



Evidence Base Report: Microinsurance for Orphans and Vulnerable Children



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Evidence Base Report: Microinsurance for Orphans and Vulnerable Children

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by Michael Samson,* Maarten Fröling,* Christine Hougaard**
and Tyler Tappendorf**

With contributions by: Annie Dupre,* Sarah Brauner* and Hannah Markus*

* Economic Policy Research Institute (EPRI)

** Centre for Financial Regulation and Inclusion (Cenfri)

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EXECUTIVE SUMMARY

Despite substantial progress over the past decade, HIV remains a global challenge that requires “continued and strengthened international solidarity and determination to address this most serious of contemporary health challenges” (UNAIDS 2013, 2). At the household level, HIV poses serious threats to socioeconomic, health, and developmental outcomes. These impacts are particularly visible in the plight of orphans and vulnerable children (OVC), defined for the purpose of this study as children under the age of 18, who have lost one or both parents to HIV, have at least one chronically ill parent, live in a household headed by a chronically ill individual, and/or are infected themselves.

Although governments offer a range of social protection mechanisms, many OVC households remain vulnerable due to additional social, economic and psychological factors. Furthermore, social insurance, a systematic framework that allows a group of individuals to collectively spread their risk (Pitzer 2003, 3), typically excludes low-income households employed in the informal sector—leaving them vulnerable to shocks and prone to make risk-averse decisions that lead to sub-optimal development outcomes. Microinsurance, defined as low-premium insurance intended for the poor in developing countries, is a market-based solution and potential complement to traditional social protection interventions to address the vulnerabilities of the OVC population. Microinsurance, as a social protection instrument, can work independently or in tandem with existing social protection programs—as a complement to other government provided services and products.

The impacts of HIV on households are well-documented in the literature: OVC households are often impoverished and the children experience emotional suffering, neglect, and increased responsibility. Moreover, the household pattern of consumption is changed to reflect the increased need in health care which leaves fewer resources to attend to the child’s basic needs. Based on these findings, health, life, and burial insurance are identified as the most relevant microinsurance products to meet the specific needs OVC households and ensure increased social protection for orphans and vulnerable children.ⁱ

Despite the positive outcomes associated with microinsurance, it has a number of limitations as a social protection instrument, which include: (i) design challenges in providing cover for specific vulnerabilities faced by HIV-affected households; (ii) sustainability challenges for the market mechanism to extend cover to OVC households with limited ability to pay premiums; (iii)

ⁱ This review does not cover loan microinsurance which pays to cancel the remaining principal on a loan in the case of sudden death or disability of an insured caregiver, thus helping the affected household avoid falling into deep debt. Nonetheless, as anti-retroviral therapy becomes more available and easier to adhere to, there are growing possibilities to insure HIV-positive people. Loan insurance, therefore will merit study as uptake of it by HIV-positive people grows. This review also does not cover education insurance -- i.e., payment of the school fees of dependents when an insured caregiver dies or becomes disabled -- however this topic is addressed in Technical Guidance Brief 3 (see below description of the briefs).

distribution challenges in reaching and targeting OVC households; and (iv) microinsurance is suitable to cover some, but not all risks, leaving OVC households exposed to risks unaddressed by microinsurance products. Furthermore, insurance by its nature can focus only on reducing vulnerability in the face of risk events and is not a direct instrument to alleviate chronic poverty by addressing the underlying causes of vulnerability. Although redistributive in terms of risk, microinsurance schemes do not directly redistribute wealth.

Distribution is important to determining the reach and viability of microinsurance, and the delivery of microinsurance products and services, which requires a number of different actors in the value chain across a variety of distribution channels, deserves specific mention. Microinsurance distribution targeted at orphans and vulnerable children could potentially benefit from being linked to existing social protection networks and structures in terms of mapping, targeting, and/or distribution. Moreover, because of the limited commercial viability of schemes targeted towards low-income vulnerable households, OVC-targeted microinsurance could benefit from public-private partnerships. Innovative solutions with regard to viability and funding are a key step forward in designing microinsurance schemes that provide sustainable support to OVC populations where offerings such as direct subsidies and/or premium subsidies could be possible choices. However, the state of evidence on the scope for leveraging such structures for OVC populations and the challenges of these offerings present severe limitations.

The report identifies several knowledge gaps in the literature that form the base for the series of four technical guidance briefs (TGBs) to complement this report. These guidance briefs will address or provide:

- 1) A full analysis of the role of microinsurance in a larger OVC social protection landscape
- 2) The existing state of health microinsurance and how health microinsurance can target orphans and vulnerable children
- 3) The potential of linking microinsurance benefits to education by means of savings-linked microinsurance to benefit orphans and vulnerable children
- 4) The role of public-private partnerships in microinsurance and how these partnerships can be tailored to the needs of orphans and vulnerable children

Microinsurance for orphans and vulnerable children is an under-researched field but the possible benefits and potential outlined in this report justify further studies to explore microinsurance's full potential to benefit OVC households.

INTRODUCTION

The HIV pandemic has resulted in an estimated 17.8 million orphans worldwide, with the virus affecting 35.3 million adults and children living with the virus globally (UNAIDS 2013, 4). Infection with HIV has an immediate negative impact on personal health while households vulnerable to the effects of HIV face a number of socioeconomic challenges. These include lost productivity, increased health and travel expenses, stigmatization, funeral expenses, and ultimately, the psychological impact of the loss of a caregiver and breadwinner (FAO 2003; ILO 2003; UNAIDS 2006, 81; Sengupta et al. 2011, 1075-1087).

Governments use a range of social protection policy tools to support vulnerable segments of society—including orphans and vulnerable children. Public provision of health care, social assistance grants and the child welfare system can all provide direct support to targeted groups, such as orphans and vulnerable children (OVC). These provisions, however, are challenged by fiscal constraints and various delivery bottlenecks, which means that such programs rarely cover the entire targeted population or addresses the risks to which these individuals are exposed. In the face of exclusion from social protection, microinsurance schemes represent viable risk management instruments to fill the gap and improve the extensive provision of social protection to excluded groups (Jacquier et al. 2006, 45).

Insurance is a mechanism to protect against medical and other risks of vulnerable populations beyond what can be achieved through direct public provision. For this reason, many countries institute a social insurance system which has traditionally been limited to individuals who are formally employed, and for whom social insurance contributions are compulsory. The poor and vulnerable typically do not benefit from such interventions as they are often unemployed or informally employed. In most developing countries, the private insurance sector thus only reaches the top-end of the market, leaving the majority of the population vulnerable to uninsured risks.

Microinsurance is defined as low-premium insurance intended specifically for low-income groups. It seeks to provide protection against specific perils faced by these groups in exchange for a regular payment which should be proportionate to the risks faced. Microinsurance products target low-income underserved groups and have the potential to fill the gap between those reached by social assistance at the very bottom of the wealth distribution, and those served by social or private insurance from the middle and upper section by targeting low-income underserved groups (Churchill 2006, 12-13). Groups in the lowest income quintile can benefit from *protective* and *promotive* social protection strategies¹ that aim to strengthen their economic well-being (LIFT II Project, 2012). For these groups, with limited access to financial means, microinsurance products may serve as useful tools to mitigate exposure to uncovered risks, provided that the product has perceived value and the premium is low.

¹ Devereux and Sabates-Wheeler (2006) define protective social protection as measures with the aim of guaranteeing relief from deprivation while promotive measures serve to increase real incomes and capabilities of recipients.

For microinsurance to fulfil this role, several questions should be addressed, including:

- What role can microinsurance play vis-à-vis other, more traditional social protection mechanisms?
- Which vulnerabilities are most relevant for insurance coverage?
- Is microinsurance for orphans and vulnerable children commercially viable and sustainable?
- What types of microinsurance products are relevant for orphans and vulnerable children, and what product modifications (if any) would be required?
- What are the challenges for insurance to cover HIV-affected households?
- How can microinsurance be targeted at households with orphans and vulnerable children?
- What distribution channels can be leveraged to reach orphans and vulnerable children?
- How could the private and the public sector cooperate to co-fund or administer microinsurance targeting orphans and vulnerable children and their households?
- What are the optimal institutional arrangements for this?

The rest of this document unpacks these questions. It provides an introduction to relevant issues and topics regarding the role of microinsurance in reducing vulnerability of households with orphans and/or vulnerable children and investigates the current state of evidence in this regard. It begins by defining orphans and vulnerable children for the purpose of analysis, and then provides an introduction to the topic of social protection, gaps in provision, and the potential role of microinsurance in improving well-being for OVC households. The findings of this paper will flow into a series of four technical guidance briefs (TGBs) commissioned by ASPIRES.² Each of the TGBs explores an evidence gap that was identified in this evidence base report.

ORPHANS AND VULNERABLE CHILDREN

Defining orphans and vulnerable children

The term “orphans and vulnerable children” (OVC) was introduced in the literature to describe orphaned children in the context of HIV (Skinner et al. 2004, 1). There are several definitions for the term that differ on the degree of inclusivity of age qualifications and the circumstances which lead to increased vulnerability (ibid.). One of the most accepted is the definition from the United States President’s Emergency Plan for AIDS Relief (PEPFAR), which defines orphans and vulnerable children as “children who have lost a parent to HIV, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects” (PEPFAR 2012, 20). However, to operationalize the concept in the context of microinsurance market dynamics, this study necessarily employs a

² TGB 1 -- The role of microinsurance vis-à-vis other social protection mechanisms for orphans and vulnerable children; TGB 2 – OVC-Relevant Health Microinsurance; TGB 3 – Exploring savings-linked microinsurance for orphans and vulnerable children; and TGB 4 – Applying an OVC lens to Public-Private Partnerships in microinsurance. All TGBs are available from the ASPIRES page on Microlinks: <http://bit.ly/1rwRue3>.

slightly narrower definition of orphans and vulnerable children as youth under the age of 18 who:

- have lost one or both parents to HIV; and/or
- have at least one chronically ill parent; and/or
- live in a household headed by a chronically ill individual (including child-headed households); and/or
- are themselves living with HIV.³

Because this report is focused on social protection for orphans and vulnerable children, the discussion centers on households, given that social programs (and insurance products) are typically targeted at the household rather than directly at children.

The effects of HIV on OVC households

Due to increased interest from both policymakers and researchers in understanding the effects of HIV on poverty, a large body of evidence-based literature documents the direct impact of HIV on children. As the virus predominantly affects people of childbearing age, its effects on families with children are especially pronounced. HIV not only results in orphans, but also limits the ability of children and households to deal with exogenous shocks and risks. Essentially, if households are affected by HIV “more money is spent caring for sick members, leaving fewer resources for the children in the household” (UNICEF 2006, 11). Effective microinsurance and social protection programming must address a range of effects of HIV on households. A conceptual frame for understanding the effects of HIV on households is illustrated in Figure 1.

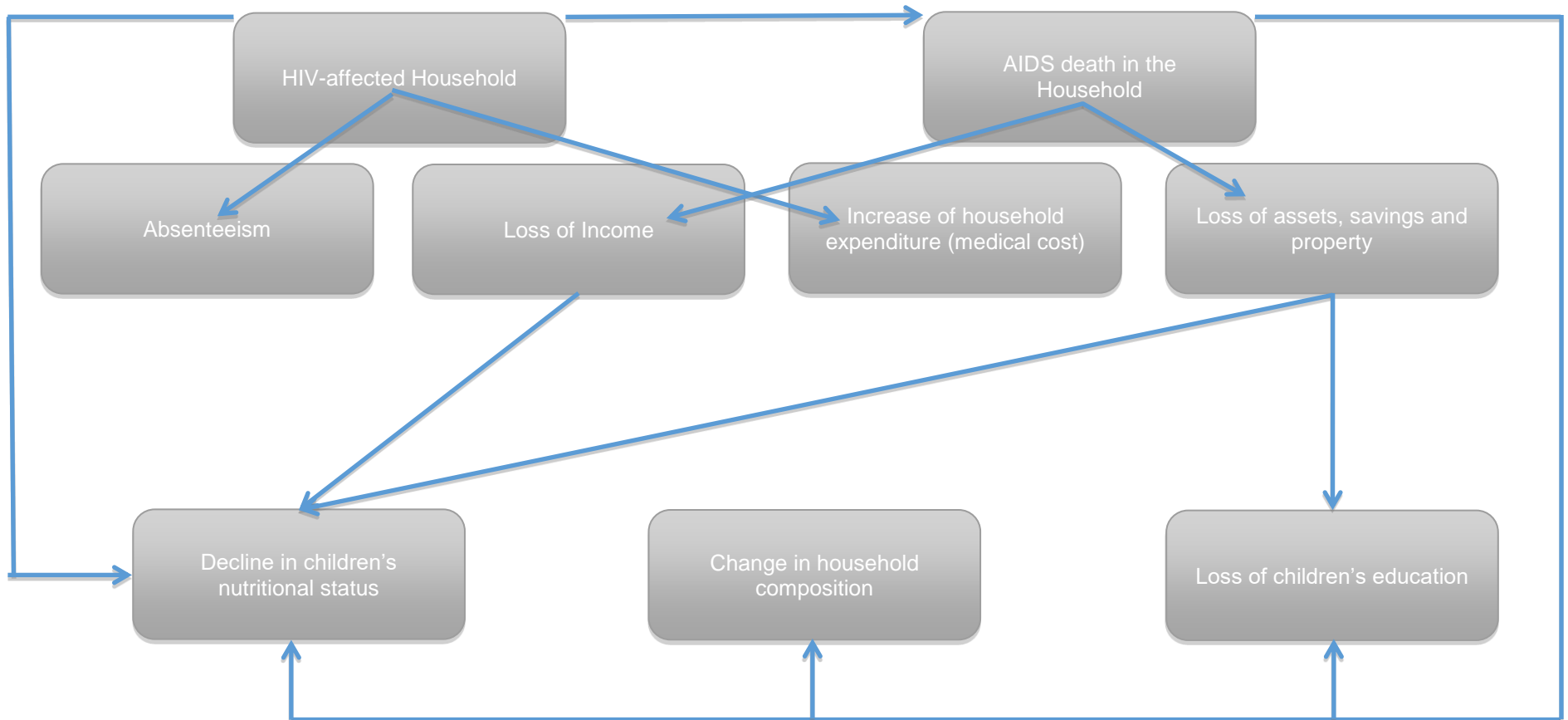
Gaps in social protection strategies addressing OVC vulnerabilities

