted by CRS in this pilot.

⁵ Catholic Relief Services - Benin; "Report on the Supply and Demand of Healthcare for Populations in Kotopounga and Chabicouma Related to the Launching of a System of Community Health Microinsurance." Internal Report. September 2010.

⁶ All monetary sums are presented in F CFA with USD equivalents in parentheses, using the July 2012 average exchange rate of 1 USD = 533.7 F CFA.

premium after they had been informed of the original lower price, but before they started to save to meet the annual premium. By October, 2011, 850 SILC group members expressed their intention to register for the HMI, along with family members for a total of 2,840 “preregistered” beneficiaries.⁷ Due to delays related to NSIA’s actuarial study, and the limited availability of NSIA personnel at the end of the calendar year, the launching of the product was postponed from September 1, 2011 to March 1, 2012. Of the 77 mature SILC groups in the HMI pilot region, 33 have at least one member who opted to subscribe to the HMI product.

Table 2 Cost of HMI per person per year

Insurance type	Premium proposed in feasibility study	Premium proposed by NSIA actuaries	Final premium per person per year
Health	2,100 F CFA (\$3.93)	2,223 F CFA (\$4.17)	2,223 F CFA (\$4.17)
Term-life Rider	600 F CFA (\$1.12)	1,385 F CFA (\$2.60)	1,257 F CFA (\$2.36)
Total Annual Premium	2,700 F CFA (\$5.06)	3,608 F CFA (\$6.76)	3,480 F CFA (\$6.52)

Subscription to the HMI product is voluntary and individual, with a monthly premium that has been collected bi-annually in this pilot (in February and July 2012). Primary membership to the HMI is currently limited to SILC members, and costs 290 F CFA (\$0.54) per person, per month, or 3,480 F CFA (\$6.52) per person, per year. The product covers 70% of costs at participating local health centers, including products sold at those health centers’ pharmacies. The client’s copay covers the difference of 30% and must be paid at the time of service. The HMI product covers consultations at 100% and includes a mandatory life insurance rider that covers death and permanent disability. HMI does not apply to non-participating health service providers, even in the case of referral. During the first four months of the pilot, four health centers participated in HMI; e.g., two private clinics⁸ and two public health centers. A fifth public health center officially joined during the time of this study. Appendix A provides a detailed list of services covered by the HMI product. Appendix B provides a list of services and the average cost of the services covered at the participating health centers.

The HMI policy provides for a maximum reimbursement of 40,000 F CFA (\$74.95) per person, per year in medical expenses, and a life insurance payout of 100,000 F CFA (\$187.37). The life insurance rider was added to the HMI product at NSIA’s request based on internal analysis that life insurance would make the HMI product profitable. The health

⁷ “Preregistered” means simply that an individual expressed his or her intent to join HMI at the time of enrollment. No other commitment (such as pre-payment, documentation, etc.) was required.

⁸ The two private clinics are run by the Catholic Church.

insurance alone (without the life insurance rider) was expected to lose money. In the first four months, the opposite appears to have occurred. While the HMI product is currently profitable, the life insurance accounted for 57.55% of claims (Appendix C). It is possible that this is because clients have not become accustomed to using the HMI. As such, one would expect to see health center claims increase in the future. NSIA staff expressed surprise at the high number of life insurance claims in the first four months of the pilot program, potentially questioning the financial structure of the product.

Members of SILC groups were offered the opportunity to enroll for HMI in February 2012 for either a five-month or ten-month period, with services beginning March 1, 2012. The first enrollment period occurred from February 13 to 21, and the second occurred at the same time as this research; e.g., from July 5 to 13. Both enrollments took place in the villages, and were conducted by a team comprised of staff from CRS, Caritas Natitingou, and NSIA. To subscribe, SILC members were required to provide two photographs of each member they wish to include along with the premium payment for the upcoming enrollment period. They were further required to provide the names and ages of those they wish to enroll, and to sign an enrollment registry, either with a signature or an index fingerprint. In return they received an insurance booklet (on the spot), with a photograph of each covered member, stamped with an official NSIA/CRS seal to denote the number of months covered. The insurance booklet lists the conditions of the HMI and where it can be used.

To prepare SILC groups for the HMI product, Caritas Natitingou developed a series of learning conversations (LC)⁹ on six themes; e.g. (1) why subscribe to the HMI; (2) prevention/life insurance; (3) selection of dependents (children); (4) polygamous couples; (5) payment without damage; and (6) fraud. Sensitizations were held with the SILC members using the LC approach. Finally, CRS trained the health center employees on the HMI product, including its coverage and functioning, and on how to complete the required administrative paperwork.

2. SCOPE OF WORK

CRS commissioned this study to better understand if the HMI product is meeting client demand, how demand for HMI is changing, the perceived benefits and downsides of HMI, and the current strengths and weaknesses related to general functioning of HMI in its early stages. The study aims to identify challenges and to propose possible solutions to ensure the successful scaling-up of the HMI, particularly how it might be linked to the Government of Benin's Régime d'Assurance Maladie Universelle (RAMU).¹⁰

⁹ Learning conversations are a tool used to teach groups new ideas and problem solving skills based off a theory of positive deviants. A learning conversation is led by an animator or group facilitator who shares a short story about a question or a problem that is relevant for the group. After listening to the story, the group discusses possible solutions, and how to apply the solutions to similar problems faced in their own community.

¹⁰ Universal health insurance scheme

3. METHODOLOGY

The study took place in the Diocese of Natitingou in Northern Benin. The field work was supported by CRS' partner, Caritas Natitingou. The field research was conducted from July 4 through 14, 2012, in the Chabicouma and Kotopounga "arrondissements" (districts).

The study used a qualitative methodology to explore the diverse experiences of SILC members with the HMI product. Due to the limited size of the sample these findings cannot be extrapolated or generalized to other SILC groups, or to other HMI schemes. They can only be said to be representative of the study sample population. Relevant literature informed this study (Appendix D). Additionally, this study draws on quantitative information gathered by CRS over the course of designing and launching the HMI product, including client profiles and hospital records. This allowed certain findings to be triangulated and verified.

The target sample for this study was designed so as to gain a comprehensive understanding of the functioning of the HMI, and therefore included participating SILC groups (both subscribers and non-subscribers), CRS and partner staff, local health and government officials, national health and government officials, healthcare providers, and NSIA staff. Given the time constraints, it was not possible for all 33 SILC groups in the pilot to participate in the study. Instead, to ensure a wide range of views and experiences, a target sample of 16 SILC groups was randomly selected. To ensure the selected groups were representative of each health provider and animator, the sample was stratified by the health center frequented.

The stratified selection yielded seven groups that frequent St. Joseph's Health Center (45%), seven groups that frequent Boderima and Kotopounga Health Centers (42%), and two groups that frequent Yarikou Health Center (12%). During the field study, two groups could not be interviewed due to logistical conflicts with the date and time proposed, including a funeral in one village. These two groups both frequent the health centers Boderima and Kotopounga, yielding a final sample of seven SILC that frequent the health center St. Joseph's, five that have access to Boderima and Kotopounga, and two that have access to Yarikou health center. Of the 14 groups interviewed, seven were located in Chabicouma and seven in Kotopounga "arrondissements."

Data was collected from SILC groups via focus group discussions (n=19) and qualitative individual interviews with SILC members (n=6). In the data analysis, individual interviews are combined with focus group discussions (FGD), yielding a total of 25 "interviews/FGDs." Individual interviews were conducted when there was only one HMI subscriber in the SILC group or when there was only one person available for the interview. We permitted participants for FGD to self-select, based on which SILC group members were available at the time of the meeting.

Of the 25 interviews/FGDs, 14 were held with subscribers to HMI, and 11 were held with non-subscribers. We sought to interview SILC group members who decided to subscribe to the HMI and those who did not, so as to understand both points of view and how the groups might differ. Where possible, FGD were held with only HMI subscribers, and then with only non-subscribers. This was intended to isolate groups with relatively different experiences; i.e. for those who did not subscribe to HMI, they could speak openly about their concerns, experiences, and knowledge related to HMI, without being swayed by the opinions of those who subscribe to HMI, and vice-versa. It allowed for triangulation of certain data. Two interviews had a mix of subscribers and non-subscribers. All other interviews were of either subscribers or non-subscribers. For the purpose of the data analysis, the responses from mixed groups are coded as responses from subscribers, unless the respondent explicitly stated that he or she was not enrolled or was responding to a question for non-subscribers. In total, the research team spoke with 97 SILC group members. Appendix E provides a full list of all individual interviews and FGDs, while Appendix F shows the FGD interview guides used for insured and uninsured groups.

The SILC groups interviewed had total memberships ranging from 21 to 62. The number of group members enrolled in the HMI ranged from 1 to 22 members, while the proportion of group members in HMI ranged from a low of 2% to a high of 43%. Figure 2 shows the 33 SILC groups (out of 77) that have one or more members that subscribed to the HMI product, with the number of subscribers to the HMI in each SILC group (x-axis), and the number of members in each SILC group (y-axis). The triangles represent the 16 groups that were randomly selected for this study, while the circles represent the remaining 17 groups that were not selected. From this Table, it appears that the random selection of SILC groups yielded a mix of groups in which a high proportion of members subscribed to the HMI (right hand side of the graph) and groups in which a low proportion of members subscribed to the HMI (left hand side of the graph).

their collective savings. By the time registration occurred in February 2012, five months later than initially communicated to the groups, many had spent their savings and could no longer pay the premium. Additionally, many SILC members expressed distrust of the product, fearing that NSIA would take their money without providing the promised services. Unpredictable premium collection dates and changing premium costs may have added to concerns, contributing to the lower than expected enrollment.

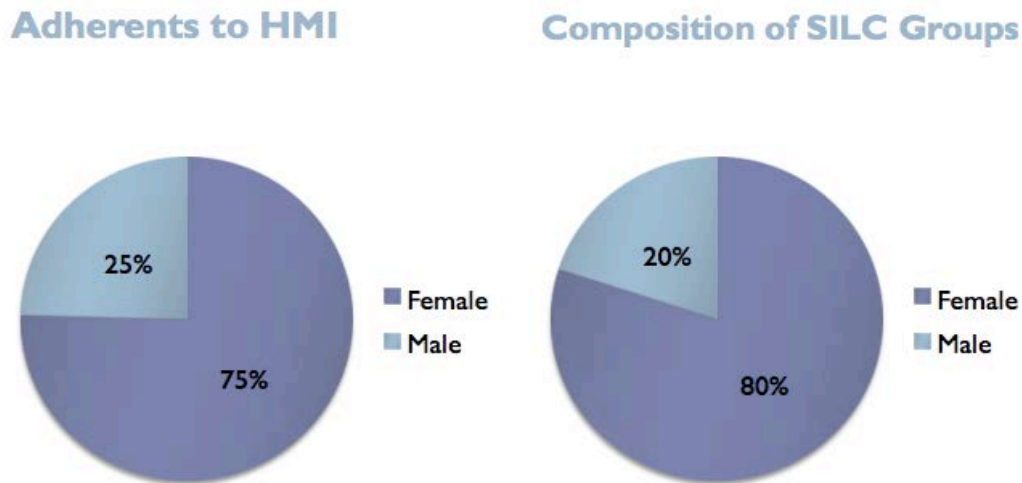
Feedback about the HMI product was generally positive. All but one SILC group (13/14) expressed the desire to continue subscribing to HMI and to add dependents, or to join in the future. However, in July 2012, when CRS and NSIA conducted the second registration for the HMI, total enrollment in the program actually decreased. During this weeklong subscription and renewal period, 193 SILC members subscribed as primary policyholders, with 404 dependents. Only 59% of the SILC members who subscribed in February renewed in July. The overall subscription rate in July, accounting for new subscribers as well as active subscribers who chose to renew, was 76% (Appendix G).

