PlaNet Paper

Innovation at the heart of health microinsurance schemes in Africa

PlaNet Finance shares its experience in Benin and Madagascar and defines the key success factors in providing access to healthcare for the most deprived

This document was produced by Eloïse ORANGE, Health Microinsurance Project Manager in Benin, PlaNet Finance Benin and Glenn ANDRE, Health Microinsurance Project Manager in Madagascar, PlaNet Finance Madagascar.

INTRODUCTION

Healthcare is considered to be a human right and a public good in its own right and therefore appears in the Universal Declaration of Human Rights[1] of 1948. However, limitations on significant resources, both at governmental and population level, continue to hold back access to health services and financing of them throughout the world. According to an in-depth study carried out by Swiss Re[2], the second largest insurance company in the world, health microinsurance services could cover 4 billion people who are currently excluded from care provision. Thus, health insurance is one of the priority needs to be covered expressed by those with the lowest incomes in most developing countries: only around 0.3% of the populations in sub-Saharan Africa have access to health insurance[3].

As a result, over the last decade, the governments of low income countries and development organisations have been focused on promoting health microinsurance as a way of improving access to and financing of healthcare, extending social protection and fighting poverty.

In this document PlaNet Finance aims to identify the main key success factors for health microinsurance (MicroAssurance Santé - MAS) projects arising from its two pilot initiatives, run with the support of PlaNet Guarantee (a subsidiary of the PlaNet Finance Group) in Benin and Madagascar from 2009 to 2012 in partnership with Sanofi.

CONTEXT

Health microinsurance is one of the priority needs of populations in developing countries

According to studies by the International Labour Office (ILO)[4] carried out in 2010, **26% of households in low and medium income countries resort to taking out loans or selling their belongings to cover their healthcare costs**. Health microinsurance, through mutual health insurance schemes, is often the only possible response to reduce the cost of personal healthcare expenses, thereby enabling access to healthcare for low income populations. In fact, health microinsurance reduces the cost of personal healthcare expenses by taking over healthcare costs, particularly in the event of serious incidents; it also assists with access to high quality healthcare and encourages a significant improvement in behaviours. In this way, it promotes the highest possible standard of health among populations[5], puts them in a position to be able to work and to free up the income required to for their subsistence, and can enable their children to receive a minimal level of schooling.

The development organizations agree on the benefits of promoting health microinsurance by pursuing several objectives[6]

- *Contribution to the operation of the health sector.* Health insurance should enable the removal of the financial barrier to accessing costly healthcare and, simultaneously, provide stable resources to healthcare providers.
- *The contribution to the extension of social protection in developing countries.* The promotion of health microinsurance is part of the current move by governments to extend social protection

---

[1] Universal Declaration of Human Rights adopted 10 December 1948 by the General Assembly of the United Nations.
[2] Source: SIGMA, Microinsurance - Risk protection for 4 billion people, N°6/2010, published by Swiss Re, 2010.
[3] Source: Etats des lieux de la micro-assurance en Afrique, Michal Matul, Michael J. McCord, Caroline Phily and Job Harms, Fonds pour l'innovation en microassurance, BIT, October 2009.
[4] Source: Protecting the Poor: A microinsurance compendium. Vol. II, published by the ILO and the Munich Re Foundation.
[5] For the SKY project run by GRET in Cambodia, a significant improvement in access to healthcare was noted in the areas concerned: 0.3 contacts with a per person and per year healthcare structure and 3 contacts per person and per year on average.
[6] Source: La microassurance de santé dans les pays à faible revenu, AFD, Alain Letourmy et Aude Pavy-Letourmy.

for informal populations through the implementation of universal health coverage schemes, as is the case in Benin, for example.