Social protection encompasses “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance social status and rights to the marginalized” (Devereux & Sabates-Wheeler 2006). Through inclusive rights-based approaches, social protection has been shown to achieve broad developmental outcomes across sectors through complex support pathways aimed at breaking the vicious cycle of poverty (Samson 2013). In this cycle, “the lack of adequate protection leads to risk-averse behavior, especially among low-income groups. Without protection, many poor people decide against investing in income-generating activities or human capital” (Wiechers 2013, 7). Establishing reliable social protection mechanisms for the poor and vulnerable to cope with risks therefore encourages investment and human development and provides a means to escape poverty (ibid.). Annex A provides a description of components of social protection frameworks.

Social protection programs in developing countries are a fundamental first step to bring the most vulnerable members of a population to a minimum threshold of living standards—and yet, by their nature, social protection schemes are general and broadly based. The attempt by social protection programs to reach as many beneficiaries as possible with either a targeted or

³ Note that, in contrast to the PEPFAR definition, this description includes children who are/have been directly affected by HIV, but excludes those who live in high HIV prevalent areas but have no HIV directly in their home environment.

Figure 1: Conceptual Framework for the Socioeconomic Impact of HIV on a Household



Source: Adapted from United Nations, 2004

universal common benefit removes the opportunity for heterogeneity in personal preferences or for varying degrees of risk within the targeted population. This generality points towards a gap in social protection that more specific intervention tools, such as microinsurance, likely can fill. As Zanjani and Koven argue “there may [...] be a role for [...] insurance that fills gaps left by the public sector and by large-scale commercial microinsurance programs” (2013, 18). One example, from Guatemala, is Aseguradora Rural Vivosegura women’s health insurance product that attempts “to balance the health needs of low-income women with their limited capacity to pay” (Poulton & Magnoni 2013). This example illustrates that microinsurance can be used to fill niches in demand regardless of the presence of larger schemes.

The greatest challenge for developing countries in reaching vulnerable groups, such as the OVC population, stems from the limited scale and scope of existing social insurance schemes (Deblon & Loewe 2011). In general, social insurance schemes, as they currently exist, reach only a small fraction of the population. Only 24.7 percent of the population in Africa is estimated to have health coverage.⁵ This share is 81.7 percent in Latin America, 58 percent in Asia, and 72.9 percent in the Middle East (ILO 2014, Annex Table B.11). Similarly, social insurance for older populations and the unemployed remains relatively limited across developing countries (ILO 2014, Annex Table B.3). Deblon and Loewe (2011, n.p.) explain that “most efforts to extend the coverage of social insurance have failed so far due to financial, administrative, and political reasons:

- 1) Most existing schemes are based on formal employment relations and contributions are shared by employees and employers. These rules are difficult to apply to people in unstable, informal employment, especially self-employment.
- 2) Social insurance organizations face administrative problems in monitoring enrollment of workers in the informal economy, collecting their contributions, and controlling for their claims.
- 3) Groups of employees that are already insured often oppose the integration of additional groups into social insurance schemes. They are afraid to be negatively affected—especially when the new groups are poorer on average than themselves.”

In addition to these challenges, social insurance schemes in developing countries usually only cover a limited number of relevant risks or fail to cover all involved costs, resulting in limited product value for the policyholder. Other risks, such as agricultural production or property affected by climate change, are rarely covered by social insurance. As is detailed in the next section, microinsurance offers a mechanism to at least partly cover the various outlined gaps.

MICROINSURANCE

Defining microinsurance

From a consumer perspective, microinsurance can be defined⁶ as “the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the

⁵ Coverage includes affiliated members of health insurance or estimation of the population having free access to health care services by the state.

⁶ For a full overview and discussion on microinsurance definitions, see Ingram & McCord (2011).

likelihood and cost of the risk involved” (Churchill 2006, 12). From a product point of view, “[m]icroinsurance is a financial tool that helps low-income households mitigate risk and plan for the future. It enables them to cope with unpredictable and irregular outcomes, while also preparing them for financial emergencies that threaten their livelihood” (Financial Access Initiative, 2010). Simply put, microinsurance is insurance that is accessible to the low-income market. In most developing countries, this is quite a broad concept, as the bulk of the population could be regarded as low-income by international standards. Thus microinsurance is a mainstream topic dealing with the development of the retail insurance market to serve a broader part of the population. It is ‘mainstream’ insurance adapted to the needs of poor populations in developing countries by offering low premiums, and corresponding lower or different coverage, to help mitigate livelihood risks (Churchill & Matul 2012, 12).

Why is microinsurance needed? Traditional insurance products fail to adequately attract usage from low-income households due to their complexity and high premiums. For example: a multi-peril agricultural insurance product or a comprehensive in- and out-patient health insurance product will simply not be affordable to the majority of the population in a low-income country such as Tanzania.⁷ The bulk of the low-income population, many of whom live in rural areas, are not formally employed and do not have a bank account, are also difficult to reach through traditional insurance distribution channels such as branch-based or broker-based sales. The low uptake of traditional insurance products by low-income households can also be attributed to demand side factors such as low financial literacy. Numerous insurance diagnostic studies have quoted qualitative and quantitative demand-side research that shows that people perceive insurance to be “not for us” or “for the rich” and may not sufficiently understand the concept of insurance.⁸

Thus, microinsurance is not merely insurance with smaller premiums, but requires a rethink of product design, distribution models, claims procedures, etc., to match the realities of the target market. This is particularly relevant where microinsurance is specifically targeted to orphans and vulnerable children. The vulnerable economic position of the target market further undermines affordability, while health profiles may undermine viability from a commercial insurer’s perspective. Furthermore, ORPHANS AND VULNERABLE CHILDREN are difficult to reach as a defined target group for distribution purposes. These challenges create distinct design and distribution considerations in microinsurance for orphans and vulnerable children and may also call for some public involvement, such as through public-private partnerships (PPPs). Despite these differences, the guiding principles of microinsurance and “mainstream” insurance are largely the same. Membership is voluntary, unless otherwise mandated by the government, and members pay a regular premium that, at least partially, equals the anticipated pay-out of benefits. As the International Labour Organization (ILO 2006, 24) explains, “the use of the mechanism of insurance implies:

- Pre-payment and resource-pooling: the regular payment of contributions (before the risks occur) that are pooled together.

⁷ For a full overview of the Tanzanian microinsurance market, see Hougaard et al. (2012).

⁸ For various access to insurance country diagnostic studies, please see www.a2ii.org.

- Risk sharing: the pooled contributions are used to pay a financial compensation to those who are affected by predetermined risks, and those who are not exposed to these risks do not get their contributions back.
- Guarantee of coverage: a financial compensation for a number of risks, in line with a predefined benefits package.”

As the principles of microinsurance are the same, the plans also present similar challenges to an insurance scheme’s viability, such as moral hazard⁹ and adverse selection.¹⁰ Microinsurance’s sustainability is further challenged by the small margins on the products and the difficulty of setting up delivery challenges, as is detailed in a subsequent section.

Microinsurance also distinguishes itself as more than just a financial product; it is a strategic tool for different development agendas such as financial inclusion, pro-poor financing, rural development, social security development, and mitigation of climate change. By reducing vulnerability of rural households, microinsurance can mitigate the risks threatening lives, productivity, and assets. Moreover, microinsurance can support asset building by preventing depletion of savings and serve as a safeguard in case of emergency. In these ways, microinsurance contributes to household resilience, strengthening, and development (Klein, 2009).

Microinsurance as a social protection instrument

Microinsurance is typically a market intervention while the provision of social protection is a public intervention. Microinsurance can help fill gaps in publicly-provided social protection to better protect poor households. In particular, PPPs in microinsurance have the potential to enhance outcomes for OVC households and the poor.

The microinsurance market has expanded dramatically over the last decade, not the least because of the proliferation of microfinance programs and products, which have provided evidence that commercial financial service providers can work successfully among the poor in developing countries (Churchill & Matul 2012, 11; Wiechers 2013). Between 2008 and 2011, the number of insured people and property increased by a reported 200 percent (McCord et al. 2012, XIII). Moreover, as of this year, 33 of the world’s 50 largest insurance companies offer microinsurance as compared to only seven in 2005 (Churchill 2014, n.p.). Accordingly, in 2012, an estimated 500 million risks were covered by microinsurance, 4.8 percent of which were in Africa (Churchill & Matul 2012, 11). The most popular product and driver of microinsurance usage in Africa was basic life products with 70 percent of all microinsurance clients covered by some sort of life product in that region (McCord et al. 2012, 9, 11). The microinsurance sector has expanded dramatically, but there is still significant room for growth, both vertically and horizontally.

Beyond protecting the most vulnerable from shocks they may otherwise be unable to mitigate, “[m]icroinsurance is a form of social organization, based on the concepts of solidarity and risk-

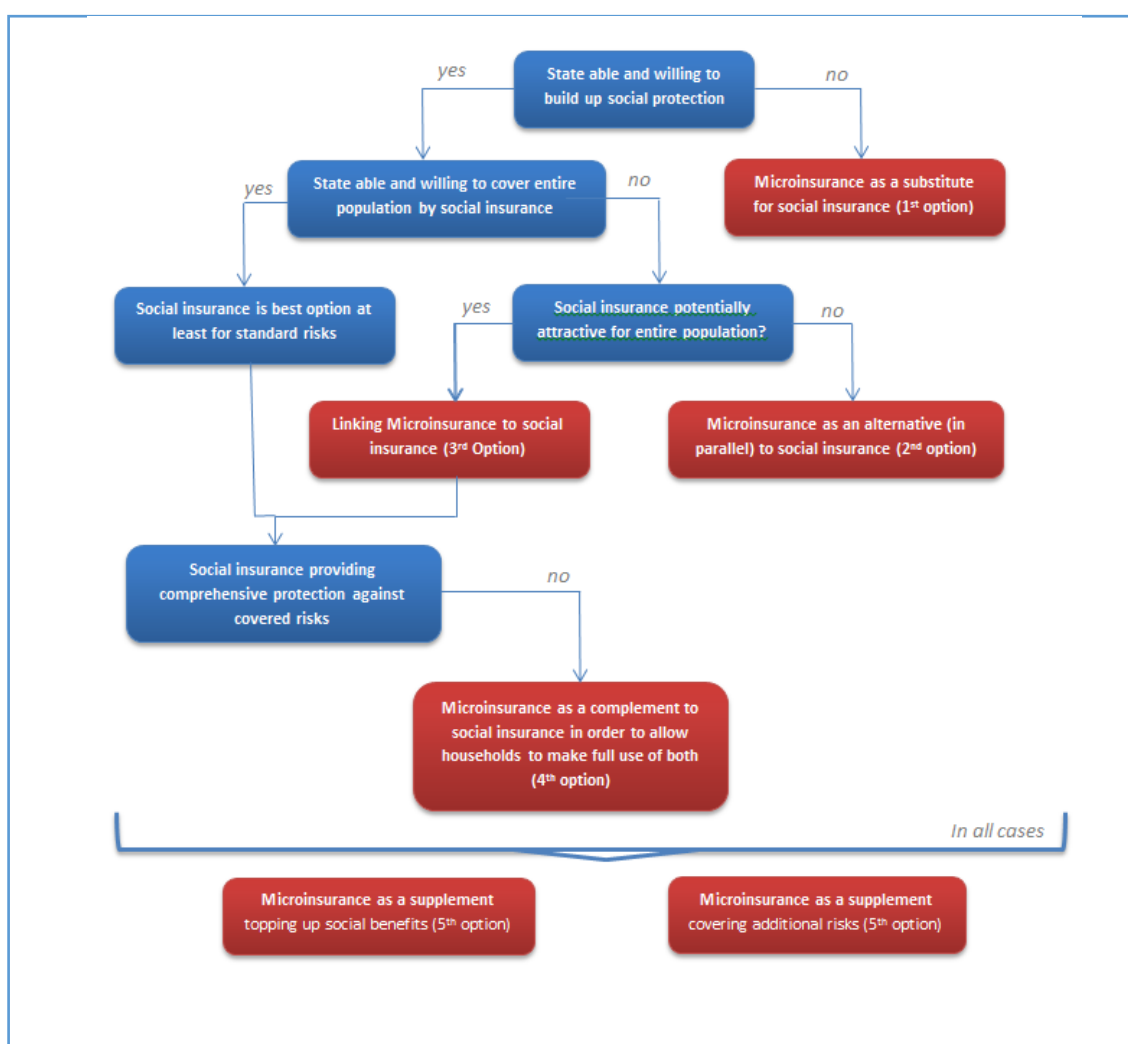
⁹ The event where policyholders engage in more risky behavior because they have insurance coverage (ex-ante) or behavior where the insured claims higher amounts than they are entitled to (ex-post).