In both Kotopounga and Chabicouma, SILC members expressed that they had not received sufficient notice of when they would have the opportunity to renew. Multiple groups were informed only a few days in advance, or even on the morning of renewal. Of the 14 SILC groups interviewed, four indicated that late notice of renewal date precluded some from subscribing or renewing in the second phase and five indicated that financial difficulties at this time of year precluded some from subscribing in the second phase. The remaining five groups did not explicitly mention the time of year or specific renewal date as an obstacle to subscribing to HMI. Communication of information on the renewal date was worst in Kotopounga. This is reflected in a lower policy renewal rate, where 44% of active subscribers renewed in July. Including new members, the subscription rate was 53.2% of the initial number of subscribers. In Chabicouma, the results were higher at 59.4% renewal and 94.4% overall subscription in July.

In the first enrollment period, men made up 24.6% of primary subscribers to the HMI but only 20% of SILC membership in these groups (Figure 3). They are therefore slightly over represented as primary HMI policyholders. However, 23/62 male primary policyholders insured a wife as a dependent, indicating that perhaps the over representation simply shows that men are listed as the primary policyholder while both husband and wife share the plan. Only 6/190 female primary policyholders added a husband to their plan as a dependent. This could be for a systematic reason, i.e. men are considered the head of household in Benin and responsible for significant health costs (Klein, 2007, pp. 469–471); men typically have more income and savings than women; or there is some difference in training that causes men to subscribe more than women. Of those insured as dependents in the first enrollment cycle, 47.5% were female and 52.5% were male, indicating that primary subscribers are not systematically prioritizing male or female dependents. It will be

important to continue to monitor gender-disaggregated data on both primary subscribers and dependents to identify any trends that might be indicative of underlying social norms or an aspect of the program.

Figure 3: Disaggregation of HMI membership and SILC group membership by male and female



Although the average household is estimated to have six dependents, the average number of dependents enrolled per principal subscriber was 1.83 in February. This increased in July to 2.03, even though the total number of subscribers decreased. Therefore, on average those who joined HMI in July enrolled more dependents, suggesting that these subscribers find the HMI worth the cost.

In the initial phase, 84.5% of dependents were children, 6.3% spouses, and 9.2% categorized as “other.”¹¹ The most common age of dependents in the first phase was five, with a range of 1 to 65 years. The majority of respondents enrolled dependents with no source of income, stating that they expect adults and older children to purchase their own health insurance or contribute to the premium payment. In four of the 14 groups interviewed, primary policyholders opted to enroll all of their dependents in the HMI. In the remaining 10 groups, subscribers selected certain children for the HMI, picking the youngest child (10/10 groups), the child that gets sick the most often (2/10 groups), a husband or wife (2/10 groups), and the child already in possession of a photograph (1/10 groups). In 13 of 14 SILC groups, respondents expressed the desire to enroll more children as dependents in the next renewal cycle, to the extent that it was financially feasible. A respondent who did not wish to increase the number of his dependents explained that he was concerned that in the case

¹¹ Although CRS does not keep the data on the definition of “other,” this is most likely a person considered a member of the household, who is not a direct ascendant or descendent, for example, a niece, nephew, or cousin.

that he died and the family received the life insurance benefit that the multiple dependents might argue over how to divide the payout.

4.1.2. Why do people subscribe to HMI?

Interestingly, while uninsured SILC members listed decreased cost of care and improved access to care as their perceived two benefits to HMI, insured SILC members listed additional benefits as well. These were decreased worries and fears about health emergencies, decreased surprises, increased ability to follow treatment, and increased solidarity within their SILC group. Many of these benefits are highly interrelated. For example; respondents explained that they liked the decrease in cost at the time of service because it facilitates access to health services. Each benefit is described in detail below in Table 3.

Table 3 Reported benefits of HMI for SILC group members

HMI Status	Decreased cost of care	Improved access to care	Decreased worries	Decreased surprises	Ability to follow treatment	Increased solidarity	Total interviews
Uninsured	9	3	0	0	0	0	11
Insured	14	7	7	3	1	1	14
Total	23	10	7	3	1	1	

Decreased cost of healthcare was by far the most commonly cited benefit of HMI, mentioned in (14/14 interviews/FGDs with subscribers and in 9/11 interviews/FGDs with non-subscribers. Even subscribers who paid the entire cost upfront, and received reimbursements weeks later, reported satisfaction with the lower cost of care. One interviewee explained, “The thing I appreciate most is the reduced cost. When I go to the health center, I fear that my money won’t be enough. But with the insurance booklet, I took money back to the house because I paid practically nothing for care.” Numerous interviewees mentioned that the (copay) cost was low enough to “pay from my own pocket,” linking low cost to autonomy and improved access to care.

The second most frequently cited benefit of HMI was improved access to healthcare. Before HMI, many SILC members financed healthcare costs with loans either from neighbors or from the SILC loan fund, sometimes using one to reimburse the other. SILC members explained that to procure a personal loan, it is usually necessary to explain the need, thereby exposing potentially sensitive or private concerns to the community. Not only is this embarrassing (Sawyer, 2011), but it can take a long time to find a sympathetic ear as one goes house to house explaining the problem. In turn, this can delay access to care. One

respondent stated, “If your neighbor says no, you are out of luck...[Y]ou would have to go buy medicine in the market...you turn and you turn, and go to the traditional healer.” Another woman explained, “Before, when I went to the health center, people asked me, ‘Why did you come to get care when you don’t you have money to pay?’ Today, HMI is good because the cost of healthcare has become accessible.” These responses reflect both improved access to healthcare and to privacy, a right taken largely for granted in the West.

Only a few people stated affirmatively that they have gone to the health center earlier than they would have without HMI, even when prompted on the subject. This could be due to the recent rollout of the product, giving clients few opportunities to change their health seeking behaviors. However, a number of respondents did express that HMI removes hindrances to seeking care, as described above.

Decreased fears and worries about health emergencies was another common theme among subscribers. Some subscribers explained that even if they never used the HMI, they would continue to subscribe because it provides them with peace of mind. Another woman explained, “What I like about HMI is that it decreases my worries and fears related to health. Today, the costs are low and I don’t have to wait to go to get care. I can finance my own treatment.” These subscribers explained that it is impossible to know who will fall sick, when, and with what illness, and therefore HMI is useful to help make healthcare costs more predictable and to mitigate the cost for emergencies.

A few respondents described decreases in unexpected health costs. For example; one man liked the HMI because it permitted him to pay forward for healthcare costs. He explained that when he went to renew his HMI for the second cycle, he learned that he had already paid for the full 10 months.¹² Paying a one-time cost was mentally less taxing for him than covering the full price of healthcare each time it occurs. Others described an improved ability to follow prescribed treatments (in terms of attending follow-up appointments), and an increase in the sense of group solidarity.

4.1.3. Why don’t some SILC members subscribe to HMI?

SILC members expressed a variety of reasons for declining to subscribe or renew their HMI policy. The reasons were; (a) the cost of HMI,¹³ (b) logistical constraints related to accessing savings or loans, (c) a lack of knowledge about the product, (d) a lack of need for the product, (e) a lack of trust in the product, and (f) concern about the limited services available at the health centers. Interestingly, non-subscribers reported cost and logistics as the most common reasons for not subscribing to HMI, while subscribers said that others did not subscribe because they did not understand or trust the product. The frequencies of

¹² On the other hand, the term of coverage is stamped in the insurance booklet. The client’s surprise indicates that he is not familiar with where he can find information about the status of his coverage.

¹³ While no respondent requested a free service, it became clear from interviews and FGDs that for some SILC members, any cost multiplied by the number of household members would likely be too high for them at this time.

responses to the question “why do some people decide not to subscribe to the HMI?” are listed in Table 4.

Table 4 Reported reasons that SILC group members do not subscribe to HMI

HMI Status	Cost	Logistics	Lack of need	Lack of understanding	Lack of trust	Limited services	HM by Plan Int'l	Total interviews
Uninsured	9	5	3	3	1	1	0	11
Insured	4	2	3	7	7	1	1	14
Total	13	7	6	10	8	2	1	

Overall, cost was the most frequently reported reason for declining to purchase HMI, as well as the reason most frequently given by uninsured SILC members. Respondents voiced a number of different concerns related to cost. Primarily, interviewees expressed that they are poor and lack the means to subscribe. Some explained that if they bought HMI, they would not have money to invest in their income generating activities or farms. Some respondents asked if it would be possible to decrease the premium or to make health insurance a package product for the entire household. In two interviews, participants mentioned that they had declined to subscribe to HMI because they could not afford to insure all their children. These respondents preferred to enroll no one, rather than to choose between children. Many female respondents explained that their children consisted of both their own biological offspring, and those of co-wives.¹⁴ Respondents seemed to consider all children in the household equally their responsibility for coverage. Finally, two respondents expressed that health insurance is a kind of obligation or commitment that should not be entered into lightly. These respondents wanted to be sure they could commit financially to HMI in the long run, rather than purchase it now and drop out later.

The second most frequently reported reasons not to subscribe to HMI, according to uninsured SILC members, fall into the category of logistical problems. For example; numerous groups stated that they were not informed sufficiently in advance and thus did not have access to savings from the SILC group on short notice to pay the HMI premium.¹⁵ Furthermore, the short notice period made it difficult to gather funds from other sources in a timely manner. Finally, personal conflicts (travel, illness, etc.) with the premium payment

¹⁴ Polygyny is common in Benin although outlawed in 2004. In the 2006 DHS survey, 42.3% of women aged 15-49 reported that they were in a polygamous union (<http://www.measuredhs.com/publications/publication-FR197-DHS-Final-Reports.cfm>).

¹⁵ The savings groups save their contributions in a lockbox, secured with multiple locks, the keys to which are held by different members of the SILC group, such that it is difficult to gather all the key holders to open the lockbox on short notice.

dates and the lack of a photographs prevented certain SILC members from subscribing. Members of three SILC groups explained that it is very difficult to make payments in the month of July because they have very little disposable income at that time. Although this can be seen as a cost issue, it is more a logistical obstacle, because offering enrollment at a different time of the year would alleviate the problem.

The third most frequently given reasons, according to non-subscribers, were a lack of knowledge and understanding of the product, and a lack of interest or need. When asked to elaborate, those that stated they were uninterested in HMI generally reported irregular use of healthcare services or a lack of need for health insurance in the past. One respondent said; “HMI is not interesting. We are always in good health, so why subscribe for healthcare coverage?” Another group said that they have no difficulty paying for healthcare costs at the local health center because they can save in their group and take loans when necessary. Additionally, they felt that when they need medical care, they often were referred to the regional hospital, and therefore HMI in its current form would be of little value, as it is limited to local health centers. Others reported that the HMI is difficult to understand, and cited confusion as to how to register beneficiaries, on what services are available, and as to what happens if one buys HMI but never uses it.

Subscribers, on the other hand, cited lack of understanding and lack of trust more frequently as the reasons for why they believe that others do not join HMI. In 10/14 interviews with insured SILC members, one or both of these explanations was given. In these interviews, respondents explained that they believe that non-subscribers fear that their premium payments will be lost or stolen, that HMI will not last so it is not worth subscribing at the beginning, or that they want to observe how it works before they subscribe. Conversely, a number of groups explained that they were only able to join HMI in the first phase because of the trust they have for Caritas and CRS, based on affiliation with the church and past positive experience with SILC groups. One woman explained, “To integrate into the SILC group was difficult. My husband told me, “People are going to steal your savings.” To integrate into HMI is surely the same situation. But because we saw that the church, that is, Caritas, brought it, there was more trust, and we decided to subscribe. And today, we have seen that savings in the group works.” It seems plausible that trust is indeed a major issue for both subscribers and non-subscribers; however, it may be easier for subscribers to voice this concern to a researcher and CRS-affiliated translator than for non-subscriber to say it.