¹⁰ Adverse selection is caused by asymmetric information between insured and insurer that can lead to a vicious cycle of higher prices (to compensate for the information asymmetry) and lower demand.

pooling, which involves the active participation of the group's members" (ILO 2000, 87). The structure of microinsurance schemes can act as an inclusionary mechanism for the disenfranchised and otherwise excluded members of the population for whom conventional means of insurance are often inaccessible (ILO 2002). Moreover, community-based microinsurance schemes "can exploit informational advantages that are not available to private or public insurers that deal with individuals, thereby overcoming moral hazard and adverse selection problems" and "[resolving] enforcement problems common in rural low-income economies using peer monitoring" (Bhattamishra & Barrett 2008, 34).

Microinsurance as a social protection instrument can work both independently of, or in coordination with, existing social protection programs. Figure 2 provides an overview of these possible different roles. As a beginning, microinsurance can act as a substitute to social insurance in a context where the state is unable or unwilling to extend or build up social protection. In situations where "microinsurance is more attractive than other social protection

Figure 2: Potential Roles of Microinsurance as a Social Protection Instrument



Source: Adapted from Deblon, Y. & Loewe, M. (2011)

programs because of its adjustment to the specific needs and abilities of the low-income group” it serves as an alternative to social insurance (Wiechers 2013, 10). It can also be linked to social insurance to increase take-up or share resources and networks. A complementary role applies when “social insurance only covers parts of the costs incurred due to risk events” (Deblon & Loewe 2011, n.p.). Social insurance could, for example, cover in-patient costs whereas microinsurance covers out-patient costs. The last role of microinsurance is that of supplementing existing social insurance provision by covering additional health risks, treatments, or medicines not covered by social insurance (ibid.).

There are, however, a number of limitations to microinsurance as a social protection instrument. First of all, microinsurance “is no substitute to social [assistance] schemes, because it addresses vulnerability rather than chronic poverty, while social [assistance] schemes provide immediate support to people in poverty” (ibid.). The difference is thus most evident in the time-lag: the effects of social transfers on poverty are immediate whereas the impact of insurance is only measurable over the long term. Secondly, although microinsurance schemes are redistributive in terms of risk, they do not necessarily redistribute wealth because they only target low-income people.

Microinsurance, similar to social insurance, is also more suitable to cover certain risks than others. While life, accident, and funeral insurance are relatively simple products to offer, crop, pension, and health microinsurance can prove to be significantly more challenging and expensive (ibid.). These challenges are particularly evident in small community-based microinsurance schemes when shocks affect the entire community. The use of a larger re-insurer can help overcome this challenge (Bhattamishra & Barret 2008). Weather indexed crop microinsurance gets around the costs by using nearby weather stations to determine if a loss has occurred instead of inspecting farms. Furthermore, payouts are made automatically and no claims forms need to be completed, making them fast to process (Oxley 2008, 14). However, such schemes are subject to data limitations and other challenges, including basis risk, which is “the risk that a farmer experiences a poor crop yield, but the data provided by the weather station does not trigger a claims payout” (Lloyds 2013). There are few documented cases of sustainable weather index insurance schemes beyond the pilot phase or without subsidy or donor funding.¹¹

It is important to note that microinsurance does not compete with or replace public social protection interventions. A study across six countries found that microinsurance is most successful when it is (i) combined “with other risk management measures” or (ii) “integrated into a comprehensive social protection policy” (Ramm & Ankolekar 2014, 59). When effectively integrated into a “comprehensive social protection framework,” microinsurance is a good means “to mitigate the risks and reduce the vulnerability of [the underserved] poor and low-income households, particularly of the informal economy” (Ramm & Ankolekar 2014, 71). To illustrate, both the government of Rwanda and Cambodia used community-based health microinsurance as a step towards universal health care in their respective country (ibid.).

¹¹ For an overview of relevant issues in index insurance see, for example, Carter (2012), Sharma & Mude (2012), and Loster & Reinhard (2012) in Churchill and Matul (2012).

OVC-relevant microinsurance products

Although there are many different microinsurance products currently available—ranging from burial insurance to coverage against natural shocks—not all of them are equally valuable to OVC households. The following section describes health microinsurance, burial insurance, and life insurance as most relevant to the specific vulnerabilities of orphans and vulnerable children. The usefulness of these types of products depends on the socioeconomic and geographical context in which the OVC household lives.

Health Microinsurance

The benefit of **health microinsurance** to OVC households is twofold. First, by covering medical expenses, microinsurance can reduce the socioeconomic burden on the household and prevent a change in the consumption pattern, potential asset disposal, and/or other sub-optimal coping behaviors (Monas & Bignami-Van Assche 2008, 3). Secondly, by providing access to health care, HIV-infected caregivers can prolong their productive lifespan and ease the socioeconomic burden of illness. The focus of this section discusses the challenges and evidence available on health microinsurance for OVC populations.

Providing health microinsurance to OVC households holds multiple challenges. The costs of antiretroviral therapy (ART) and treating the inevitable symptomatic conditions of individuals infected by HIV, although falling, remain considerable and the concomitant premiums are out-of-reach for people living in poverty. Consequently, UNAIDS reports that 54 percent of HIV-infected individuals in Sub-Saharan Africa had access to ART in 2016 (UNAIDS 2017), up from 37 percent in 2014 (UNAIDS 2014, 27). Financial viability is a major challenge -- a commercial microinsurance scheme targeted solely at HIV-positive individuals is not viable unless the premium amount matched the costs of treatment, making the product unaffordable to poor clients. From an insurer's point of view, it would be logical to exclude expensive and ongoing treatments like ART from the cover package, or exclude chronically-ill individuals, unless there is a large enough pool of HIV-negative individuals willing to absorb some of the treatment costs so that the premium can be kept low (solidarity principle). However, in countries with a high HIV prevalence, especially among the poorer segments of the population, such a set-up is largely infeasible unless there are substantial subsidies (from government, bilateral and multilateral donors, and NGOs), coupled with strong support for adherence to treatment in order to significantly decrease the prevalence of HIV-related illnesses. As ART costs drop, there will be expanding opportunity for insurance product innovation to serve people living with HIV, especially for those who earn good incomes and live close to access points for ART supplies and related support mechanisms.

A further challenge is the complex value chains involved in distributing health microinsurance that rely on diverse networks of healthcare providers and administrators that also increase costs. In addition to a variety of actors, the long list of health care services and costs associated with these services make it a challenge to price and costly to administer such insurance products. Provider reimbursement models further complicate these insurance schemes, where one must find a balance between controlling fraud and moral hazard, simplifying administrative procedures, and ensuring incentives for the highest quality of patient care. This burden explains

why hospital cash-back insurance products,¹² which can simplify administration processes and pricing and reduce costs, are gaining increasing popularity. These products, however, come with their own drawbacks. With primary care being the largest source of out-of-pocket health expenditure and only 5 percent of clients experiencing hospitalization (Churchill & Matul 2012, 117), hospital cash-back insurance products provide questionable client value.

Robust evidence on the impact of health microinsurance specifically on orphans and vulnerable children is currently unavailable. Because of the challenges attached to offering health microinsurance to OVC populations, commercial insurers are cautious to enter the market. Nonetheless, there is a substantive yet incomplete evidence base from a range of countries on the effects of offering health microinsurance to poor populations. However, these studies generally focus on the economic impact of health microinsurance, rather than the respective health outcomes. This trend can mainly be attributed to “the difficulty in measuring objectively the health status of insured and the long-term visibility of the effects” (De Bock & Ontiveros 2013, 5).

Figure 3 presents the findings of 15 studies on health microinsurance and illustrates their findings regarding financial outcomes, health outcomes, and the usage of health care services (see Annex B for an overview). These studies were selected based on online searches with key terms (and combinations thereof) such as: microinsurance, orphans and vulnerable children, OVC, health microinsurance, quantitative, impact, evaluation, HIV, AIDS, vulnerable, populations, effects, outcomes, quantitative, analysis, etc. The studies that are included are those of which the results are publicly available, have a scientific quantitative study design, and a large enough sample size to give externally valid results. The figure also shows the study design and the evaluation method(s) and the country/region in which the study took place. Half of the studies suggest that health microinsurance reduces out-of-pocket expenses in half of the cases.

One-fifth of the studies found mixed results (20 percent) while the remaining 30 percent could not detect any significant impact. Sekabarage, Diop, and Soucat (2011, 52-46), for instance, found a reduction in the level of direct illness-related spending and catastrophic out-of-pocket spending while evaluating the community-based *mutuelles* in Rwanda. Wagstaff et al. (2009), in contrast, found no results when assessing the effects of a medical scheme in China on expenditure. These differences can possibly be explained by differences in insurance coverage, as the scheme in Rwanda covers both out-patient and in-patient costs, where the program in China has clients pay for out-patient costs with a savings account.

Evidence on the effects of beneficiaries’ health is limited. Wagstaff and Pradhan (2005, 20) found positive effects using anthropometric indicators on young children in Vietnam compared to comparable uninsured peers. However, Levine, Polimeni and Ramage (2012, 27) did not find “a detectable effect on objective measures of children’s health [in Cambodia] (BMI, height-for-age, and weight-for-age).”

¹² An insurance product that has a health trigger, such as hospitalization, but pays a specified cash payout to the policyholder, rather than reimburses actual medical expenses.

Figure 3. Evidence on Health Microinsurance

Figure 3.1 Impacts on Financial Outcomes

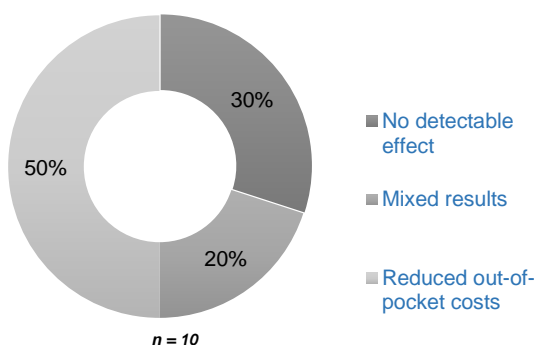
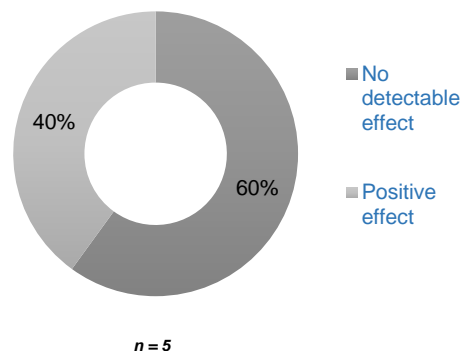


Figure 3.2 Impacts on Health Outcomes



Total Number of Studies: 15

Study Design

Quasi Experimental: 7

Randomized Control Trial: 3

Evaluation Methodology

Logit/Probit models: 4

Difference-in-Difference: 5

OLS regressions: 1

Country/Region

Burkina Faso: 1

Cambodia: 1

China: 3

West Africa: 1

Nicaragua: 1

Rwanda: 1

Figure 3 suggests that there is no conclusive evidence on the impact of health microinsurance on health outcomes. This gap in the literature calls for further research, but it also reveals the difficulty of evaluating the respective health outcomes of interventions. Commonly-used indicators such as anthropometric measurements and self-report illness provide an incomplete picture of the true effect of an intervention on the beneficiary's health, particularly in the long term. More accurate proxies are, however, more invasive of a participant's privacy, raising ethical dilemmas, and difficult to implement on a large scale (Wynn, Dutta, & Nelson 2005, 25-41).

While there is a lack of evidence on the positive effects of providing health microinsurance to OVC populations specifically, the benefits of providing ART to HIV-infected caregivers in the short term have been well-documented (Duggan & Evans 2005). Evidence which argues that the long-term benefits of providing medical treatment to the HIV-infected extends far beyond individual health outcomes has now also emerged. To illustrate, a study using data covering a consecutive period of eight years among HIV-positive miners in Africa found that providing ART¹³ results in an increase in the productive capacity of a person living with HIV (Habyarimana, Mbakila, & Pop-Eleches 2009, 22-23). This, in turn, alleviates the economic pressures on the household and the burden on the child(ren) (ibid.). Moreover, vulnerable children living in treated households "are more likely to attend school than those in households with untreated adults" (Thirumurthy et al. 2012, 1). Naturally, orphans and vulnerable children also benefit from access to healthcare themselves. A study in rural Namibia, for example, found

¹³ This is, of course, in addition to saving 5.5 million lives from 1995 to 2012 in low- and middle- income countries and reducing transmission by 65 percent (UNAIDS 2013).

a reduction in stunting, anemia, and parasitic infections between baseline and midline among orphans and vulnerable children visiting a mobile clinic (Aneni et al. 2013, 7).

In the absence of studies which evaluate the health outcomes of health microinsurance on orphans and vulnerable children or their households, the evidence this report must draw from is circumstantial and it is still inconclusive, supporting the call for more research. The literature is more united on the benefits of providing health care to orphans and vulnerable children and/or their HIV-infected caregivers.

Life and Funeral Microinsurance

The second type of insurance that is relevant for orphans and vulnerable children and their caregivers is the provision of **financial means after the death of a household member**. Funeral services and arrangements are among the most costly purchases that families across the world make (Hougaard & Chamberlain 2011). In a South African township, funerals were reported to cost approximately 15 times the monthly income of a resident (Roth 1999, 1). Similarly, in Ethiopia, a funeral can make up a quarter of the annual income (Hougaard & Chamberlain 2011, 4). These costs are particularly threatening for HIV-vulnerable households for two reasons: (i) there is a high probability that these homes will lose their primary income earner as HIV results in a disproportionate number of deaths among adults in their working prime; and, (ii) life insurance schemes have traditionally had discriminatory policies that exclude HIV-related deaths (Collins & Leibbrandt 2007, 75-81). The expansion of ART access has caused insurers in places such as South Africa to take a different approach. AllLife, one of the biggest insurers in its respective field, now accepts HIV-positive clients as long as they take regular tests, adhere to ART programs and maintain their health (at a cost of about two to five times higher than that for HIV-negative individuals) (IRIN 2009, n.p.). Furthermore, funeral insurance commonly does not apply any medical underwriting. Rather, anti-selection risk is managed through the imposition of a waiting period, typically six months.

Box 1: Methods Used to Estimate the Impact of Microinsurance Products

A number of methodologies are employed to estimate the causal effect of microinsurance products. Three studies reviewed used binary variable regression techniques (i.e. logit, logistic and probit regressions). Rwanda's *mutuelles* is evaluated using logistic regression (Sekabaraga, Diop & Soucat, 2011) while the evaluation of Tanzania's Community Health Funds uses probit regressions (Msuya, Juttling, & Asfaw, 2004). This method, like multiple regression analysis, is prone to omitted variable bias, as not all variables are easily observed or measurable (Wooldridge 2012).

Gnawali et al. (2008) evaluate the effects of a benefits package in Burkina Faso using propensity score matching (PSM) methodology and find an increase in the use of health care services. Partitioning the effects by subgroups revealed that the benefit is unequally distributed and chronically ill individuals were more likely to face exclusion from the scheme. An evaluation of the Yeshasvini in India using PSM additionally finds a reduction in out-of-pocket expenses (Aggarwal 2010). While ideal for evaluating programs post-implementation, the method has a number of drawbacks. The most important is the strong assumption that factors that are excluded do not bias the study (Caliendo & Kopeinig 2005).

Randomized controlled trials are a method of evaluation that directly addresses this challenge by randomly assigning participants into treatment and control groups. Given their experimental nature and provided that randomization works, RCTs provide a good measure of the causal effect of the health microinsurance scheme (Duflo, Glennerster, & Kremer, 2006). Dercon et al. (2012) evaluate the outcomes of the Bima ya Jamii in Kenya, a randomized control trial for inpatient hospitalization cover, funeral insurance, and cover for inability to work. They find that the insurance scheme reduces out-of-pocket expenses albeit with a number of exceptions. No significant differences in health status are detected between the insured and uninsured.

While burial insurance alleviates the initial burden of funeral costs on the households, more specialized **life insurance** products can also cater to specific needs of orphans and vulnerable children. For example, certain products allow for savings over time to cover educational expenses, or the payment of school fees upon the death of the main policyholder. **Savings-linked insurance** addresses a common reservation toward insurance products, which is that they do not build value over time when not used. Examples of such schemes include Max New York Life, Bajaj Allianz, SBU Life, and ICICI in India. The key feature that distinguishes these and other programs is the balance between savings and insurance. In savings-linked insurance, “the design of the product is influenced by the way in which the insurers view the importance of insurance to savings, and how they allocate the customer’s contributions across both these benefits” (Rusconi 2012, n.p.). In other words, insurers strike a balance between the proportion of the premium that is put on a (virtual) savings account and the share that is used for insurance purposes. This design is an asset but is also potentially problematic because it complicates the product’s design and therefore requires the target population to have a relatively high level of financial literacy in order to understand the choices. In Indonesia, bolstered by the success of Bajaj Allianz Life (3.4 million covered lives), a similar product was introduced in 2010 to respond to two pressing needs: health and education costs (Allianz 2012, 2). Consumers paid a monthly premium that insured them for life and five life-threatening diseases. All premiums were returned in full at the end of each five year term, and the recommended use of the returned amount was the education of the client’s children (ibid.). The product had limited success due to problems relating to implementation, data capturing and management, and foremost—consumer education. This project outcome demonstrates the importance of highly developed financial literacy for target groups to support implementations of microinsurance linked to savings.

Linking microinsurance delivery to social protection programs

Health, funeral, and life insurance are a few key products to suit the needs of OVC households, but how should they be distributed to reach this population? Microinsurance products leverage a number of unique distribution strategies as compared to more traditional insurance policies; however, the potential to align microinsurance distribution with existing social protection programs and infrastructure provides a potentially useful way to specifically reach underserved groups such as orphans and vulnerable children in a cost-effective fashion.

Box 2: Savings-Linked Insurance

Savings-linked insurance products are designed in several ways based on a trade-off between simplicity and flexibility. The principle is the same; the (monthly) contribution is used to accumulate value of time while covering the risk of death until maturity. These products thus overcome the feeling that policyholders have wasted their money because they do not see a return of the premium paid if the insured event did not occur.

The majority of products will guarantee a maturity benefit that is equal to the total amount of contributions plus the net investment returns on the portfolio. Products which do not guarantee a maturity benefit will usually promise a higher death benefit. There is thus a trade-off between high insurance benefits and high saving benefits.



The savings benefit can be linked to certain investments such as a child’s tertiary education (as is often encouraged) but this is not a design requirement (Rusconi 2012).

The provision of microinsurance product services, especially in the case of health microinsurance, entails more than simply delivering the insurance product to the client. Whereas traditional insurance is usually distributed by an agent directly, the microinsurance delivery chain incorporates several entities with a distinct role. The supply chain of microinsurance is typically made up of:

- Insurers: the entity carrying the insurance risk;
- Delivery channels: the actor selling the insurance policy and providing basic service;
- Technical service providers: who provide the technology or administrative expertise to operationalize microinsurance products;
- Client aggregators: like MFIs, retailers or mobile network operators, who provide access to a base of clients to which a microinsurance product can be distributed;
- Policyholders: the individuals or groups who buy the product; and
- The covered lives: those to whom the cover applies (usually family members) (Roth, McCord, & Liber 2007, 4).

In addition, health microinsurance value chains also include the healthcare providers and network administrators.

Given the low-premium nature of microinsurance, reducing distribution cost is a key consideration. This challenge is most often overcome by utilizing the infrastructure, reach, and payment mechanisms of third parties with an existing client or membership basis. Existing distribution channels of microinsurance are diverse, ranging from traditional broker and agent distribution, to sales through utility companies, cash or credit-based retailers, third-party bill payment providers, banks, MFIs or mobile network operators. As Smith et al. explain, “the current wave of microinsurance innovation is characterized by insurance companies partnering with non-traditional distribution channels to deliver insurance products to their unserved or under-insured client bases” (Smith, Smit & Chamberlain 2011, 29). Furthermore, microinsurance can be distributed through state structures such as municipal councils or a variety of community-based groups.¹⁴

The combination of microfinance and microinsurance seems instinctive as both offer financial services. As a result, existing microfinance institutions are often used to offer microinsurance products. However, microfinance institutions “reach only a small percentage of the potential microinsurance market” and combining the two types of products has produced inconclusive results (Churchill & Matul 2012, 24). For instance, Banerjee, Duflo, and Hornbeck (2014, 6) found that bundling existing microfinance outlets with microinsurance programs caused people to drop out of both programs so that they would not have to be part of the microinsurance scheme. Nonetheless, there are also plenty of examples where microfinance institutions have been successful in providing voluntary microinsurance products (Churchill & Matul, 2012).

Savings groups are also increasingly used as a platform for microinsurance. For example, self-help groups are one of the categories of microinsurance agents defined in India, and there are numerous documented examples of insurance distributed through such groups (Roth et al. 2005). In Uganda, CARE launched an initiative to link village savings and loan associations (VSLAs) to funeral insurance (CARE 2011). Similarly, in a number of sub-Saharan African

¹⁴ For a full overview of microinsurance business models and distribution channels, see Bester et al. (2013).

countries, Savings and Credit Cooperatives (SACCOs) play an important role in distributing insurance to their members, Kenya being one prominent example (Smith et al. 2009). Catholic Relief Services (CRS) collaborated with the Benin branch of Nouvelle Société Interafricaine d'Assurance to deliver a health microinsurance product covering primary health care expenses through savings groups known as Savings and Internal Lending Communities (SILC) (Tyler 2015, 1). A study in 2012 showed that the health microinsurance product contributed to reduction of health expense-related stress and increased access to health services (Tyler 2015, 1).

Several studies have also highlighted the implicit or informal risk mitigation role fulfilled by savings groups. For example, in Mozambique members of so-called *xitique*s (rotating or accumulating savings groups) would help each other out, should a risk event occur (Cenfri 2015b). Although there is no explicit premium, there is thus a degree of risk pooling. In Malawi, informal savings clubs often have a “funeral fund” to which members contribute (Cenfri 2015a). In other instances, as documented in Swaziland and Zambia, members of rotating savings groups have the option to swap their turns, should a risk event mean that they have urgent need for cash (Thom et al. 2015). Increasingly, as is for example the case with so-called *stokvels* (savings groups) in South Africa, insurers are looking to tap into these structures for distribution purposes (Thom et al. 2014; Hougaard et al. 2012).

Linking microinsurance to existing social protection structures could be another way to distribute insurance to reach the greatest number of people most efficiently. Furthermore, it provides a way of targeting insurance specifically to the households of orphans and vulnerable children. Social protection institutions or programs could serve as aggregators of clients, facilitators of premium payments through conditional cash transfers, or links to service providers like public health facilities. For example, Yeshasvini community-based health insurance in India largely attributes its ability to keep costs low to existing infrastructure such as hospitals and by targeting populations already involved in cooperative societies in rural areas (Aggarwal 2010, 23). The provision of health microinsurance is particularly challenging because of the diversity of actors involved in delivery. To illustrate, the health microinsurance scheme known as Niramoy in Bangladesh encompasses a model which “has assembled all relevant parties including major health care providers, locally active microfinance institutions, pharmaceutical companies, a social business company and a prominent commercial insurer under one umbrella to carry out” all the tasks involved in designing and implementing a health microinsurance scheme (Ahsan et al. 2013: 6). Although promising, channeling microinsurance through existing social protection programs remains relatively unstudied, representing a key knowledge gap.