Many respondents mentioned concerns with the quality and supply of care available at the participating health centers. Complaints related to long waits, exacerbated by limited availability of nurses, were mentioned. For example; many patients who frequent the St. Joseph’s health center reported that the nuns’ prayer schedule limited their availability to see and treat patients. At other health centers, nurses were unavailable due to travel for

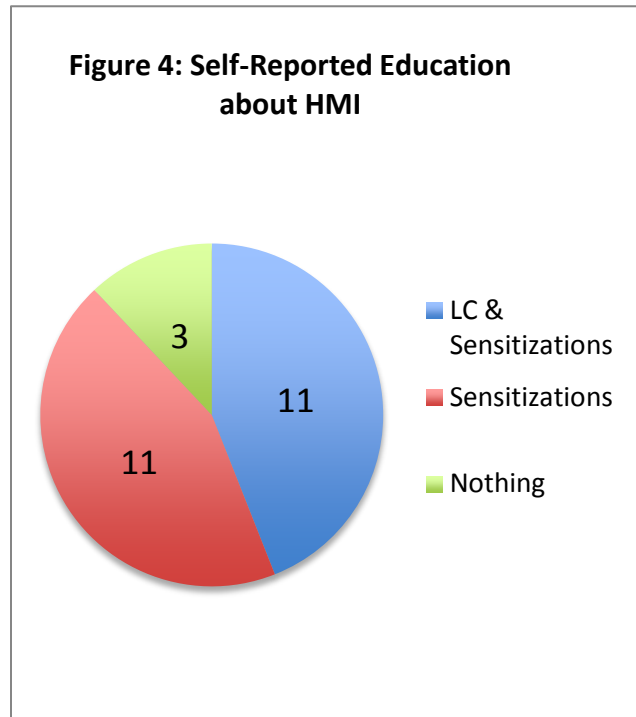
training. Tamar Klein verifies that long waits are a common problem in across health facilities in Benin (Klein, 2007, p. 476). The participating SILC groups are all within at least 10 kilometers of a health center. At the time of this study, there were three participating centers in Kotopounga (Boderima, Yarikou and Kotopounga), and only one in Chabicouma (St. Joseph's). Many respondents in Chabicouma requested that the public health center in the area join the HMI plan, demonstrating participants' desire for choice. The public health center at Chabicouma has subsequently joined the HMI, and CRS has scheduled a training for the health center on the product.

Only two groups explicitly stated that people do not subscribe to HMI because of the limited services provided. However, many respondents expressed the desire for the HMI to cover services at regional hospitals, which has been a recurring theme since the health needs study conducted in September 2010. In that study, almost all those interviewed (131/141) in CRS' preferred that a health insurance product cover services at both the local health center and the hospital. Only nine respondents preferred that the service cover only services at the level of the local health center. The first feasibility study conducted by CRS and NSIA projected that the cost of the annual premium per person for services at regional hospitals and local health centers would be over twice as much, at 4,800 F CFA (\$8.99) as coverage at just the local health center, originally projected at 2,100 F CFA (\$3.93). Given this choice, SILC members opted for the less expensive product that covered costs at the local health centers, rather than the more expensive option that would cover costs at the regional hospitals in Natitingou and Tanguiéta. Interviewees expressed a strong desire for care at the regional hospitals, with four groups asking if it would be possible for the HMI to work at that level. Additional concerns with quality of care were expressed by those who have used the HMI. These are discussed in greater detail in section 4.1.5.

One group mentioned that the non-governmental organization (NGO) Plan Benin, an affiliate of the NGO Plan International, had attempted to launch a health mutual in the same area. Some members of their group took Plan Benin's work more seriously because they were offered T-shirts and other incentives (such as transport costs) to participate in the planning and launch meetings. The group reported that Plan Benin collected 1,000 F CFA (\$1.87) from participants, but nothing has concrete has happened yet.

Clearly, perceptions about why certain SILC members have so far declined to subscribe to HMI differ between HMI members and non-members. While non-members focus on cost and logistics, members emphasized lack of trust and understanding. It is apparent that many HMI subscribers think that the product is worth the cost and inconveniences of registration. Subscribers expressed this viewpoint when they argued that if non-subscribers understood the benefits available, they too would join. Whether non-members do not yet understand the benefits or whether they simply value the benefits differently is difficult to establish at this early stage in the pilot. However, the reported desire to observe the program before signing

on, the low exposure to sensitizations and LC, the explicit requests for additional sensitization, and the numerous questions posed by SILC members about HMI during the interviews, imply that trust and understanding may indeed be significant factors. Literature on insurance supports this interpretation, explaining that trust is a major factor, absent which programs are likely to fail (Ridde, Haddad, Yacoubou, & Yacoubou, 2010; Wiesmann & Jütting, 2000; Schneider, 2005).



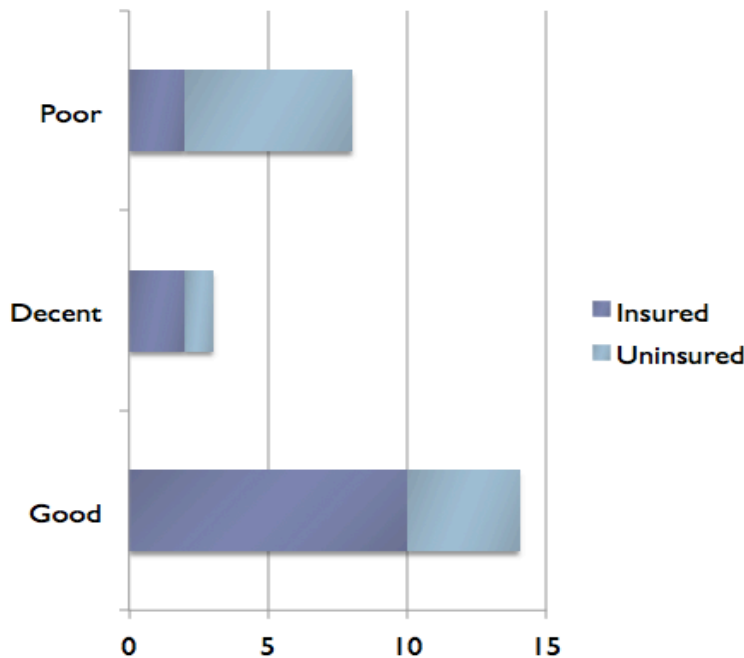
4.1.4. Do participating SILC groups understand the HMI product?

Although CRS and Caritas Natitingou have been developing and promoting the HMI since 2010, education on the product could be improved. Over half of those participating in interviews and FGDs (14/25) did not participate in a LC session or did not remember them. Three of the members interviewed reportedly received neither LC nor sensitization on the HMI. CRS staff explained that during the LC phase, certain facilitators were unavailable and thus could not reach every SILC group. Additionally, few respondents were able to remember the content of the LC sessions, explaining that they were a long time ago. The LCs most frequently remembered were

“Why subscribe to HMI” and “Selection of children.” Of the three members interviewed where no sensitization and no LC were reported, two were from the same SILC group. This specific SILC group had refused sensitization and participation in LC session because they were categorically opposed the HMI. They did not see the HMI service as useful due to the limitation to participating local health centers. The third member that reported no LC and no sensitization was a woman who had missed the sensitization provided to her group. She stated that for her, it is better to observe first and consider joining next year.

Perceptions and demand for HMI clearly are related to knowledge and understanding of the product (Figure 5). Although all but three people in one of the groups interviewed reportedly received sensitizations, and half of those participated in LC sessions, understanding of the components and functioning of the HMI product was fairly weak overall. Unsurprisingly, subscribers generally had a much better understanding of the product than non-subscribers; however, subscribers were in need of additional education on the product.

Figure 5 SILC member understanding of HMI



SILC Member Understanding of HMI

At least one person in the interview gave the correct response:

Poor: No idea about the percentage paid by NSIA.

Decent: An idea of the percentage paid by NSIA; knowledge of how to find additional information.

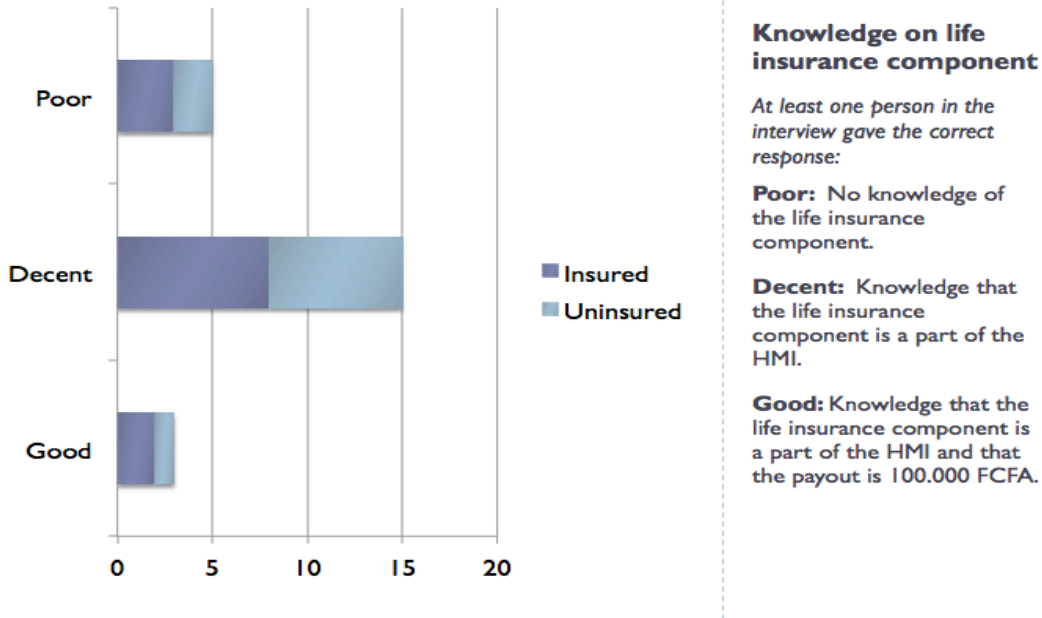
Good: The division 30% / 70%; consultations are free; and the timing of renewal

**This HMI product is the first exposure any interviewees have had to any type of insurance.*

Fourteen SILC groups are classified as having “good” understanding of HMI. This coding is generous, as it depends on a single person in the interview providing a correct answer to the question. Arguably, SILC members have access to other group members, and therefore one knowledgeable person can serve as a resource for all; however, from the interviews it became apparent that individual members often do not share this information with other group members. This may be because of the personal nature of health problems and healthcare or simply an issue of what comes up in conversation. For example; a number of interviewees asked whether they would have to pay to renew the premium for the second cycle if they paid for, but did not use HMI, in the first cycle. This question demonstrates that some subscribers do not understand the concept of health insurance, believing that HMI should decrease their overall costs rather than make their costs more manageable and predictable. Therefore, it does not seem reasonable to assume that a single knowledgeable member can ensure good decision making for all the members of the group.

In particular, understanding of the term life insurance component of HMI is weak (Figure 6). Although knowledge of the life insurance component was mentioned in 18 out of 25 interviews/FGDs, in only 3 of those did someone know the correct payout value (100,000 F CFA). In five interviews, respondents knew that in the case of a death it was necessary to create a dossier with records, while five groups knew nothing about the life insurance component.

Figure 6 SILC member knowledge on life insurance component of HMI



Since

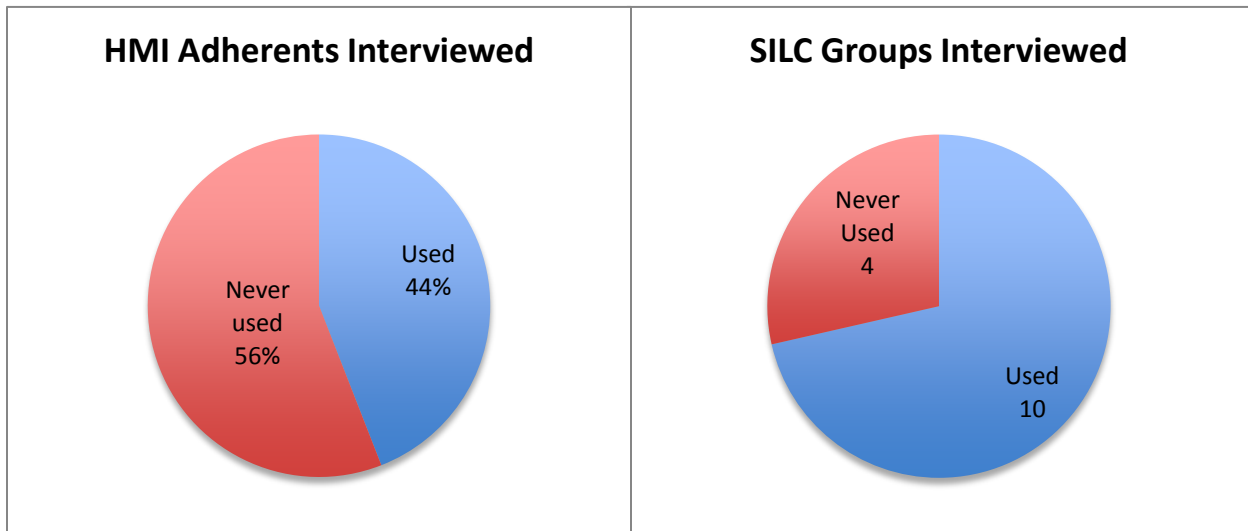
March 2012, four life insurance claims have been filed. Only two of these had been reimbursed by the time of study (paid in July). For the others, NSIA stated that it planned to reimburse them in August. Various problems had arisen in relation to these deaths, including burial without a death certificate that has delayed completion of the dossiers. No interviewees reported that their impression of the HMI worsened as a result of the difficulties with the life insurance payouts. One woman reported the contrary; i.e., that after a death in the community, people came from Cotonou to see the family. From her perspective, this demonstrated that NSIA is concerned with the welfare of the family. On the other hand, members of NSIA expressed concern with the higher than anticipated number of deaths in the rollout of the program, although no one went so far as to accuse clients of fraud.

The SILC groups that did know about the life insurance thought that it was a positive component of HMI product, explaining that it would help the family in a time of need, supporting children, and helping to pay funeral costs. From the individual interviews and FGDs, it is clear that the life insurance component may be a persuasive reason to join HMI for those who would otherwise remain unconvinced. One group explained that they were not comfortable asking about the details of the life insurance, because they feared it might cause bad luck. This emphasizes the need to provide additional information and sensitization on the life insurance component of HMI, even if groups do not request it outright.

4.1.5. What are clients' experiences using the HMI product?

Forty-four percent participating SILC members (26/59) reported having used the HMI in the past five months for either themselves or a covered dependent (Figure 7). Of the 14 SILC groups interviewed, in 10 of the groups at least one person in each has used HMI at least once. Those who have not yet used the HMI explained that no one enrolled in the product has been sick yet. Healthcare providers reported a total use of 235 "services" to NSIA. Assuming one user per service, this would mean that 32.9% of subscribers have used HMI. This is probably an overestimation, given that each service includes each item separately (consultation, treatment, etc.). As such, this indicates that HMI users were over represented in this study's sample. It is possible that those who have used HMI self-selected into the FGD and individual interviews.

Figure 7 Self-reported usage of HMI product in initial phase



Additionally, records from health centers show that HMI clients reported mixed experiences using HMI. Of the 235 "services" provided in the initial cycle, almost all were for general curative consultations (45.95%) or prescriptions (51.48%). The remaining services comprise simple births (1.27%), prenatal consultations (0.42%), and deaths (0.85%). Healthcare providers reported that the majority of the general curative consultations were for malaria treatment. Of the ten interviews with SILC members, who had used the HMI in the initial cycle, seven reported experiencing problems with reception at or treatment by the healthcare provider. Problems cited were:

- A few respondents mentioned that clients were turned away from participating health centers or told that the center did not accept the HMI;
- Respondents reported that at Yarikou, St. Joseph and Boderima the healthcare providers required some subscribers to leave their insurance booklets, documents, and payments for the total cost of service at the health center until the administrative documents were filled out, at which time they could return to the health center to

retrieve their documents and reimbursements (equal to 70% of the total service cost, covered by NSIA). Two of the reported instances took several weeks and in one case, over a month;

- Five subscribers reported being made to wait until all the other patients had been seen before they would take them for consultation;
- One subscriber reported being denied certain services, including access to pharmaceutical products that should be covered by the insurance; and
- Two subscribers reported that healthcare providers complained that the HMI increases their workload;
- One client reported that a blank receipt had been left with the healthcare provider and that is incorrectly filled in to claim services that she did not receive.

If these and similar problems persist and/or are or become pervasive, they will pose a serious threat to the success of HMI.

4.1.6. Interaction between HMI and SILC Groups

Of the interviews with HMI subscribers, seven groups said that they used their personal savings to meet the premium payment, six saved in their SILC group, and one sold productive assets (chickens) to make the payment. Of the six that cited saving in their SILC group, only three indicated that they increased their regular savings level to make the premium payments. Groups indicated that they did not know exactly how much they would need to save to cover the premium for themselves and beneficiaries. One man explained that they started saving 100 F CFA (\$0.19) per week, and at the end of the year they would see if it was enough. Increasing savings by 73 F CFA (\$0.14) per week would cover the annual premium of a single member, and 507 F CFA (\$0.95) per week would cover a principal subscriber and six dependents.

A study conducted in the same area in August 2011, found that SILC groups start with an average of savings contribution of 464 F CFA (\$0.87) at each meeting in their second cycle, increasing to an average of 640 F CFA (\$1.20) in the third cycle and 814 F CFA (\$1.53) by their fourth cycle (Sawyer, 2011). These findings demonstrate that the savings contribution for HMI is achievable, but not insignificant, as concluded in the feasibility study.

Of the 14 SILC groups, six made no new rules and did not plan to make any new rules in their SILC group in relation to HMI. Six groups planned to add new rules to increase the mandatory contribution to the social fund or require that the share-out from the social fund be used for HMI, and two groups had already made new rules to that effect. Follow up questions were asked about the current and past use of their social funds, and how that would change in the future with new rules. Respondents did not express concern that the use of the social funds would change, mainly responding that because it is used for health costs and to help pay funeral costs, the HMI would directly replace the role of the social fund.

Additionally, respondents indicated that the social fund was small and, in the selected groups, could only provide gifts of between 500 F CFA (\$0.94) and 2,000 F CFA (\$3.75), whereas the HMI would be more helpful in mitigating higher costs.

The HMI was originally designed to be a group product such that all members of participating SILC groups would join at the same time. If some members refused to join, no one in the group would be eligible. This was intended to diversify risk and capitalize on the group dynamic to motivate participation. Because of logistical challenges discussed earlier, the product was eventually offered at an individual level so that the rollout would not be further delayed. When asked about whether a group or individual product was preferable, interviewees presented a mixed response. In 11 interviews, respondents preferred a group product; in 10 interviews, respondents preferred an individual product; and in four interviews, there was disagreement or ambivalence. The most commonly cited reasons for an individual product was that SILC members have different size households and so they would need to save different amounts, which was complicated; that some people were motivated to save and others were not; and that if they gave loans to people to join, they could not be sure that those people would pay back the loans. Those who advocated for a group structure explained that they wanted everyone to join—two groups stated that they would like everyone in the village to have the HMI—emphasizing solidarity.

4.1.7. Key observations from SILC group FGD and interviews

These findings demonstrate that there is a clear demand for HMI, with the potential to increase after clients gain familiarity with the product and experience some of the additional benefits, such as decreased fears and worries, decreased surprises or shocks, and an improved ability to follow recommended treatments. Additionally, a key observation that emerges from these findings is the importance of trust in the rollout of this program among all parties, but particularly for the SILC member, who in this case, are all rural village residents. People living in rural villages are an exceptionally vulnerable population, particularly disadvantaged when interacting with outsiders due to limited access to information or formal legal, social, or economic services. Additionally, many are poor and resource strapped, meaning that any unexpected costs can have dire consequences in the short and long-term. Logically, many of those who live in these rural villages are suspicious of outsiders and averse to risk. Therefore, rural populations remain difficult to access as a HMI client base, not just because of logistical obstacles such as infrastructure and language, but because of a lack of trust. As discussed in section 4.1.3, SILC members are willing to try NSIA's HMI product because of their confidence in CRS and Caritas. Trust is not static, so it is essential that CRS and Caritas work to maintain their good relationships with the SILC groups. Moreover, to ensure sustainability, both NSIA and the healthcare providers must develop a strong level of trust between themselves and the clients. Pressure and incentives cannot replace trust, particularly in contexts lacking formalized structures for social and

business interactions. Above all, this emphasizes the importance of a good start to HMI to solidify the trust of early adopters and entice the remaining observers.

Second, HMI has had (as yet) little impact on the functioning and savings of the SILC groups. With exception to the two groups that have already changed their savings habits to subscribe to the HMI, all SILC groups allowed members to decide individually and voluntarily whether to join HMI, and how they would meet the premium payment. If groups do carry through with their plans to change savings rules, it will be important to observe how this impacts individual members, in terms of membership in the group, individual savings and borrowing habits, and group solidarity.

Third, at this early stage, it appears that clients are generally using HMI to mitigate costs while maintaining their same health seeking behaviors. Ideally, from a social development perspective, HMI should motivate clients to seek healthcare earlier and for additional services. A primary example would be prenatal care and delivery (childbirth) services. Although these costs are sharply reduced with HMI, and would help improve maternal and infant health, only one interviewee stated that his wife used HMI at the health center. No women interviewed actually reported going to the clinic for prenatal consultations. The aggregate data shows that only 2.3% of healthcare reimbursements were for childbirth or prenatal consultations. Additional sensitization on the possible uses of HMI could help clients take advantage of the services.

Finally, the decrease in subscribers during the July 2012 renewal period cannot be ignored. SILC groups explained that those who did not renew had logistical problems; however, significant issues of trust and comprehension may play a supporting, or even primary role. Regardless of the reasons, if the number of subscribers continues to decrease at the next enrollment opportunity planned for December 2012, the product will not survive the pilot stage.

4.2. Insights and perspectives from key person interviews

The key person interviews findings highlighted the different interests that each actor brings to the table. While these interests are compatible in the long-term, there are many complications and conflicts in the short-term. Insights and perspectives from each of these critical actors will help CRS to understand where interests work together and where they conflict.

4.2.1. Insights and perspectives from CRS Staff

Three CRS staff members were interviewed for this study: Jérôme Dadjo, Xavier Tohou, and Caroline Anderson. All three agreed that there is a demand for HMI, explaining that the product originated directly from the demands of SILC members. Each explained how the product has been designed to meet client needs as closely as possible. Together, they

outlined many of the same concerns that have been discussed thus far throughout the study report, with a focus on challenges related to the interests of NSIA and the healthcare providers.

CRS staff indicated that NSIA seems hesitant to take on any risk associated with the HMI product, even though they agree that it is a unique opportunity. One CRS staff member explained that HMI will not make much money, particularly in the short-term, so it is not a priority for NSIA. Because of this, NSIA has missed important deadlines, most notably the original registration period in September 2011, and fails to take initiative and ownership of the product. CRS staff described the problems that HMI clients are facing when seeking healthcare, and emphasized the need to somehow motivate healthcare providers. CRS staff explicitly expressed that motivation should not come from financial remuneration. Instead, CRS has focused on gaining support from healthcare officials at the zonal level (Zone Coordinators) to pressure the providers to make a good faith effort to implement the HMI. Additionally, CRS staff explained that quarterly meetings with all stakeholders would help foster accountability by allowing HMI subscribers, healthcare providers, and NSIA to discuss their experiences with the product. Mr. Dadjo proposed presenting an award to the healthcare center that has most successfully implemented the HMI program as another form of motivation.

Overall, CRS staff thinks that as SILC members see how the product works and observe the benefits of HMI, more people will enroll. Over time, CRS hopes that the coverage of HMI can increase to include regional hospitals, and be offered to rural populations across Benin. They were particularly interested in working with government officials to develop a plan for HMI to become a part of RAMU. This would potentially provide some subsidy for the program, which would help the product cover more services without becoming too costly to clients, and help scale-up the product offering across Benin. In this scenario, the Government of Benin (GoB) in the long run, could serve as the intermediary in place of CRS or Caritas.