Viability, funding, and regulation

Similar to social insurance, microinsurance can be administered by a combination of public entities, commercial companies, community-based organizations, partner-agent schemes, and NGOs. All of these bodies experience difficulty in covering low-income, vulnerable populations in low- and middle-income countries as a result of the limited purchasing power of low-income households, high cost of distribution, and the high risk that specific population pools will be susceptible to disease and death. Successful microinsurance schemes are therefore usually built into existing groups within communities while viability on the long term is achieved by (i) acquiring and keeping large numbers of clients, (ii) reducing structural costs, and (iii) managing claim costs (Microinsurance Innovation Facility 2013, 8). Because microinsurers work with

relatively small premiums and margins, Angove and Tande also argue that it is important to enroll clients in large numbers to cover costs and improve profitability (2011, 5). A study analyzing 95 microinsurance initiatives found that the majority of schemes have achieved scale by tapping into existing client aggregators like community groups, cooperatives, banks, or microfinance institutions (Thom et al. 2014, 25-35).

One vehicle to scale-up implementation—especially of health microinsurance—is through public-private partnerships (PPPs). These partnerships combine the resources of national or regional governments with the local knowledge and expertise of private entities and may enable microinsurance schemes to become more viable. For example, in India, Kenya and the Philippines, the government has partnered with MFIs, NGOs and savings/credit cooperatives to roll out universal health care products. While Kenya and the Philippines have a partnership where the government outsources the enrollment and distribution of insurance, India has partnerships where third-party insurers also provide risk carrying, claim processing, and network management (Kimball et al. 2013, 16-20). PPPs can likewise be established to help promote access and take-up of ART treatment, which is subsidized by many countries but has low take-up rates, particularly in rural areas. In Côte d'Ivoire, a PPP to distribute ART was established in 2008, and preliminary data suggests that “the interventions implemented both reduced employer costs related to HIV care and management among their employees and saved lives while improving employees’ well-being” (Beauliere et al. 2010).

Though there is high potential, PPPs are complex and challenging. In order to be successful, they require both public and private objectives and support to align. On the public side, there must be political support and a willingness to allocate fiscal resources to the often costly programs. The private side must have the capacity to deliver as well as an incentive to invest in the project. Other important organizational issues include:

- Time: Building up a microinsurance scheme with national coverage takes time and roll-out differences between regions are likely to occur during the implementation stages.
- Inequity: Unequal access and distribution of resources between one public entity and multiple private entities, particularly if there are few incentives for private companies to operate in certain areas (e.g., rural and extremely poor).
- Costs: Strong government oversight may be required to ensure that third parties are delivering a service which adheres to national standards as well as keeping costs to consumers as low as possible.

Other public-private cooperation can consist of public entities providing infrastructure, financing and organizing research, financing services, creating appropriate legal environment, and integrating microinsurance into relevant policies (Ramm 2011).

The consideration about government oversight is particularly important in markets with financially illiterate consumers, as the trust relationship between clients and insurers is vital for a microinsurance product to be successful. If potential clients do not trust that the insurers will be able to make the payments they are entitled to, or they believe the insurer is corrupt, then they will be less likely to purchase the product (Zimmerman, Magnoni & McCord 2013). Furthermore, although microinsurance can help to protect households, having a policyholder living in a household can expose them to new unintended risks. For example, legitimate claims are sometimes not paid out, and failed insurance companies can leave devastated communities in their wake. It is therefore crucial to have a strong regulatory framework that focuses on consumer protection (Roth, McCord & Liber 2007, 10). Unfortunately, insurance regulatory

frameworks in the poorest countries are often modeled after more prosperous nations “and designed for commercial insurers offering non-life cover or employee benefits to companies” (ibid.). These regulations and requirements are consequently too exhaustive for small microinsurers. As a result, “microinsurers...tend to operate beneath the regulatory radar, or with the regulator’s blind eye turned”; a highly undesirable situation from the consumer’s point of view (ibid.).

Some important issues to consider when designing an effective regulatory framework should include: (i) protection of the solvency of the insurer (and thus the sustainability of the insurance); (ii) oversight of accurate and adequate information on insurance policies for potential buyers; (iii) a minimum capital requirement; and (iv) an insurance ombudsman where disadvantaged policyholders can seek redress. The importance of regulations, particularly a minimum capital requirement, and proper actuarial models for microinsurance was illustrated by a study in Uganda that showed that a single claim for a surgery could make the insurer insolvent for the rest of the fiscal year (Dror 2001, 674).

Lessons learned in microinsurance

Donor support is necessary in most countries to reach and to provide real value to clients in the medium term. However, the Consultative Group to Assist the Poor (CGAP) argues that third-party funders need “appropriate expertise and resources to engage effectively in microinsurance because it is a relatively new, complex, and risky” service (Latortue, Montesquiou, & Ward 2008, 1). The Bill and Melinda Gates Foundation is an example of a funder that supported microinsurance initiatives from the beginning. The organization sought areas of financial inclusion where other players were not yet active to encourage further development. Insurance and savings were choices given the potential of the credit market at the time. In 2006 and 2007, the Gates Foundation supported two of the first microinsurance schemes which aimed to be self-sustainable; First Microinsurance Agency Pakistan (implemented by Aga Khan Agency for Microfinance (AKAM)), and MicroEnsure (ME). Both companies struggled in their early years to find the appropriate strategy to target and market their products while achieving sustainability. In 2011, AKAM was undone because it failed to reach scale. Similarly, ME still struggles “to cover its significant expenses, and cannot be commercially viable until it does” as concluded by Koven and McCord (2013).

The early difficulties that these programs faced fed the realization by donors that additional research was needed in the area of microinsurance before a program could be successfully introduced. Accordingly, the ILO launched the Microinsurance Innovation Facility in 2008 with funding support from Bill and Melinda Gates Foundation. The foundation has also co-funded the Microinsurance Learning and Knowledge (MILK) Project in 2011. Despite these early challenges, a study by the Microinsurance Network in 2012 found that “the involvement of donors in microinsurance has increased over the years in all topics” (McCord et al. 2012, n.p.).

On the demand side, there is often a limited understanding of insurance (Chandani 2008a, 12). This challenge is a significant barrier to the growth of the industry because the demand for microinsurance “is often assumed, misunderstood, or oversimplified” (ibid.). For instance, standard products are “downscaled” to fit the budget of the poor, but fail to tailor the product to their specific needs (ibid.). It is therefore important for donors to conduct (or support) research that reveals the priority needs of potential clients. An example of this kind of research is the

FinMark Trust's FinScope household survey of financial services in South Africa. This study, found that a lack of consumer education on insurance products was an important reason for the low uptake of insurance products in South Africa (FinMark Trust 2012, 50). Moreover, results from 2013 suggest that using new technologies and mobile phones might be the most effective means of reaching excluded populations (FinMark Trust 2013, 59-64). A further challenge to implement microinsurance products successfully is the lack of awareness of insurance as means to cope with risks. A randomized study in India linked the absence of demand to the households' lack of understanding of the products and the processes involved in purchasing microinsurance products (Sahu 2010, 106). A similar result has been found in Africa, where a lack of understanding of the value of microinsurance has had a negative impact on demand for these instruments (Matul et al. 2010, 8). These studies show that insurance literacy is an important determinant of demand (McCord 2001, 25-38). To summarize, consumer education is a very important component of microinsurance, both to introduce insurance as a risk management tool and to fully explain the different products available to ensure that consumers make an informed choice.

Based on these observations, the following actions are recommended: (1) encouraging educational campaigns on insurance to help consumers make informed choices, (2) supporting the development of insurance products for low-income markets, and (3) collecting data on demands and characteristics of potential markets (Chandani 2008a, 13-14). Chandani explains that the "donor should build the technical and MIS [Management Information System] capacity of existing retail-level providers to improve data collection and analysis, such that data is standard and, as far as possible, captured and shared on a national or regional basis" (2008a, 13). By sharing this data, insurers will have a better understanding of the risks involved when entering a market and will therefore be able to charge more appropriate and hopefully lower premiums. The remaining challenge is to convince the insurers of the public nature of the actuarial information, as some insurers may be disinclined to share this information with their competition (Chandani 2008a). Donors could therefore condition their support on an obligation to at least partially share the information.

Local institutional capacity to implement and provide microinsurance to low-income clients is also vital for the sustainability and initial implementation of a scheme. Ideally, microinsurance providers would work through existing "insurance providers in markets where they are in place and have the necessary expertise" (Chandani 2008a, 18). Such institutions have existing structures in the form of information systems and operations management and knowledge of the local market. In unexplored or underexplored markets, government support in the form of time-bound, conditional subsidy might provide commercial insurers with the necessary assistance to "test and scale up a new product line and develop appropriate marketing strategies to reach a diversified client base" (Chandani 2008a, 18). During this phase, donors can offer technical guidance in addition to conditional financial support (see for example the Microinsurance Academy in India).¹⁵ Additionally, giving both informal and semi-informal insurers similar kinds of trainings might push them "into the light" and allows for better regulation of the market. In sum, donor support should be clearly defined, time-bound, and be backed by technical expertise (Rosenberg et al. 2003, 1).

¹⁵ See <https://www.microinsuranceacademy.org/>

A number of specific lessons have emerged on the topic of health microinsurance. In developed countries, private insurance is mainly purchased by the rich while the “healthcare financing for low-income people is provided through government subsidized insurance or other programs” (Zanjani & Koven 2013, 17). This suggests that it would be difficult for commercial microinsurers in developing countries to reach scale without donor support as poor and vulnerable individuals are less inclined to buy insurance in general. Using subsidies or support to reduce premiums in the initial phases of setting up a scheme to entice demand might result in a large enough pool for a product to sustain itself in the long term once the economies of scale are operational. A fitting example in this regard is the Rashtriya Swasthya Bima Yojna program in India which achieved scale far beyond independent insurers as a result of government support. (Koven, Chandani, & Garand 2013). However, this scheme is now struggling to develop a business model that will allow self-sustainability and further research in this area is therefore required. Nonetheless, when governments are not able or unwilling to provide this kind of support, donor support can be a viable option, as it was for the PharmAccess programs in Tanzania and Nigeria (Budzyrna, Chandani, & Mangnoni 2013, n.p.). However, donor support should only be provided in scenarios where schemes are likely able to sustain themselves once they have reached scale.

CONCLUSIONS AND IDENTIFIED EVIDENCE GAPS

HIV has a number of negative socioeconomic effects on a household, particularly for orphans and vulnerable children. Because governments in developing countries are often unable to afford or administer universal social protection services, orphans and vulnerable children often remain without sufficient risk coverage to mitigate the shocks flowing from an HIV infection in the household.

The potential of microinsurance as a complementary intervention to existing social protection interventions to OVC households is promising but relatively unexplored. There are no health microinsurance products specifically targeted to orphans and vulnerable children or their caregivers. As a result, there are no evaluations of the success of such interventions to improve the livelihood of OVC households. Nonetheless, the literature suggests that providing health microinsurance to vulnerable populations can contribute to their health and socioeconomic well-being. There are also studies which argue that providing health care to orphans has positive outcomes. To advance the research agenda on microinsurance in the OVC context a number of key questions are outlined below, followed by a short discussion on their relevance.

1) How can microinsurance be integrated in a social protection framework? What can we learn from existing examples? Is the role of microinsurance context dependent and can we develop models? Is microinsurance a more cost-effective way of reaching social protection objectives?

Microinsurance is a potential means to address the gaps in national social protection frameworks. To maximize the benefits of microinsurance, it should be integrated into a wider social protection strategy so that it can complement existing interventions. The synergies of linking microinsurance to existing social protection interventions are however, under-researched. Similarly, little is known about how microinsurance can be integrated into an existing social protection framework. It is likely that the answers to these questions will be heavily dependent on the national context, which call for the development of models to help

guide integration in different environments. A first step towards advancing the research in this field is outlined in **Technical Guidance Brief 1** (*The role of microinsurance vis-à-vis other social protection mechanisms for orphans and vulnerable children*) which explores the potential place of microinsurance in a national social protection framework.

2) How can health microinsurance benefit orphans and vulnerable children? What products are able to cover the cost of care and what treatment should be covered? What are the challenges of providing health microinsurance to poor and vulnerable populations?

Health microinsurance, the most immediate need of OVC households, benefits orphans and vulnerable children by (i) providing healthcare, which reduces the need to spend a large proportion of the household income on health care, and (ii) extending the productive lifespan, or in the case of a child or pregnant women, prevent permanent neurological damage. What follows is improved food security, a smaller chance of impoverishment and a reduced burden on the children in the household. The benefits of health microinsurance to improve the livelihood of orphans and vulnerable children are thus evident. However, questions with regard to product requirement and product design in the OVC context are unanswered. **TGB 2** (*OVC-Relevant health microinsurance*) will discuss microinsurance in the OVC context and will answer the questions outlined above.

3) How can health microinsurance schemes targeted at OVC households be made viable? How can microinsurance schemes benefit from existing social protection institutions and infrastructures? What actor is best positioned to deliver health microinsurance?

The evidence base on the effects of providing health microinsurance to orphans and vulnerable children is limited and stands to benefit from further studies. The absence of microinsurance programs specifically targeted at this group points towards market challenges or significant barriers to entry. This report identified the financial viability of OVC microinsurance schemes as the greatest challenge to providing microinsurance for orphans and vulnerable children. The cost involved in providing the required medical care to HIV-infected individuals is far too great for such a targeted scheme to be commercially viable while maintaining the premium at an affordable level for OVC households. Therefore, the most important question is whether there are ways to make microinsurance schemes targeted at OVC households viable and sustainable. Possible synergies could flow from linking microinsurance to existing social protection infrastructure.

The integration of microinsurance in existing social protection programs remains under-researched. Needed research includes examinations of (i) which actor is best-positioned to provide OVC-relevant microinsurance, and (ii) which distribution channel(s) can be best leveraged to provide microinsurance. Social protection institutions or programs could, for instance, serve as cost-effective aggregators of clients, facilitators or service providers. **TGB 2** addresses some of these questions.

4) How can savings-linked microinsurance benefit orphans and vulnerable children? Is savings-linked microinsurance suitable to support economic strengthening through educational outcomes?

This report identifies health, life and funeral microinsurance as the most relevant products for the vulnerabilities of orphans and vulnerable children. Life insurance can cater to specific needs

of orphans and vulnerable children while funeral insurance alleviates the initial burden of funeral costs. Savings-linked microinsurance, a mix of a savings product and microinsurance, has the potential cover specific costs, such as education, in the event the caregiver in the household dies. However, the potential and challenges of such products in the OVC context is not well documented and will therefore be addressed in **TGB 3** (*Exploring savings-linked microinsurance for orphans and vulnerable children*).

5) Are PPPs a sustainable solution to finance health microinsurance for orphans and vulnerable children? What division of roles and responsibilities is most effective? What are the potential benefits to private and public stakeholders?

PPPs are a potentially feasible option to consider when integrating microinsurance in a social protection framework. PPPs offer a low-cost way to reach social protection objectives with the help of an experienced large quantity administrator for the government and easy access to a large pool of new clients for the insurer. Despite the promising advantages that PPPs offer for both sides, such partnerships are unknown in the OVC context. A sizable body of literature exists on the lessons drawn from past and current public-private collaborations in different contexts but further research is required on how to adapt the existing financing models for infected or affected clients, particularly in areas where the virus is highly prevalent. In order to guide such collaborations, research is first needed on how such PPPs should be adapted to the OVC context by (i) applying the strengths and weaknesses of PPPs to the specific situation of orphans and vulnerable children, and (ii) discussing financing models to keep the partnership viable and sustainable for both the private and public sector. The role of governments in arranging suitable regulatory frameworks can also not be disregarded and requires research to identify and learn from best practice. The last of the four briefs in the series, **TGB 4** (*Applying an OVC lens to Public-Private Partnerships in microinsurance*) will bring an OVC perspective to PPPs in microinsurance.

The technical guidance series will provide answers to a number of the questions listed above. However, the series and this report are meant as a stepping stone for further research in the field of microinsurance for orphans and vulnerable children and do not purport to provide comprehensive solutions to all the issues raised above. In addition to the technical guidance series, a list of useful resources available online is provided in Annex C. Although a clear case can be made for the provision of microinsurance to the OVC population, it remains a question whether microinsurance is the best complementary instrument to social protection interventions to address the vulnerabilities of this specific population. If the answer to this question is affirmative, a number of additional queries will follow regarding product relevance, product design, distribution, funding, and viability. Microinsurance for orphans and vulnerable children is an under-researched field but the possible benefits outlined in this report justify further exploration into microinsurance's full potential as a mechanism to mitigate risk and prevent impoverishment.

BIBLIOGRAPHY

- Applied Knowledge Services. (n.d.) *Types of Social Protection*.
<http://www.gsdr.org/go/topic-guides/social-protection/types-of-social-protection#informal>
- Ahsan, S. (2010). "Microinsurance, Poverty & Vulnerability: A Concept Paper," Working Papers 1, Institute of Microfinance (InM).
<https://ideas.repec.org/p/imb/wpaper/1.html>
- Aggarwal, A. (2010). Impact Evaluation of India's Yeshasvini Community-Based Health Insurance Programme. *Health Policy*. 19: 5-35.
<http://www.ncbi.nlm.nih.gov/pubmed/20803629>
- Ahsan, S. M., Hamid, S. A., Barua, S., Rifat Haider, M. & Al Asif, C. A. (2013). *Micro health insurance in Bangladesh: Innovations in Design, Delivery and Distribution Channels*. Institute of Microfinance.
www.inm.org.bd/publication/workingpaper/workingpaper17.pdf
- Allianz. (2012). *Learning Journey: TAMADERA—Savings and Protection for a Prosperous Future*.
<http://www.microinsurancefacility.org/projects/lessons/tamadera-savings-and-protection>
- Aneni, E., De Beer, I.H., Hanson, L., Rijnen, B., Brennan, A.T. & Feeley, F.G. (2013). *Mobile Primary Healthcare Services and Health outcomes of children in rural Namibia*. Boston University & PharmAccess Foundation.
www.ncbi.nlm.nih.gov/pubmed/24016257
- Angove, J. & Tande, N. (2011). *A Business Case of Microinsurance: An analysis of the profitability of microinsurance for five insurance companies*. Microinsurance Innovation Facility. <http://goo.gle/gw/NGF8>
- Banerjee, A., Duflo, E., Hornbeck, R. (2014). *Building Health Insurance and Microfinance in India: There Cannot Be Adverse Selection if there is no Demand*. American Economic Review.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4159356/>
- Bester, H., Hougaard, C., & Gray, J. & Thom, M. (2013). *Access to Insurance Initiative Cross-country Synthesis paper 1: Evolving Microinsurance Business Models and their Regulatory Implications*. <https://goo.gl/rvdl3Z>
- Bhattamishra, R. & Barret, C. B. (2008). *Community-based Risk Management Arrangements: An Overview and Implications for Social Fund Programs*. World Bank & Cornell University.
<http://goo.gl/rqrrF7>
- Bor, J. (2012). *HIV Treatment and Labor Supply in Rural South Africa*. Harvard University.
<http://goo.gl/htjn6E>
- Beaulière, A. Le Maux, A. Trehin, C. & Perez, F. (2010). *Access to antiretroviral treatment in developing countries: Which financing strategies are possible?* *Revue d'Epidémiologie et de Santé Publique*, Vol 58 (3).
<http://www.ncbi.nlm.nih.gov/pubmed/20430553>
- Bechu, N. (1998). The Impact of AIDS on the Economy of Families in Cote d'Ivoire: Changes in consumption among AIDS affected households. *Confronting AIDS: Evidence from the Developing World*. European Commission, Brussels, 1998, 343-343. <http://goo.gl/voDsWQ>
- Budzyna, L., Chandani, T. & Mangnani, B. (2013). *Doing the Math: Health Insurance and Chronic Diseases in Nigeria*. Microinsurance Learning and Knowledge (MILK).
<http://www.microinsurancecentre.org/resources/documents/policyholder-value-of-microinsurance/milk-brief-24-doing-the-math-health-insurance-and-chronic-disease-in-nigeria.html>
- Caliendo, M. & Kopeinig, S. (2005) *Some Practical Guidance for the Implementation of Propensity Score Matching*. IZA Working Paper No. 1588 <http://ftp.iza.org/dp1588.pdf>
- CARE. (2011). *Uganda: Linking Savings Groups to Funeral Insurance* Access Africa Technical Learning Series : No. 3.
http://www.seepnetwork.org/filebin/pdf/savings_led_working_group/library/Technical_Learning_Series_Publication_3_-_Funeral_Insurance_Uganda.pdf
- Chankova, A., Sulzbach, S. & Diop, F. (2008). Impact of Mutual Health Organizations: Evidence from West Africa. *Health Policy and Planning*: 23: 264-276.
<http://heapol.oxfordjournals.org/content/23/4/264.full>
- Cenfri (2015a). *Making Access Possible: Malawi*. FinMark Trust and UNCDF:
<http://cenfri.org/making-access-possible/map-malawi>
- Cenfri (2015b). *Making Access Possible: Mozambique*. Trust and UNCDF:
<http://cenfri.org/making-access-possible/map-mozambique>

- [possible/map-mozambique](#)
- Chandani, T. (2008a). *Lessons Learned and Recommendations for Donors Supporting Microinsurance*. CGAP Working Group on Microinsurance and USAID. <http://goo.gl/yQpGO4>
- Chandani, T. (2008b). *Microfinance and HIV/AIDS Note #3. Microinsurance for Markets Affected by HIV/AIDS*. USAID. <http://goo.gl/4MeJb6>
- Chankova, S., Sulzback, S. & Diop, F. (2008). *Impact of mutual health organization: evidence from West Africa*. Health Policy and Planning, 23(4):264-276. <http://heapol.oxfordjournals.org/content/23/4/264.full>
- Churchill, C. (Ed.) (2006). *Protecting the Poor: A Microinsurance Compendium*. Munich Re Foundation, CGAP working group on Microinsurance & ILO. <http://goo.gl/yVLiHZ>
- Churchill, C. (2014). "Microinsurance: Much Progress, but Challenges Remain." ILO. http://www.ilo.org/global/about-the-ilo/newsroom/comment-analysis/WCMS_237793/lang--en/index.htm
- Churchill, C. & Matul, M., editors, (2012). *Protecting the Poor: A Microinsurance Compendium*. Volume II. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_175786.pdf
- Collins, D. L. & Leibbrandt, M. (2007). *The Financial Impact of HIV/AIDS on Poor Households in South Africa*. AIDS 2007, 21: S75-S81. <http://www.ncbi.nlm.nih.gov/pubmed/18040168>
- Deblon, Y & Loewe, M. (2011). *The Potential of Microinsurance for Social Protection*. Bonn/Eschborn. http://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID2221997_code249474.pdf?abstractid=2221997&mirid=1
- De Bock, O. & Ontiveros, D. U. (2013). *Literature Review on the Impact of Microinsurance*. <http://www.microinsurancefacility.org/sites/default/files/repaper35.pdf>
- Dercon, S., Gunning, J.W., Zeitlin, A. & Lombardini, S. (2012). *The Impact of a Health Insurance Programme: Evidence from a Randomized Controlled Trial in Kenya*. ILO Research Paper No. 24. <http://www.ilo.org/public/english/employment/mifacility/download/repaper24.pdf>
- Devereux, S. & Sabates-Wheeler, R. (2006). *Transformative Social Protection*. IDS in Focus. Issue 01. www.ids.ac.uk/files/dmfile/Wp232.pdf
- Dror, D. (2001). *Reinsurance of Health Insurance for the Informal Sector*. Bulletin of the World Health Organization, 2001, 79: 672-678. <http://www.ncbi.nlm.nih.gov/pubmed/11477971>
- Dror, D. M. & Alexander S. Preker (eds.) (2002). *Social Reinsurance: A New Approach to Sustainable Community Health Financing*, Part 3. http://www-wds.worldbank.org/external/default/WDSCContentServer/WDSP/IB/2003/08/27/000012009_20030827151353/Rendered/PDF/265280PAPER0Social0reinsurance.pdf
- Duflo, E. G. Glennerster, R. & Kremer, M. (2006). *Using Randomization in Development Economics Research: A Toolkit*. Abdul Latif Jameel Poverty Action Lab. <http://goo.gl/ZZDuCp>
- Duggan, M. G. & Evans, W. N. (2005). *Estimating the Impact of Medical Innovation: A Case Study of HIV Antiretroviral treatments*. National Bureau of Economic Research. <http://www.nber.org/papers/w11109.pdf>
- EPRI. (Forthcoming). *HIV-Sensitive Social Protection: 5-Country Targeting Evaluation*. UNICEF.
- FAO (2003). *Measuring impacts of HIV/AIDS on rural livelihoods and food security*. Sustainable Development Department. http://www.fao.org/sd/2003/PE0102a_en.htm
- Financial Access Initiative. (2010) *Microinsurance 101: How do poor deal with risk?* <http://www.financialaccess.org/blog/2010/11/microinsurance-101-how-do-poor-deal-risk>
- FinMark Trust. (2012). *FinScope South Africa 2012 Survey highlights*. http://www.finmark.org.za/wp-content/uploads/pubs/FinScope_SA_Booklet_2012.pdf
- FinMark Trust. (2013). *FinScope South Africa 2013 Consumer Survey*. http://www.finmark.org.za/wp-content/uploads/pubs/Pres_FSSA_2013_excluding-videos2.pdf