From CRS' perspective, HMI does not suffer from adverse selection. One respondent explained, "It just seemed that something about HMI grabbed certain people more than others—some SILC members understand the concept of insurance and had money available at the time of registration." According to this viewpoint, it is comprehension of the product rather than health status that influences membership.

4.2.2. Insights and perspectives from Caritas Natitingou

Two staff members from Caritas Natitingou were interviewed for this report: Valentin Kouagou (Coordinator of Programs) and Césaire Doko (Supervisor of the health microinsurance program). Their insights focused more heavily on the field rollout and identified problems of timing and logistics as major concerns for future success. According to Caritas Natitingou, the biggest challenge to the success of the HMI is a failure to respect

the schedule of events, making it difficult for SILC members to be present on the day of registration and to make the premium payments. This is true both at the micro level (e.g., poor information related to the exact dates of registration) and at the macro level (e.g., timing of the second registration period in July, when people have very little disposable income and day-to-day commerce and survival takes precedence over long-term health).

Caritas indicated that the second largest problem was comprehension and trust. They explained that SILC members need to see more concrete benefits from the HMI product to understand how it can directly assist them. They suggested that NSIA should give the life insurance payouts immediately after a death as this would help link the payout to the HMI. Others would observe the payout and understand that HMI can provide a valuable service to them in a time of need. Caritas observed the need to motivate healthcare providers to improve welcoming and service in relation to HMI so that clients see the benefits. They expressed that perhaps some animators were not sufficiently convincing when providing information about the product. This highlights a gray area for CRS and Caritas Natitingou. While the product was originally designed to reflect the demands of the target population, it can only work if a sufficient number of people subscribe. CRS and Caritas must therefore decide to what degree they want to promote the product to instill trust and enthusiasm in the population.

4.2.3. Insights and perspectives from healthcare providers

Staff from four healthcare providers were interviewed for this report, including two private clinics (St. Joseph and Boderima) and two public health centers (Chabicouma and Yarikou). All healthcare providers expressed certain concerns about the HMI, particularly the additional administrative paperwork required for reimbursement by NSIA. Healthcare providers said they are being asked to increase their workload without any compensation, which, from their perspective, is different than for other stakeholders. Additionally, healthcare providers indicated that clients, particularly those with HMI, lacked patience, even when other patients were clearly in need of more immediate attention. Providers explained that because of limited capacity, sometimes they ask HMI members to wait while they help the sickest clients first, because they know that the paperwork will lengthen the visit. Others verified that they have asked patients to leave their insurance booklets, administrative paperwork, and payments at the center to pick up at a later time with the appropriate reimbursement, so they can fill out the documentation when the center is less busy. Healthcare providers said they were willing to work with CRS, Caritas Natitingou, and NSIA to resolve these challenges to the extent that it might improve access to health services for the local population. The paperwork is arduous and constitutes a genuine time commitment that either decreases time for seeing other patients or requires working additional, uncompensated hours.

Dr. Christel Faidherbe, who runs the private health clinic at Boderima, stated that HMI provides no benefits to her, at this time. She explained that the paperwork is so burdensome that it takes twice as long to see a patient with HMI as one without HMI, making it impossible for HMI to increase her profits. She expressed further frustration with the delay in reimbursements from NSIA, and a general disappointment in lack of clarity and support from NSIA and CRS in relation to the product. She reported that another health mutual had approached her with a contract that she declined because she has signed a contract for HMI with NSIA. She closed the interview in saying that her ultimate goal is to improve health and welfare in the region, so if HMI is useful to her patients, she will continue to accept it and make a good faith effort to support its success despite these significant inconveniences.

Although health workers have been trained to complete the forms, they report that the process is complicated, unintuitive, and time consuming. As such, one healthcare provider devised a different system of record keeping that she finds more appropriate. NSIA has thus far accepted the new format with no complaints. Another concern is that only the head nurse is qualified to fill out all the administrative paperwork, thus increasing the workload of the most qualified person in the facility, whose attention might be better directed to address the needs of patients. Healthcare providers said that even if HMI drew enough clients to warrant hiring another employee, there are few applicants with technical capacity to do administrative record keeping.

These weaknesses at healthcare provider level are confirmed in the reimbursements that health centers have requested from NSIA. Only the two private healthcare providers, St. Joseph's and Boderima, had submitted receipts to NSIA for reimbursement. As might be expected, the reimbursement amount has increased from March to June, ostensibly as more clients have had the opportunity to become familiar with the product and go to the health center. Additionally, healthcare providers are become more adept at filling out paperwork and submitting reimbursements in a timely manner. At the time of research, the two other public health centers, Kotopounga and Yarikou, had not yet submitted any reimbursement requests, explaining that since the product was launched, they have only had nine and three HMI clients respectively, and therefore did not think it was worth submitting the receipts for reimbursement at that time. The low utilization may reflect the reports that certain patients with HMI were turned away from these health centers and discouraged from using the HMI. When asked about the complaints from HMI subscribers, both nurses from Kotopounga and Yarikou confirmed the delays at the health centers, delays processing paperwork and patient reimbursements, but denied refusing to serve HMI patients or to provide certain pharmaceutical products. At this point, both became defensive and expressed frustration with a high workload and low pay.

The nuns at St. Joseph's health center were more positive, expressing that they are seeing certain benefits from HMI. First, the workload is becoming less burdensome as they become

accustomed to it. Second, they are seeing an increase in patients, and therefore an increase in income. Third, they expressed the hope that more patients would lead to financial or material support in the future. At the time of this research, Saint Joseph's health center had received far more HMI clients than the other clinics combined. This indicates that it is possible to make HMI a positive thing for healthcare providers.

4.2.4. Insights and perspectives from NSIA

Three people were interviewed from NSIA: Anaud Makoutode (HMI Project Point Person, based in Cotonou), Pascal Agbodjogbe (Head of the Control Section, based in Cotonou), and Philibert Sabi Yerima¹⁶ (Natitingou Satellite Office Manager). Mr. Sabi Yerima is contracted by NSIA to run the office in Natitingou, and is therefore not a direct employee of NSIA. NSIA staff expressed similar viewpoints on a number of topics. First, NSIA staff expressed that they "are not a charity," and therefore are unwilling to invest capital in HMI until they have evidence that it will be profitable in the long-term. Even so, all respondents described how HMI could potentially reach rural populations across Benin and even other West African countries, thereby making even a small per-policy profit margin a worthwhile investment.

Second, NSIA staff complimented the work of CRS, explaining that they would not have access to these populations without the assistance of CRS and Caritas Natitingou. NSIA requested that CRS remain involved with the project for as long as possible; e.g., for a minimum of two more years. Additionally, they said that the rollout of the program would not be possible without the financial support of CRS, who is currently paying per diems and transport costs for NSIA. Finally, all respondents specifically commended the work of Jérôme Dadjo as proactive and of high quality in supporting the pilot. This feedback reflects the essential role that CRS has played in the creation and launching of this product. It further indicates that more needs to be done for NSIA to take full ownership of the product to ensure future sustainability. In terms of future plans, NSIA mentioned that they are waiting to conduct an annual evaluation of the pilot before making any additional investments. If the product is profitable, they will petition their superiors at NSIA to make HMI an official product. If not, they will stop offering it, although it was not clear as to whether they would stop immediately or continue until the end of the pilot period.

NSIA staff was divided on their impression of the life insurance component. One respondent explained that the life insurance component is desirable both because it will bolster the program financially, and because it provides a social service to the client, supporting people or families who lose a breadwinner. NSIA staff; however, expressed surprise that there had been four deaths in the first four months of the pilot, leading one respondent to express his doubt that the life insurance component was well designed for this target population. One respondent expressed concern that no contract existed between NSIA and the client,

¹⁶ This person is not a NSIA employee. Rather, he has been contracted to manage the satellite office.

although the insurance booklet effectively functions as a contract, including the conditions of the HMI, the identity of the client, and an official NSIA/CRS stamp.

Finally, NSIA staff expressed frustration that clients don't know how to properly fill out paperwork to make claims, at times do not seem to understand the concept of insurance, and arrive to enrollment sessions late, even though they have "nothing to do" and "can come anytime." This highlights an underlying challenge: a cultural difference between NSIA staff members and their client base. Currently, CRS and Caritas Natitingou bridge this gap, and communicate between NSIA and the client base. However, in the long-run, if NSIA wants to scale-up HMI, it will be necessary to establish better relations with clients. In this case, that means understanding that rural poor people are not lazy and unoccupied. Rather, they work long hours farming or on small income generating activities, and have no reason to trust that strangers from the capital have their best interest at heart.

4.2.5. Insights and perspectives from government officials

Government officials, including the Director and the Assistant Director from the Ministry of Health's "Agence Nationale de l'Assurance Maladie (ANAM),"¹⁷ the coordinating physicians for the sanitary zones Kouandé and Natitingou, and a representative from the "Direction Nationale de la Protection Sanitaire (DNPS)"¹⁸ expressed enthusiasm for NSIA's HMI, while raising questions related to feasibility. In particular, they indicated that the program is novel in its partnership with a private insurance company to provide services to rural populations that function almost entirely in the informal sector. All offered their support for the project, and requested to be informed of future advancements.

4.3. Key challenges to the implementation and scaling up of HMI

In theory, HMI has the ability to create a virtuous cycle of benefits for all the relevant stakeholders, including the clients, the healthcare providers, NSIA, and the GoB. The findings of this study demonstrate that while many of the necessary components are in place, it will be necessary to make certain adjustments to ensure that positive feedback loops are realized. The flowchart mapped in Figure 8 illustrates a theoretical cycle of a health insurance scheme. When each part functions correctly this reinforces the other parts, resulting in a continually improving situation. When demand for HMI increases, health services improve, profits for the healthcare providers and the insurance company increase, costs of providing the health insurance decrease, and eventually client health and welfare improve.

¹⁷ National Healthcare Insurance Agency

¹⁸ National Directorate for Health Protection

Figure 8 Interactions between supply and demand for health insurance and health care

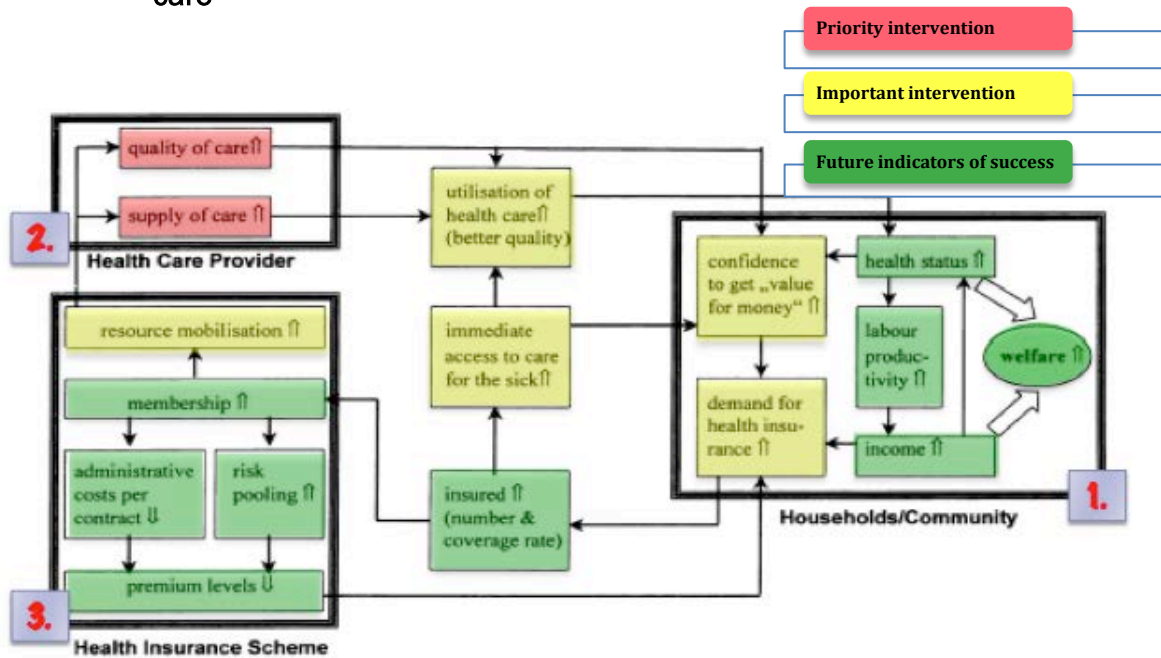


Figure 8 is color coded to highlight priority interventions for the studied HMI. The red indicates problems that must be addressed immediately to allow for the future success of the HMI program. Yellow indicates areas where it is necessary to dedicate additional resources to the current program. Green indicates future indicators of success, or aspects that currently are headed in a good direction, but must be continually monitored. Each area is discussed further in the following section.