- Fitzpatrick, A., Magnoni, B. & Thornton, R. (2011). *Microinsurance Utilization in Nicaragua: A Report on Effects on Children, Retention, and Health Claims*. Microinsurance Innovation Facility. Research Paper No. 5. <http://www.ilo.org/public/english/employment/mifacility/download/repaper5.pdf>
- Franco, L. M., Diop, F. P., Burgert, C., Kelley, A., G., Makinen, M. & Simpara, C. H. T. (2008). *Effects of Mutual Health Organization on use of Priority Health-care Services in Urban and Rural Mali: A Case-Control Study*. Bulletin of the World Health Organization: 86: 830-838. <http://www.pubfacts.com/fulltext/19030688/Effects-of-mutual-health-organizations-on-use-of-priority-health-care-services-in-urban-and-rural-Mali-a-case-control-study>
- Galarraga, O., Wirtz, V. J., Figueroa-Lara, A., Santa-Ana-Teller, Y., Coulibaly, I., Viisainen, K., Medina-Lara, A. & Korenromp, E. L. (2011). Delivery Unit Costs for Antiretroviral Treatment and Prevention of Mother-to-Child-Transmission of HIV: A Systematic Review for Low and Middle Income Countries. *Pharmaco-economic*: 29 (7). <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC21671687/>
- Gnawali, D. P., Pokhrel, S., Sie, A., Sanon, B., De Allegri, M., Soares, A., Dong, H. & Sauerborn, R. (2008). The Effect of Community-Based Health Insurance on the Utilization of Modern Health Care Services: Evidence from Burkina Faso. *Health Policy*: 90: 214-222. <http://www.ncbi.nlm.nih.gov/pubmed/19036467>
- Grant, A. (2002). Clinical features of HIV disease in developing countries. *Lepr Rev*: 73(2): 197-205. <http://goo.gl/ZQF6yS>
- Gumber, A. (2001). *Hedging the Health of the Poor: The Case for Community Financing in India*. World Bank. <https://openknowledge.worldbank.org/bitstream/handle/10986/13663/288750Gumber1Hedging0the0Health1whole.pdf?sequence=1>
- Habyarimana, J., Mbakila, B. & Pop-Eleches, C. (2009). *The Impact of HIV/AIDS and ARV Treatment on Worker Absenteeism: Implications for African Firms*. George Town University, Debswana Diamond Company, and Columbia University. <http://goo.gl/CEtHKr>
- Hougaard, C. & Chamberlain, D. (2011). *Microinsurance Paper No. 10: Funeral Insurance*. ILO. <http://goo.gl/Rw03gF>
- Hougaard, C., Chamberlain, D. & Aseffa, Y. (2009). *Towards a strategy for microinsurance development in Zambia. A market and regulatory analysis*. https://a2ii.org/sites/default/files/reports/zambia_country_diagnostic_2009.pdf
- Hougaard, C., de Vos, M., Bowman, N., Mahori, N., & Bester, H. (2012). *Tanzania Access to Insurance Diagnostic: Headline findings summary and way forward*. Bellville, South Africa: Cenfri. http://cenfri.org/documents/microinsurance/2012/Tanzania/TZ%20Access%20to%20Insurance%20Diagnostic_Doc%201_Hheadline%20findings_30.10.12.pdf
- Ingram, M. & McCord, M. J. (2011). *A Discussion Paper: Defining "Microinsurance": Through for a journey towards a common understanding*. Microinsurance Centre. <http://www.microinsurancecentre.org/resources/documents/defining-microinsurance-thoughts-for-a-journey-towards-a-common-understanding/download.html>
- IRIN (2009). *Southern Africa: Life Insurance for HIV-Positive People, at a Price*. <http://www.irinnews.org/report/86698/southern-africa-life-insurance-for-hiv-positive-people-at-a-price>
- ILO (2000). *World Labour Report: Income Security and Social Protection in a Changing World*. Geneva: ILO. <http://goo.gl/OZG2Yr>
- ILO (2002). *Contributing to the fight against HIV/AIDs within the informal economy: The existing and potential role of decentralized systems of social protection*. Working paper. Geneva: ILO. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_117557.pdf
- ILO (2003). *Socioeconomic Impact of HIV/AIDS on people living with HIV/AIDS and their families*. Geneva: ILO. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_121236.pdf
- ILO (2006). *The Role of Microinsurance as a tool to face risks in the context of social protection*. ILO/STEP—GTZ. Geneva: ILO. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/instructionalmaterial/wcms_secsec_93.pdf

- ILO (2014). *World Social Protection Report: Building Economic Recovery, Inclusive Development and Social Justice*. Geneva: ILO.
http://www.ilo.org/global/research/global-reports/world-social-security-report/2014/WCMS_245201/lang-en/index.htm
- Jacquier, C., Ramm, G., Marcadent, P., & Schmitt-Diabate, V. (2006). The social protection perspective on microinsurance. In *Protecting the Poor: A Microinsurance Compendium* (Vol. 45, No. 64, pp. 45-64). International Labour Organization (ILO) in association with GSE Research.
- Kimball, M. Phily, C. Folsom, A. Lagomarsina, G. Holtz, J. (2013). *Leveraging Health Microinsurance to Promote Universal Health Coverage*. ILO Microinsurance Paper No. 23. <http://goo.gl/OJFCJA>
- Klein, B. (2009). *Working Group A: Microinsurance as a Risk Management tool in Rural Areas*. German Development Cooperation (GTZ) and Federal Ministry for Economic Cooperation and Development (BMZ). <http://goo.gl/3O2hu1>
- Koven, R. & McCord, M. J. (2013). *Microinsurance- only Multinational Intermediaries: The Early Years*. MILK Brief #19. Microinsurance Learning and Knowledge. <http://goo.gl/EQ0AXU>
- Koven, R., Chandani, T., Garand, D. (2013). *The Business Case for Health Microinsurance in India: The Long and Winding Road to Scale and Sustainability*. MILK Brief #26. Microinsurance Learning and Knowledge. <http://goo.gl/0nl1U8>
- Landmann, A. & Frölich, M. (2013). *Can Microinsurance Help Prevent Child Labor? An Impact Evaluation from Pakistan..* ILO Research Paper No. 32. <http://goo.gl/PRjmc>
- Latortue, A., Montesquieu, A. de, & Ward, V. (2008). *Microinsurance: What can donors do?*. CGAP Brief. CGAP. <http://www.cgap.org/publications/microinsurance-what-can-donors-do>
- Lei, X. & Lin, W. (2009). The New Cooperative Medical Scheme in Rural China: Does More Coverage Mean More Service and Better Health? *Health Econ.*: 18: 25-46. <http://onlinelibrary.wiley.com/doi/10.1002/hec.1501/epdf>
- Levine, D., Polimeni, R. & Ramage, I. (2012). *Insuring Health or Insuring Wealth? An experimental evaluation of health insurance in rural Cambodia*. Agence Francaise de Development. <http://goo.gl/7WsLMs>
- LIFT II Project (2012). *Economic Strengthening for Orphans and Vulnerable Children*. Washington DC: FHI 360. <http://theliftproject.org/economic-strengthening-for-orphans-and-vulnerable-children/>
- Lloyds. (2013). *Weather based insurance for farmers* <http://www.lloyds.com/news-and-insight/news-and-features/emerging-risk/emerging-risk-2013/weather-based-insurance-for-farmers>
- Magnoni, B., Budzyna, L., Sobol, D. & Zimmerman, E. (2013). MILK Brief #22: "Doing the Math"—Outpatient health insurance in Tanzania. Appleton, WI: The MicroInsurance Centre.
- Matul, C., McCord, M.J. , Phily, C. & Harms, J. (2010). *The Landscape of Microinsurance in Africa*, ILO Working Paper No. 4: 1-53. http://www.ilo.org/public/english/employment/mifacility/download/mpaper4_landscape_en.pdf
- McCord, M.J. (2001). *Health Care Microinsurance—case studies from Uganda, Tanzania, India and Cambodia*. Small Enterprise Development, 12(1): 25-38. <http://goo.gl/jukRDF>
- McCord, M., Steinmann, R., Tatin-Jaleran, C., & Ingram, M. (2012) *The Landscape of Microinsurance in Africa 2012*. Munich Re-Foundation and GIZ. <http://goo.gl/u3g1hH>
- Mermin, J., Lule, J., Ekwaru, J.P., Downing, R., Hughes, P., Bunnell, R., Malamba, S., Ransom, R., Kaharuza, F. Coutinho, A., Kigozi, A., & Quick, R. (2005). *Cotrimoxazole prophylaxis by HIV-infected persons in Uganda reduces morbidity and Mortality among HIV-uninfected family members*. AIDS 2005, Vol. 19, No 10. <http://www.ncbi.nlm.nih.gov/pubmed/15958834>
- Microinsurance Innovation Facility (2013). *Annual Report*. http://www.microinsurancefacility.org/ckfinder/userfiles/files/annualreport2013_en_v2.pdf
- Microinsurance Network (2014). *Key Concepts*. <http://www.microinsurancenet.org/microinsurance/key-concepts>
- Mishra, V., and Bignami-Van Assche, S. (2008). *Orphans and Vulnerable Children in High HIV Prevalence Countries in Sub-Saharan Africa*. DHS Analytical Studies No. 15. Calverton, Maryland, USA: Macro International Inc. <http://goo.gl/zolWeN>

- Msuya, J. M., Juttling, J. P. & Asfaw, A. (2004). *Impacts of Community Health Insurance Schemes on Health Care Provision in Rural Tanzania*. ZEF Discussion Papers on Development Policy, No. 82. <http://purl.umn.edu/18722>
- Newell, M., Coovadia, H., Cortina-Barja, M., Rollins, N., Gaillard, P. & Dabis, F. (2004). *Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: A pooled analysis*. Ghent International AIDS Society (IAS) Working Group on HIV Infection in Women and Children. www.ncbi.nlm.nih.gov/pubmed/15464184
- Oxley, A. (2008) *Micro crop insurance and protecting the poor lessons from the field*. Micro Insurance Agency. https://idrc.info/fileadmin/user_upload/idrc/former_conferences/idrc2008/presentations2008/Oxley_Aaron_Micro_Crop_Insurance_and_Protecting_the_Poor_Lessons_from_the_Field.pdf
- Pitzer, J. (2003). *The Definition of a Social Insurance Scheme and its Classification as Defined Benefit or Defined Contribution*. International Monetary Fund. <https://www.imf.org/external/np/sta/ueps/2003/063003.pdf>
- PEPFAR (2012). *Guidance for Orphans and Vulnerable Children Programming*. PEPFAR. <http://www.pepfar.gov/documents/organization/195702.pdf>
- Polonsky, J., Balabanova, D., McPake, B., Poletti, T., Vyas, S., Ghazaryan, O. & Yanni, M. K. (2009). Equity in Community Health Insurance Schemes: Evidence and Lessons from Armenia. *Health Policy and Planning*: 24: 209-216. <http://heapol.oxfordjournals.org/content/24/3/209.full.pdf+html>
- Poulton, D. & Magnoni, B. (2013). *Doing the Math—Women's Health Microinsurance in Guatemala*. Microinsurance Learning and Knowledge. MILK Brief #28. <http://www.microinsurancecentre.org/resources/documents/policyholder-value-of-microinsurance/milk-brief-28-doing-the-math-womens-health-microinsurance-in-guatemala.html>
- Ramm, G. (2011). *Public Private Partnerships in Microinsurance*. Discussion Paper #001. Microinsurance Network. <http://goo.gl/EvDL4k>
- Ramm, G. & Ankolekar, M. (2014). *Situating Microinsurance in Social Protection: Lessons from Six Countries: Microinsurance Network*: <http://www.microinsurancenet.org/sites/default/files/SituatingMicroinsuranceinSocialProtection.pdf>
- Roth, J. (1999). *Informal Microinsurance Schemes: The Case of Funeral Insurance in South Africa*. Working Paper No. 22. ILO. <http://goo.gl/1GPkGY>
- Roth, J., Churchill, C., Ramm G. & Namerta. (2005). *Microinsurance and Microfinance Institutions Evidence from India. Good and Bad Practices Case Study No. 15*. CGAP Working Group. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122471.pdf
- Roth, J., McCord, M. J., & Liber, D. (2007). *The Landscape of Microinsurance in the World's 100 Poorest Countries*. The Microinsurance Centre, LLC. <http://www.microinsurancecentre.org/resources/documents/unknown/the-landscape-of-microinsurance-in-the-worlds-100-poorest-countries-in-english.html>
- Rosenberg, R., Mwangi, P., Christen, R.P., Nasr, M. (2003). *Microinsurance Consensus Guidelines*. CGAP Working Group. <http://www.cgap.org/sites/default/files/CGAP-Consensus-Guidelines-Disclosure-Guidelines-for-Financial-Reporting-by-Microfinance-Institutions-Jul-2003.pdf>
- Rusconi, R. (2012). *Savings in Microinsurance: Lessons from India*. Microinsurance Innovation Facility: Briefing Note 12. <http://goo.gl/eJCM72>
- Sahu, B. (2010). *Microinsurance in India: Outreach & Efficacy*, Centre for Microfinance Research & Bankers Institute of Rural Development. <http://goo.gl/9aYpo0>
- Samson, M. (2013). *How are countries using social protection to benefit the poor?* in OECD, *Development Co-operation Report 2013: Ending Poverty*, OECD Publishing. <http://goo.gl/ebIrtP>
- Schneider, P. & Diop, F. (2001). *Synopsis of Results on the Impact of Community-based Health Insurance on Financial Accessibility to Health Care in Rwanda*. The World Bank. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/06/02/000265513_20040602160133/Rendered/PDF/289030Schneider1sis0of0Results1whole.pdf
- Sekabarage, C., Diop, F. & Soucat, A. (2011). *Can innovative health financing policies*

- increase access to MDG-related services? Evidence from Rwanda. Health Policy Plan. Suppl 2:ii52-6.
http://heapol.oxfordjournals.org/content/26/suppl_2/ii52.full
- Sengupta, S., Banks, B., Jonas, D., Shandor Miles, M. & Smith, G. C. (2011). *HIV Interventions to Reduce HIV/AIDS Stigma: A Systematic Review*. AIDS Behav.; 15 (6); 1075-1087.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128169/>
- Sepehri, A., Sarma, S. & Simpson, W. (2006). Does Non-Profit Health Insurance Reduce Financial Burden? Evidence from the Vietnam Living Standards Survey Panel. *Health Econ.*: 15: 603-616.
<http://www.ncbi.nlm.nih.gov/pubmed/16389632>
- Skinner, D., Tshoko, N., Mtero-Munyati, S., Segwabe, M., Chibatamoto, P., Mfecane, S., Chandiwana, B., Nkomo, N., Tlou, S. & Chitiyo, G. (2004). *Defining Orphaned and Vulnerable Children*. WK Kellogg Foundation. <http://goo.gl/HkYBHQ>
- Smith, A., Smit, H. & Chamberlain, D. (2011). *Beyond Sales: New Frontiers in Microinsurance Distribution: Lessons for the next wave of Microinsurance Innovation*. ILO & Cenfri. <http://goo.gl/Mfrk3k>
- Smith, A., Chamberlain, D., Smit, H., Ncube, S. & Chelwa, G. (2009). *Kenya microinsurance landscape Market and regulatory analysis*. FSD Kenya ILO & Cenfri.
http://www.fsdkenya.org/pdf_documents/12-07-26_CENFRI_study.pdf
- STRIVE. (2014). *Poverty and Livelihoods*. London School of Tropical Hygiene.
<http://strive.lshtm.ac.uk/drivers/poverty-and-livelihood-options>
- Thirumurthy, H., Galarraga, O., Larson, B. & Rosen, B. (2012). *HIV Treatment Produces Economic Returns Through Increased Work and Education, and Warrants Continued US Support*.
www.ncbi.nlm.nih.gov/pubmed/22778336
- Thom, M., Gray, J., Müller, Z. & Leach, J. (2014). *Scale: Thinking Big*. Microinsurance Innovations Facility.
<http://www.microinsurancefacility.org/sites/default/files/mp30%20v3.pdf>
- Thom, M., Gray, J., Hougaard, C., Cooper, B., Mburu, S., Saunders, D., Slabber, M. & Muller, Z. (2015). *Making Access Possible: Swaziland*. Cenfri.
www.finmark.org.za/publication/map-swaziland
- swaziland
- Tyler, Angie. (2015). *Delivering health microinsurance through savings groups in Benin*. Catholic Relief Services.
<http://goo.gl/yTRxzr>
- UNAIDS. (2006). *Report on the Global Aids Epidemic..*
http://data.unaids.org/pub/GlobalReport/2006/2006_gr_ch04_en.pdf
- UNAIDS. (2013). *2013 Report on the Global HIV/AIDS epidemic*.
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaidsglobalreport2013_en.pdf
- UNAIDS (2014). *The Gap Report*.
<http://www.unaids.org/node/42898>
- UNAIDS (2017). *Factsheet – World AIDS Day 2017: Global HIV Statistics*.
http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf
- UNICEF (2006). *Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS*. UNAIDS and PEPFAR.
http://www.unicef.org/publications/index_35645.html
- United Nations (UN). (2004). *The Impact of AIDS*. United Nations Publication. New York.
http://www.un.org/esa/population/publications/AIDSimpact/6_CHAP_III.pdf
- Wagstaff, A., Lindelow, M., Jun, G., Ling, X., & Juncheng, Q. (2009). *Extending health insurance to the rural population: An Impact Evaluation of China's new cooperative medical scheme*. The World Bank, Ministry of Health, Beijing, China.
<http://www.ncbi.nlm.nih.gov/pubmed/19058865>
- Wagstaff, A. & Pradhan, M. (2005). *Health Insurance Impacts on Health and Nonmedical Consumption in a Developing Country*. The World Bank. World Bank Policy Research Working Paper 3563, April 2005.
<https://openknowledge.worldbank.org/handle/10986/8988>
- Wang, H., Yip, W., Zhang, L. & Hsiao, W. C. (2009). *The Impact of Rural Mutual Health Care on Health Status: Evaluation of A Social Experiment in Rural China*. *Health Econ.*: 18: 65-82.
<http://www.ncbi.nlm.nih.gov/pubmed/19267321>
- Wiechers, T. (2013). *Microinsurance and Social Protection*. Discussion paper #003. Microinsurance Network.
<http://goo.gl/NQ8tP2>

- Wooldridge, J.M. (2012). Introductory Econometrics: A Modern Approach. 5th Edition. South western Cengage Learning. <http://goo.gl/UFAQYe>
- Wynn, B. O., Dutta, A. & Nelson, M. (2005). *Challenges in Programme Evaluation of Health Interventions in Developing Countries*. Center for Domestic and International Health Security. <http://goo.gl/jX3BFT>
- Zanjani, G. & Koven, R. (2013). *Microinsurance Lessons from History*. Microinsurance Learning and Knowledge (MILK) & Microinsurance Centre. <http://goo.gl/9GFvgu>
- Zimmerman, E., Magnoni, B. & McCord, M. (2013). *Lessons from 15 Studies on Client Value of Microinsurance*. Microinsurance Learning and Knowledge (MILK) & Microinsurance Centre. <http://goo.gl/4y3wQC>

ANNEX A: DESCRIPTION OF SOCIAL PROTECTION FRAMEWORKS

National social protection frameworks typically encompass a number of different types of interventions that complement each other. Initiatives can be administered by a combination of the state, commercial companies, community-based groups, or other actors. In addition to distinguishing interventions based on the entity administering it, other social protection programs can be distinguished according to the manner in which they are funded. The two main funding alternatives are non-contributory and contributory schemes.¹⁶ As shown in Table B.1, the former is usually organized by the government but can be administered by a private entity and typically subsidized by a public authority. The latter can be administered by both private and public entities and includes insurance to cover risks such as disability, unemployment, or death. Other types of social protection interventions include labor market regulation and community-based support.¹⁷ Whereas the first is usually designed to protect the employed, the second is most commonly informal to fill gaps in social protection systems (Applied Knowledge Services).

Table B.1: Categorization of Social Protection Interventions

Social Protection Types	Description	Administered by
Social Assistance (Non-Contributory)	Cash or in-kind transfers to vulnerable individuals or households. These transfers can be conditional (school attendance) or unconditional (social pensions).	Government/Public Authority
Social Insurance (Contributory)	Beneficiaries make contributions to a scheme to mitigate risk, such as health insurance or unemployment insurance schemes.	Government/Public Authority and Commercial/Private Companies
Labor-market Interventions	Programs designed to protect workers, such as minimum wage legislation.	Government/Public Authority
Community-Based or 'Informal' Social Protection	Mechanisms by which social safety nets and coping strategies are provided and sustained at community level.	Traditional Networks/Communities

Sources: Applied Knowledge Services; Deblon & Loewe 2011





¹⁶ An example of non-contributory scheme is a cash transfer such as the Child Support Grant (CSG) in South Africa.

¹⁷ Examples of labor market regulations are training and skills development and employment counseling but also minimum wages or minimum requirements for working conditions.

ANNEX B: OVERVIEW OF EVIDENCE ON HEALTH MICROINSURANCE

Country	Type of Insurance	Insurance Scheme/ Program Name	Product Details	Targeting Mechanism	Scale	Study Design	Evaluation Methodology	<u>Result</u> Effect on usage of health care services	<u>Result</u> Effect on financial security	<u>Results</u> Effect on health status
India Gumber 2001	Health	Self-Employment Women's Association (SEWA)	Medical costs and Maternity Care	Self-Selection (Community-based insurance)	1,200 households	Quasi-experimental	Logit Models		Mixed results	
India Mahal et al. 2012	Health	-	Outpatient services, non-hospital care.	Rural Population	889 households	Randomized controlled trial	Difference-in-Difference	Increase in use of health care	Reduced expenditure (though the effect is small)	
Kenya Dercon et al. 2012	Health	Bima ya Jamii	In-patient hospitalization covers, funeral insurance, and cover for not working during hospitalization.	Rural Population	1,500 households	Randomized controlled trial	Ordinary Least Square Regression		Reduced out-of-pocket expenditures (with some exceptions)	No significant difference between insured and non-insured individuals
Mali Franco et al. 2008	Health		Preventive Measures	Self-Selection (Mutual Health Organizations)	817 households	Case control study	Logit Regressions	Increase in use of health care		
Nicaragua Fitzpatrick et al. 2011	Health	Seguro Facultative de Salud	Preventive, diagnostic, and curative health services	Informal workers. Subscribers' children up to the age of 12 are also covered.	1,614 households	Randomized Controlled Trial	Instrumental Variable	Modest increase in use of health care	No large increases or decreases in expenditures	
Rwanda Sekabaraga, C., Diop, F. & Soucat, A. (2011).	Health	'Mutuelles'	Inpatient and outpatient costs	Obligatory (85% of the population) (Community-Based)	(Unspecified) National Household Survey	Non-experimental (insured vs. not insured)	Logistic Regressions	High increase in the use of (formal) health care	Reduction in the level of direct illness-related spending and catastrophic out-of-pocket spending	
Tanzania Msuya et al. 2004	Health	Community Health Funds	Minimal package of outpatient and prevent services at a dispensary and a referral hospital	Self-Selection (Community-based insurance)	200 households	Quasi-experimental	Probit Regressions	Increase in the use of health care (decrease for informal health care)	Protection against asset loss	
Vietnam Wagstaff and Pradhan 2005	Health	Vietnam Health Insurance	Costs for inpatient and outpatient care as well as drugs used in inpatient care.	Obligatory (civil servants) and voluntary	(Unspecified) National Household Survey	Non-experimental (insured vs. not insured)	Propensity Score Matching & Difference-in-Difference	Increase in use of health care		Positive effect on health status of the insured
West Africa (Ghana, Mali, Senegal) Chankova et al. 2008	Health	-	Outpatient costs, hospitalization, drugs	Self-Selection (mutual health organizations)	1,808 (Ghana), 2,659 (Mali), 1,080 (Senegal).	Quasi-experimental	Multiple Regression Analysis	Increase in use of health care	Mixed evidence	

ANNEX C: USEFUL ONLINE RESOURCES

Institute	Description
	<p>The ILO's Impact Insurance Facility “is enabling the insurance sector, governments, and their partners to embrace impact insurance to reduce households’ vulnerability, promote stronger enterprises and facilitate better public policies. Uninsured risk has devastating consequences on future generations and constraints their entrepreneurial potential.” The Facility collects, consolidates, and shares emerging knowledge and best practices. The website provides an overview of information per region, topic, and project.</p> <p>www.impactinsurance.org</p>
	<p>The Microinsurance Centre is a consulting firm that promotes quality microinsurance by product development, microinsurance research, and advocacy. Their mission is to get simple, understood, accessible and efficient microinsurance products accessible to all individuals in developing countries. The Centre has an extensive database with information on all facets of microinsurance, ranging from business models to the role of technology.</p> <p>www.microinsurancecentre.org</p>
	<p>The Center for Health Market Innovations “promotes programs, policies and practices that make quality health care delivered by private organizations affordable and accessible to the world’s poor”. The Center’s website provides information on programs aiming to improve the health of the world’s poor. The digital platform has an interactive map where you can select health microinsurance programs based on their geographical location, approach, organizing delivery, and financing.</p> <p>www.healthmarketinnovations.org</p>
	<p>The Microinsurance Network “promotes the development and delivery of effective insurance services for low-income people by encouraging share learning, facilitating knowledge generation and dissemination, and providing a multi-stakeholder platform”. It visions “a world where people of all income levels are more resilient and less vulnerable to daily and catastrophic risks through improved access to affective risk management tool”. The Network has publications on a large range of topics related to microinsurance (i.e. agriculture, health, distribution, regulations, and supervisions), sorted by type and year.</p> <p>www.microinsurancenetwork.org</p>