4.3.1. SILC group/household level

At the household level, we see that the components for success are present. SILC group members in the pilot express a demand for HMI and have already demonstrated the ability to make premium payments, in many cases, thanks to the SILC group. They have expressed confidence in Caritas and CRS that enables them to try the product. Furthermore, in the qualitative interviews, participants reported an increasing demand for HMI, the perception that HMI is worth the cost, an improvement in access to health care, and an improvement in the ability to meet emergency health costs without using savings or loans. It is too early to observe other factors illustrated in the positive feedback loop, especially a related increase in income, increase in labor productivity, increase in health status, and increase in welfare. If HMI proves financially viable and is scaled-up to other communities, CRS might consider developing indicators measure these outcomes as the program is rolled out.

Working with mature SILC groups fosters this positive feedback cycle in two ways. First, the group provides an ideal base for sensitizations and outreach campaigns to familiarize potential clients with the benefits and characteristics of the product. Second, the group

helps potential clients save incrementally for an annual or semi-annual premium payment. Although few people used group savings to collect the amount needed to subscribe to HMI in the first enrollment period, this may be due to the late registration, such that many people had spent their savings previously designated for HMI at share-out. In the first cycle of the pilot, the SILC groups that used a group savings strategy had an average participation rate of 35.4% in HMI, while groups in which members saved individually had a lower average participation of 17.9%. Although the sample size is very small, this indicates that saving in the group can facilitate savings for the HMI product, whether by reducing cost barriers or by creating an atmosphere of positive peer pressure to save to join.

As discussed previously, the HMI was originally envisioned as a compulsory group product, in which all members of participating SILC groups would join together. Theoretically, this would help diversify risk and increase enrollment; however, in the pilot where the product is offered to individuals adverse selection did not seem to be a problem. In the first four months, the product has been profitable for NSIA. Additionally, although saving in a group helps people prepare to pay the premium, a number of enrolled individuals explained that they paid their first premium from money they had saved in the house (e.g., on an individual level). This demonstrates that potential clients are capable of making the premium payment without the support of a savings group. In turn, this means that in the future, NSIA could offer the product both to savings groups and to unaffiliated individuals. Additional awareness raising activities and education in the form of sensitization and LC session can help foster demand for the HMI, as will increased experience with the product.

4.3.2. Healthcare provider level

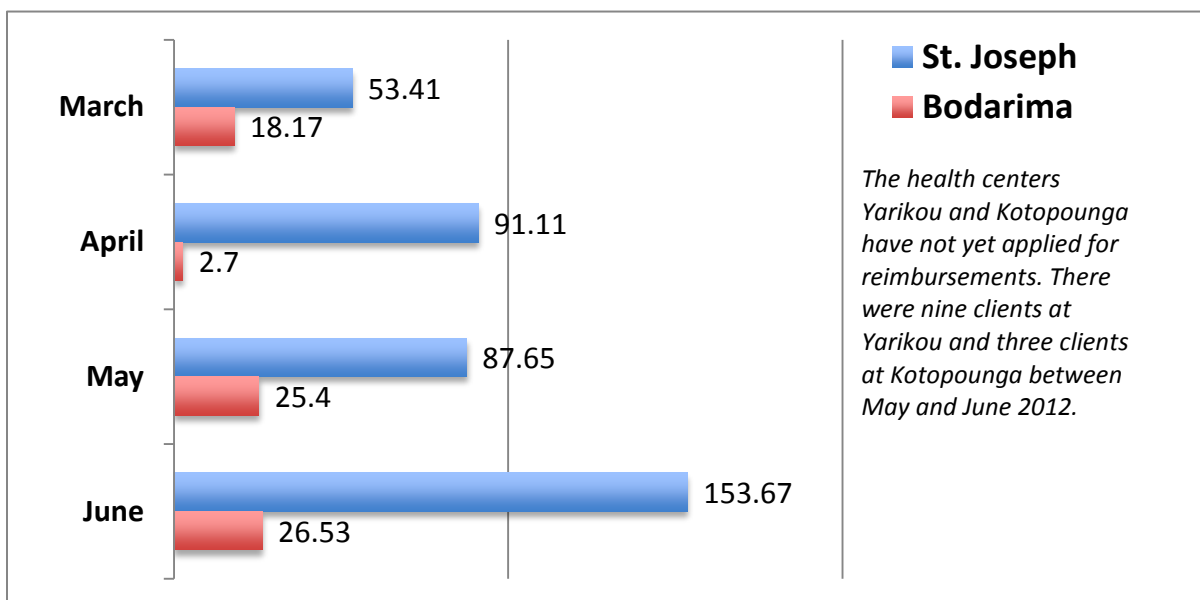
Theoretically, HMI benefits healthcare providers as well. In the short term, the product provides a sure income stream from NSIA that may be more reliable than patient payments. In the medium to long-term, HMI should motivate patients to seek care earlier and more often, thereby improving the overall health of the population. These changes should increase the profitability of health centers, enabling them to hire more staff and improve technical capacity. Additionally, more patients would help healthcare providers make a compelling argument to the GoB and NGOs for additional material, monetary and technical (training) support. All these benefits are dependent on the quality and availability of healthcare for the client base. In practice, we have seen that the healthcare providers lack the capacity (staff and expertise) and the motivation (pay, claims reimbursement, and recognition) to achieve this.

Three of the four health centers participating at the time of this research indicated that their institutions are highly frequented and that unless they hire additional nurses, they cannot serve more patients. This is difficult both because it is not in their budgets to hire additional employees, and because there are few qualified applicants in the region who want to work in rural areas. Alternatively, health centers could hire a secretary to manage documentation;

however, the same factors make this difficult. It is not possible given the current budget, and people with the necessary skills tend to live and work in cities. Due to the extra time it takes to serve HMI clients, it is not apparent how even additional clientele created by HMI would generate sufficient profit to hire an additional employee. It is likely that these problems are exaggerated during the pilot program, when everyone is learning the new system. As healthcare providers and HMI subscribers become increasingly familiar with the product, the marginal cost per client should decrease. Healthcare providers at St. Joseph health clinic in Chabicouma reported that the paperwork had become more manageable after four months of experience. Their concerns are still significant, and should be addressed to improve HMI functioning in the short-term and to assure that healthcare providers' needs are not forgotten.

A lack of motivation is a further challenge to the provision of quality health services and successful implementation of the HMI. Lack of motivation stems from a “broken” pay structure at public health centers, logistical problems related to reimbursement of health insurance claims, and difficult relationships with HMI clients. In Benin, public health centers are on government payroll. According to key person interviews, government pay is irregular. To compensate for this, some public health workers reportedly make their money by providing services off the record. If this is the case, HMI would be undesirable for healthcare workers because it requires that the service be reported, thereby preventing corruption. This is a systemic and contextual challenge that would be difficult, if not impossible, to address at the project level.

Figure 9: Reimbursements requests by health center in USD



Claims reimbursement (Figure 9), including the transfer of health service receipts to NSIA and the timely delivery of reimbursements from NSIA, poses a further challenge to the

smooth functioning of the HMI program. In the pilot, NSIA traveled with CRS to Natitingou to enroll new members and renew subscription for old members. On the same trip, NSIA delivered reimbursements to healthcare providers for the first two months (March and April). The contract between the healthcare providers and NSIA stipulates that NSIA must send reimbursements within 30 days after receiving the receipts. According to NSIA staff, this initial delay was related to setting up a system for invoices, which has been fixed for future reimbursements. It is essential that the healthcare providers send receipts each month, and that NSIA process invoices and send the reimbursements in a timely manner. If done well, this should motivate healthcare providers to promote HMI. If done poorly, it will likely continue to discourage health providers from supporting HMI.

Another challenge for healthcare providers is managing their relationship with clients. Healthcare providers reported that patients with HMI believe that they should be seen quickly and at times, before their turn. They reported that patients are not understanding of delays, and are often unwilling to wait even when there are children in need of urgent treatment for fevers or convulsions. Similar challenges have been reported with the formation of health mutuels in Benin, Guinea, and Niger, “where the removal of financial barriers by abolishing user fees has transformed the power relationships and resulted in certain abuses by patients” (Ridde et al., 2010, p. 473). To help mitigate this problem and to foster a positive relationship between clients and healthcare providers, CRS has proposed developing an additional LC session on “Patience in the use of healthcare facilities,” to encourage HMI subscribers to respect the needs of healthcare providers and other patients, who may have more serious medical issues.

Additionally, CRS has pursued a strategy to encourage, by providing positive pressure, the healthcare providers to make a good faith effort to provide quality care for HMI clients. First, CRS has secured the buy-in and support of regional health administrators, including Dr. Félicien Tossou, Coordinator of the Health Zone Natitingou-Boukoumbé-Toukoutouna, and Dr. Célestin Hounkpè, Coordinateur of the Health Zone 2KP (Kouandé-Kérou-Péhounco). Second, the healthcare providers have signed contracts with NSIA that oblige them to accept the HMI patients. Third, CRS and Caritas Natitingou have met with the healthcare providers to explain patients’ complaints. A quarterly meeting of all stakeholders is scheduled to enable HMI users, healthcare providers, NSIA, CRS, and the GoB to air any grievances, and work to improve the functioning of the product. Finally, there is a program in Benin called “Financement Basé sur les Résultats (FBR)”¹⁹ that evaluates and funds healthcare providers based on performance. Although it is not yet working with these specific health centers, there is a possibility that it may be encouraged to do so in the future, serving as an additional motivating factor. It is clear; however, that more must be done immediately to support and motivate the healthcare providers. Access to quality health care

¹⁹ Results Based Finance

is the most important component for the success of the HMI, particularly in these early stages of the program, while the population is observing and deciding if they want to join HMI in the future.

Finally, this pilot calls attention to an interesting point; i.e., the most successful HMI experience has been at St. Joseph's health clinic. This is the clinic most closely associated with CRS and Caritas Natitingou. The nurses at St. Joseph health clinic are all Catholic nuns, and have strong personal relationships with Mr. Dadjo. This close relationship, founded in a shared religion and belief system, may have helped to foster the necessary trust to motivate the sisters to make a better good faith effort to implement HMI from the beginning of the trial period (helping to explain the more positive results). This implies that a third tool to motivate healthcare providers to make a good faith effort is to build trust between healthcare providers, NSIA, and between CRS. While a religious connection provides a deep indication of trust and commitment, a professional connection is needed as well.

4.3.3. NSIA Level

NSIA's involvement distinguishes this project from the many health mutuals that exist in rural Benin. As a private insurance company, NSIA strengthens the product by externalizing risk from the groups, providing a structure to pool risk across different communities, and bringing years of experience in insurance. In the long-term, NSIA stands to gain immensely from spearheading this project. Although the profit margin per client is relatively small, the client pool is potentially very large, particularly considering that the GoB is currently working to design a universal national health insurance program, known as RAMU. One of their greatest challenges is how to provide effective health coverage to rural poor populations. If this pilot program is successful, it could potentially be integrated within RAMU. In turn, this would increase profits for NSIA by defraying implementation costs, increasing the size of the target population, and likely receiving a direct subsidy from the GoB.

Additionally, although HMI initially targets poor populations, there is hope that in the long-term, these clients and their children will increase their household incomes, and in turn, demand more extensive (and expensive) health insurance coverage, and eventually, other kinds of insurance. This is an unprecedented opportunity for NSIA to become the household insurance provider for rural populations across West Africa.

Aside from these apparent strengths and motivations for NSIA, there are a number of challenges that must be addressed in terms of resource mobilization to ensure successful long-term functioning of HMI. Although leadership at NSIA has expressed an understanding of the potential benefits of the HMI, they have been slow to demonstrate their commitment. To overcome this challenge, it is essential that NSIA dedicate the human and financial capital required to create a guarantee fund, foster relations between NSIA and the client populations, and invest in other components of the program.

This is possible in four key areas. First, a new regulation has been proposed that requires any insurance company providing microinsurance to set aside a guarantee fund. The board of NSIA has not yet approved this fund. According to NSIA staff, NSIA's board of directors is more likely to approve the fund if there is a positive review of the HMI at the end of the year, and the product demonstrates profitability. Currently, CRS is supplying the guarantee fund, such that if the reimbursements required by the HMI are more than the premium payments, CRS will pay the difference up to 10,000,000 F CFA (≈\$18,737).

Second, to date NSIA has been reluctant to invest fully in HMI. For example, in two separate interviews, NSIA personnel stated that NSIA is not a charitable organization, and this is why they are unable to invest more financial resources in HMI before proof of profitability. In addition, NSIA personnel arrived over an hour late to a debriefing meeting with government representatives, healthcare providers, Caritas staff, CRS, and the National Health Care Agency. Even if NSIA cannot accept the level of risk at this early stage, more symbolic investments of time and verbal commitment are needed to create the trust essential for program success.

Third, NSIA currently has no office in Natitingou. Instead it has contracted with an individual to work in a satellite office. This means that all formal work must be done at headquarters in Cotonou, including registering new subscribers, processing receipts and invoices, and issuing reimbursements. Although this is feasible, the process would be greatly simplified if NSIA had a greater presence in Natitingou.²⁰

Fourth, NSIA's current dependence on the involvement and leadership of CRS, both in respect to finance and logistical preparations for field visits, to maintain the relationship with the clients is not sustainable. This is likely to pose a significant problem in the transition of responsibilities from CRS to NSIA. As discussed earlier, it is essential that NSIA furnish not just the financial and human capital necessary to support the logistical functioning of the program, but also builds a relationship between their client base and the company. This may require that NSIA treats rural populations with the same respect and provide the same quality of service as they do for their more affluent urban clients.

4.4. Strategies to link HMI to Benin's future universal health insurance scheme

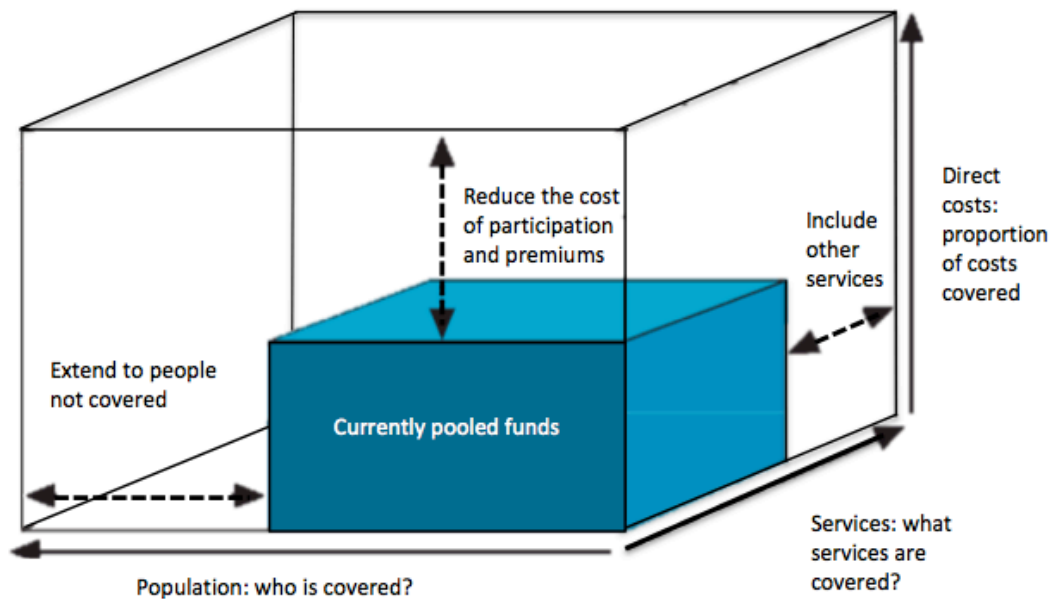
The Government of Benin is currently developing RAMU to extend health insurance coverage beyond government employees, certain artisan groups, individuals with private insurance, and health mutuals. RAMU will incorporate existing health insurance schemes, including health mutuals, under an umbrella structure. To help streamline the process the GoB intends to work with health mutuals that are already federated and encourage those that are not to become federated, providing participation in RAMU as the incentive. This; however,

²⁰ At a minimum, the secretary for the SILC group is literate. Additionally, the Caritas Natitingou SILC field agents are literate and available to assist participating SILC groups.

will not reach everyone in Benin. There is therefore a need for an additional strategy to reach the remaining part of the population to be able to offer universal coverage to rural and poor populations. NSIA’s HMI product has the potential to do this.

Discussions with representatives from the ministry of health, ANAM, and the NGO AfricMutualité, have yielded two potential ways the SILC HMI client could become part of RAMU. First, if the pilot program is successful, and the HMI is able to scale up, it would be possible for the GoB to partner directly with NSIA to offer HMI as a component of RAMU (option 1). The GoB could offer a subsidy to NSIA, in return for a product with expanded coverage to regional and national hospitals. With an appropriately structured partnership, NSIA could continue to offer the HMI at a similar or lower cost, while providing more services. This proposal would expand the product along the axis delineated in Figure 10. Alternatively, the HMI clients could join in health mutual apex bodies, removing themselves from NSIA, and thus become eligible to participate in RAMU (option 2).

Figure 10: Three dimensions to consider when moving towards universal coverage



Source: Presentation by Providing for Health (P4H) on the launch of RAMU in Benin (February 2012)

The first option, using and expanding the role of NSIA is preferable to the health mutual option for a few reasons. First, NSIA externalizes risk from the group, which should result in a more sustainable and secure insurance option. Second, NSIA’s product should be easier and faster to scale up than creating a large number of health mutuals, because the insurance company retains the expertise, thereby decreasing the need for training and raising awareness at the community level. Third, NSIA’s HMI does not require a critical mass

of people in a given area as health mutuals do. Rather, as a national actor, NSIA would have the ability to pool risk across clients from all different regions of Benin.

The second option, while less preferable, would take advantage of the progress made by CRS and NSIA in this pilot program; namely, that clients of NSIA's HMI will become increasingly familiar with the concept of insurance and how it functions, and thus be better prepared to join and manage health mutuals.

5. CONCLUSIONS AND RECOMMENDATIONS

This research and analysis demonstrates that HMI with a private insurance company is a unique opportunity with significant potential benefits for all relevant parties. The client base, the insurance company, the healthcare providers, and the GoB, stand to make significant gains if the HMI is successful. The fundamental factors necessary for success are present. At the level of SILC groups, there is demand, and they are able to make the premium payments. At the level of the healthcare providers, they have committed to the pilot program and if the program is successful, they stand to gain more clients, more income, and a more proactive approach of the clients to preventative healthcare over time. At the level of NSIA, they can make a substantial profit while providing a valued service, by expand their client base across Benin and potentially throughout West Africa. The GoB stands to gain, too, since for RAMU to be truly universal, it will be necessary to find a program that can reach rural poor populations with effective healthcare coverage. As such the following recommendations are provided to ensure the long-term success of this pilot with a particular focus on building trust between all stakeholders.

5.1. Global Recommendations

- (1) Prioritize the experiences of the first clients. Since others are observing them (evaluating the product) before joining themselves.
- (2) Promote trust in the HMI by being transparent, predictable, and proactive in all decisions, as much as possible:
 - Share findings and insights with all partners (healthcare providers, NSIA, and Caritas Natitingou);
 - Communicate feedback from partners as quickly as possible; and
 - Continue to provide a formal forum for feedback; e.g. a quarterly stakeholders meeting.

5.2. Recommendations for CRS & Caritas

- (3) Think outside the project box to find ways to build capacities and interest of NSIA, the healthcare providers, and the clients.
- (4) Work with NSIA to develop strategy to improve NSIA's ability to serve rural populations:
 - If possible, leverage relationships to convince the superiors at NSIA to prioritize HMI in a meaningful way (to dedicate the necessary resources to its success);

- Develop a detailed plan with NSIA and GoB for the transfer of responsibilities;
 - Remain involved in the HMI pilot until it is self-sustainable (likely, at least two more years), but start a transfer of responsibilities to NSIA immediately;
 - Foster the relationship between NSIA and target communities by identifying an NSIA employee to be the face of HMI in rural communities *and* at NSIA headquarters; and
 - Support NSIA in achieving recommendations 7-11.
- (5) Motivate the healthcare providers to provide higher quality service and a good faith effort at implementing HMI:
- Consider creating a formal recognition to honor the health center that welcomes and treats the most patients using HMI;
 - Consider working with the GoB to adopt NSIA's HMI into RAMU, by provide a limited subsidy to healthcare providers that demonstrate correct implementation of HMI;
 - Learn about the “Financement Basé sur les Résultats” program and find a way to use it to motivate participating healthcare providers;
 - Continue with set quarterly stakeholder meetings to share experiences (both positive and negative), as well as lessons learned and ideas for improvement; and
 - Consider adding a capacity building component for participating healthcare providers.
- (6) Strengthen sensitizations and learning conversation session to:
- Reinforce the notion that health insurance does not necessarily decrease overall health costs, but that it does improve subscribers' ability to manage healthcare costs;
 - Encourage clients to use facilities for a range of services, particularly prenatal and delivery services, which seem to be underutilized; and
 - Develop additional learning conversation sessions to address challenges as they arise, perhaps beginning with the issue of patient rights and responsibilities so as to rapidly improve the patient/provider relationship.

5.3. Recommendations for NSIA

- (7) Invest in the necessary financial and human resources to successfully manage the project. During the pilot, there are many small obstacles that must be addressed. Identify one person with the appropriate level of authority and independence to *prioritize* HMI and address challenges as they arise.
- (8) Strengthen the relationship between NSIA and the client base to develop trust:
- Establish a method of direct contact between NSIA and client populations, be it an office in Natitingou with a representative who travels to the field, or a customer service phone number; and
 - Consider holding a sensitization campaign about NSIA with local populations:
 - Start this process as soon as possible, both to make sure the relationship is strong, and to take full advantage of the presence of CRS to facilitate the process.

- Be transparent with clients so that if something isn't possible, you can explain why;
 - Treat the client base as peers; and
 - Provide opportunities to solicit questions and suggestions.
- (9) Strengthen the relationship between NSIA and the healthcare providers to develop trust:
- Contact healthcare providers regularly and provide them with a dedicated contact person at NSIA who they can call with any questions or concerns. This person should always call the healthcare provider back, so that NSIA pays the cost of the call;
 - Consider re-working and simplifying the administrative documents to require less work at the level of healthcare provider; and
 - Consult healthcare providers in the process of developing the new documents.
- (10) Establish and publicize a schedule for policy renewal dates, well in advance:
- Make these dates public (consider posting the schedule at participating healthcare centers and other public areas); and
 - Stick to the scheduled day and scheduled time.
- (11) Publicize the terms and conditions stipulated in the HMI contract and other information about the product as much as possible:
- Include a breakdown of costs, services available, the names of accepted drugs, the payout for life insurance, the documents required for the dossier in the case of a death and required timing, and the dates of renewal;
 - Consider distributing informational packets to participating healthcare centers and participating SILC groups; and
 - Laminate one copy for each healthcare center and request it be kept in a place where visitors and healthcare providers can easily reference it.

5.4. Recommendations for Future Research

- (12) Examine how mobile technology could help with logistical challenges:
- For example, rapid SMS platforms might allow healthcare providers to use forms to sending receipts digitally to NSIA;
 - Mobile money might allow NSIA to send reimbursements directly to healthcare providers; and
 - Some combination could perhaps enable perspective clients to sign up for HMI directly from Natitingou via mobile phones.
- (13) Examine how this HMI can be integrated into RAMU:
- Either through an arrangement with NSIA providing it on a national scale; or
 - By “converting the SILC groups’ HMI into health mutual.
- (14) Create a dialog with the GOB on this issue to delineate the details of how this might be possible and what the timeframe would look like.

APPENDIX A NSIA'S HEALTH MICROINSURANCE TERMS AND CONDITIONS

BENIN	
A- HEALTH/ACCIDENT	Overall reimbursement ceiling: 40,000 F CFA/assured/year (≈\$75)
Cost of consultation: Curative, prenatal and postnatal consultation	- Covered at 100% - Limited to 300 F CFA (≈\$0.56) per visit, and - 3 consultations per year
Cost of care:	- Covered at 70% - Copay of 30%
Cost of pharmaceutical products and medicines that are sold at the participating health centers	- Covered at 70% - Maximum of 4,000 F CFA (≈\$7.50) each time - Maximum 3 times per year
Medical costs for local “hospitalization”	- Covered at 70%, with a maximum of 5,000 F CFA (≈\$9.37) per year
Simple births	- Covered at 70 % - Maximum of 6,000 F CFA (≈\$11.24) per year
Small surgeries	- Covered at 70 % - Maximum of 3,000 F CFA (≈\$5.62) and limited to two times per year
B - LIFE	
Death or incapacitation of the insured	Capital: assured at 100,000 F CFA (≈\$187.37)

Eligibility criteria:

- Primary insurance policyholder must be a SILC member.
- Covered dependents are his or her spouse and up to six children.

APPENDIX B LIST OF SERVICES AND AVERAGE COST AT LOCAL HEALTH CENTERS

Health Service	Level of risk	Average cost
Consultation at health center	71%	100 F CFA (≈\$0.19)
Consultation at denominational center	29%	300 F CFA (≈\$0.56)
Medications at health center	110%	900 F CFA (≈\$1.69)
Place under observation	10%	300 F CFA (≈\$0.56)
Nursing care	40%	200 F CFA (≈\$0.37)
Small surgery	20%	200 F CFA (≈\$0.37)
Prenatal consultation	12%	950 F CFA (≈\$1.78)
Simple birth	3%	2 000 F CFA (≈\$3.75)

Source: constructed from data collected in the field during CRS' health needs study (2010).

APPENDIX C STATE OF CLAIMS AS OF JULY 17, 2012

Claims	Month	Total	USD Equivalent
Boderima	March	9,695 F CFA	\$18.67
	April - June	43,725 F CFA	\$81.93
St. Joseph's	March	28,505 F CFA	\$53.41
	April	48,625 F CFA	\$91.12
	May	51,580 F CFA	\$96.65
	June	90,115 F CFA	\$168.85
Yarikou	March-June	22,830 F CFA	\$42.78
Four deaths	March-June	400,000 F CFA	\$749.48
TOTAL CLAIMS		695,075 F CFA	\$1,302.37
TOTAL PREMIUM COLLECTED		1,921,250 F CFA	\$3,599.87

APPENDIX D SELECT BIBLIOGRAPHY

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APPENDIX E SILC GROUPS INTERVIEWED

#	SILC Group	Location	Insured/ Total Members	HMI Status	Health Center Used	No. Participants
1	Wahalabeni	Chabicoum a	11/25	Mixed/Insured	St. Joseph's	6
2	Poulousa	Chabicoum a	16/42	Insured	St. Joseph's	8
	Poulousa			Uninsured		5
3	Nongoutaba	Chabicoum a	6/62	Insured	St. Joseph's	3
	Nongoutaba			Uninsured		5
4	Poudénam	Chabicoum a	1/26	Insured	St. Joseph's	1
	Poudénam			Uninsured		5
5	Essowè	Chabicoum a	17/42	Insured	St. Joseph's	12
6	Tibobénè	Chabicoum a	13/30	Uninsured	St. Joseph's	1
	Tibobénè			Insured		8
7	Lanhessirè	Chabicoum a	22/59	Insured	St. Joseph's	1
	Lanhessirè			Uninsured		3
8	Tchokakpendé	Kotopounga	3/35	Insured	Kotopounga & Boderima	6
	Tchokakpendé			Uninsured		1
9	Tétoman	Kotopounga	5/21	Insured	Kotopounga & Boderima	4
	Tétoman			Uninsured		3
10	Yimboma Tohou	Kotopounga	2/32	Uninsured	Kotopounga & Boderima	3
	Yimboma Tohou			Insured		1
11	Tèkiri	Kotopounga	2/30	Uninsured	Yarikou	4
	Tèkiri			Insured		2
12	Tissenguiré-tiyo	Kotopounga	4/24	Insured	Yarikou	4
	Tissenguiré-tiyo			Uninsured		3
13	Tikpehina	Kotopounga	1/37	Uninsured	Kotopounga & Boderima	4
	Tikpehina			Insured		1
14	Waréyin	Kotopounga	11/31	Insured	Kotopounga & Boderima	3

APPENDIX F INTERVIEW GUIDES USED FOR SILC FGD (INSURED & UNINSURED)

Focus Group Discussion Guide for HMI Plan Members

A. Experience with health services and perception of HMI:

A1. Have any of you ever used the HMI before? If so, when and for what? If not, why not?

A2a. [Prompt for indirect costs, including transport and medicine, and also how the costs were met, i.e. SILC savings, from SILC social fund, from another family member, a neighbor, etc.]

Prompt: Tell me about a time before you bought the health insurance when you or someone in your family was sick. What did you do? Please walk me through each of the steps and be as specific as possible.

Now tell me about a time since you purchased the health insurance when you or someone in your family got sick. What did you do? Please walk me through each of the steps and be as specific as possible.

Tell me about a time since you purchased health insurance when you or someone in your family got sick with something that was not covered by the health insurance. What did you do? Please walk me through the steps and be as specific as possible?

A2b. What health center do you prefer? Why?

A3. Perceptions about health insurance:

- a. In your opinion what is the one best thing about this health insurance product?
- b. In your opinion what is the one biggest problem you have with the health insurance product?
- c. Do you intend to renew the health insurance premium when it is up for renewal? Why or why not?
- d. Have you recommend to others either in your SILC group or outside it to buy this health insurance? Why or why not?
- e. In your opinion, is HMI worth the cost you paid? Why or why not?
- f. If you could make the HMI cover one more medical need, but it would make the insurance more expensive, what would you add?
- g. If you could make the insurance cover one less medical need, and it would make the insurance less expensive, what would you take away?
- h. Why do you think some of your SILC members have decided not to buy the HMI? What would it take for them to participate in the future?
- i. In your opinion, what would it take for them to be willing to purchase the health insurance in the future?
- j. Do you worry less about what you will do when someone in your family gets sick?

A4. What convinced you to buy the HMI?

A5. Who made the final decision in your household to purchase the HMI? [Prompt: you? Your spouse?]

B. Understanding of HMI product:

B1. How did you first hear about the HMI product?

B2. Did you get training on the HMI? (If yes, from whom? What did they tell you about it, and when/in what capacity?)

B3. What are the terms and conditions of the HMI product? [Prompts: how much does it cost? When are scheduled payments? What can you use it for? What can't you use it for?]

B4. Please tell me about the life insurance component of the HMI.

- a. Do you know anyone who has received a payout?
- b. What was their experience?
- c. Is life insurance an important component of the HMI product?
- d. Does your knowledge of the offering and the experience people have had impact your feelings about the product? If yes, how?

B5. Have you ever used any other kind of insurance (crop/animal, life insurance, etc.)? If yes, please tell me about your experience with that insurance product.

C. Perceived impacts of HMI for SILC group:

C1. How were you able to save enough money for the premium payments?

C2. In your opinion has anything changed in your SILC group since the HMI became available? [Prompts: Use of the social fund? Amount of individual or group savings? Internal dynamics?]

C3. Have you made any new rules in your SILC group related to the HMI? [Prompts: Required amounts of savings, social fund deposits, borrowing and lending rules?]

- a. How much is your contribution? Has it increased or decreased since HMI?
- b. How do you use the social fund? Has it changed since HMI?

D. Beneficiaries:

D1. Who did you enroll as beneficiaries?

D2. How did you choose these beneficiaries?

D3. Would you like to add others as beneficiaries? Why or why not?

Focus Group Discussion Guide for Non-Plan SILC Members

A. Experience with health services and perception of HMI:

A1. What is your experience with using health services?

- a. What health center do you frequent?

- b. When was your last visit to a health center? For what reason?
- c. How much did you spend (estimate)?
- d. How did you finance your costs?
- e. Your husband/children are treated in what health center?
- f. What health center do you prefer? Why?

A2. [Prompt for indirect costs, including transport and medicine, and also how the costs were met, i.e. SILC savings, from SILC social fund, from another family member, a neighbor, etc.]

Prompt: Tell me about a time when you or someone in your household had need of medical care. What did you do? Please walk me through each of the steps and be as specific as possible.

- A3. Would you like to buy health insurance in the future?
- a. If yes, why did you decide not to buy the HMI this time?
 - b. If not, what would is it necessary to do or change for you to participate in the future?

A4. Who made the final decision in your household not to purchase the HMI? [Prompt: you? Your spouse?]

A5. Do you know other SILC members who have purchased the HMI? If so, what has their experience been?

B. Understanding of HMI product:

B1. How did you first hear about the insurance product?

B2. Did you get training on the HMI? (If yes, from whom? What did they tell you about it, and when/in what capacity?)

B3. What are the terms and conditions of the HMI product? [Prompts: how much does it cost? When are scheduled payments? What can you use it for? What can't you use it for?]

B4. Please tell me about the life insurance component of the HMI.

- e. Do you know anyone who has received a payout?
- f. What was their experience?
- g. Is life insurance an important component of the HMI product?
- h. Does your knowledge of the offering and the experience people have had impact your feelings about the product? If yes, how?

B5. Have you ever used any other kind of insurance (crop/animal, life insurance, etc.)? If yes, please tell me about your experience with that insurance product.

B6. What could you do so that all the members of your SILC group can subscribe to HMI?

C. Perceived impacts of HMI for SILC group:

C1. In your opinion has anything changed in your SILC group since the HMI became available? [Prompts: Use of the social fund? Amount of individual or group savings? Internal dynamics?]

C2. Have you made any new rules in your SILC group related to the HMI? [Prompts: Required amounts of savings, social fund deposits, borrowing and lending rules?]

C3. How much is your contribution? Has it increased or decreased since the HMI?

D. Preferred Service Provider (formal, informal, DIY):

D1. In the past year, for what health reason did you or someone in your household go to:

- a. The local health center
- b. The traditional healer (adjust with correct term)
- c. Buy your own medicine in the market
- d. Wait/do nothing
- e. Other? Please explain

D2. [If necessary, prompt D1: what about your husband/wife or son/daughter?]

6. APPENDIX G NSIA HMI STATISTICS AS OF THE JULY 4-5 2012 ENROLLMENT PERIOD

Type	Total Insured Feb 2012	Renewed	Lapsed	New	Total Insured July 2012	PREMIUMS COLLECTED		
						Renewals	New subscribers	Total
Policy Holders	252	133	119	60	193			
Dependents	463	287 ²¹	206	105	392			
Total	715	420	325	165	585	609,000 F CFA	239,250 F CFA	848,250 F CFA
Total						609,000 F CFA	239,250 F CFA	848,250 F CFS

²¹ Thirty of these are new dependents added to the initial policies.