- *Participation in the fight against poverty.* International institutions and bilateral cooperation agencies support the promotion of microinsurance as a "safety net" for these populations which are likely to fall into poverty in the event of a health problem.
- *The possible synergy between microfinance and microinsurance.* Microfinance was developed so that categories excluded from the traditional banking system can access basic financial services (savings, loans…). Similarly, microinsurance should be able to offer these populations lower cost services which are suitable for their needs. In this way, microfinance institutions are able to facilitate access to a significant number of low income individuals, including women, and play a role as a platform for collecting premiums. Furthermore, they constitute an ideal channel for targeted health education and raising awareness of health microinsurance products. Research undertaken by Freedom from Hunger[7] has shown an improvement in behaviours relating to health, as well as increased (geographical and financial) access to healthcare providers among MFI customers, offering health education in addition to their financial services (including insurance). Finally, it is important to note that MFIs have a direct interest in their customers being insured. This supports borrowers' repayment capabilities, which are sometimes compromised by their state of health.

The success factors identified for the development of health microinsurance

In Africa, the population covered by a microinsurance product has increased by over 200% between 2008 and 2011[8]. This strong growth in microinsurance may be attributable to four main factors[9]:

(i) the support of public authorities, to extend social protection to informal workers through the use of microinsurance and via the creation of a suitable regulatory framework and a conducive macro-economic environment;
(ii) the efficiency of payment systems, with the development of remote systems facilitating the collection of premiums, particularly in rural areas;
(iii) the effect of training and the replication of success of international insurance brokers and insurance companies, such as Allianz, Munich Re etc.;
(iv) the progressive improvement in the quality of services and the changes in health behaviours (vaccination, water sanitation etc.).

LESSONS FROM TWO PILOT PROJECTS IN BENIN AND MADAGASCAR

Lesson n°1: Microfinance institutions are a pertinent and efficient health microinsurance distribution channel for reaching informal workers and their families, in countries where the informal sector represents more than 80% of the active population.

In 2007, PlaNet Finance and Sanofi initiated a strategic partnership to improve access to healthcare for microentrepreneurs, in the form of two pilot projects in Benin and Madagascar combining health microinsurance and microfinance**.**

In Benin, creation of an association of microfinance institutions (MFIs) selling a health microinsurance product to microentrepreneurs

A feasibility study in Benin[10] has revealed that healthcare costs were one of the main financial constraints faced by microentrepreneurs, particularly in the context of repayment of their loans. In

---

[7] *Metcalfe et al, 2012.*
[8] *Source: Briefing note, The landscape of microinsurance in Africa 2012, published by Making finance work for Africa and the Munich Re Foundation.*
[9] *Source: Protecting the Poor: A* microinsurance compendium. *Vol. II, published by the ILO and the Munich Re Foundation.*
[10] *Source: Etude de faisabilité sur la mise en place d'une assurance maladie pour les IMF au Bénin, by PlaNet Finance, BIT/STEP, 2009.*

2009, PlaNet Finance[11] therefore decided, with the technical support of BIT/STEP, to implement an innovative health microinsurance model to promote access to health insurance for a vulnerable population (the customers of MFIs and their beneficiaries).

The project *Microassurance Santé au Bénin* (Health Microinsurance in Benin) is therefore based on the creation of an association between different Beninese MFIs[12]. This association, called Djidjoho, "well-being" in the Fon language, is responsible for ensuring the sale of a health microinsurance product to customers of the respective MFIs. The distribution of the product relies on a voluntary membership model (the product is offered by Djidjoho to customers of the MFIs as a complement to the financial services offering), the mandatory membership principle not having been retained by the partner MFIs.

The Djidjoho association:

(i) is responsible for activities raising awareness of health insurance and for the collection of premiums from MFI customers;
(ii) ensures a privileged link with the Benin Mutual Social Security Association (Mutuelle de Sécurité Sociale du Bénin - MSS-B), which bears the financial risk and has a relationship with the healthcare providers.

Thanks to the product distributed by Djidjoho and developed by the MSS-B, the customers of partner MFIs and their families can go to the 16 health centres contracted by the MSS-B and receive healthcare paid for by the mutual health insurance scheme for an extensive range of services.

The features of the product are the following:

(i) Target: customers of partner MFI (borrowers and savers) and their families.
(ii) Coverage: 70% (third-party payment).
(iii) Healthcare covered: general consultations; hospitalisation; surgery; specialist consultations; maternity; medicines available in the contracted healthcare centers; laboratory; ophthalmology and dental care.
(iv) Insurance premium: 1.30 EUR / month / person.

In the first instance, 70 loan officers were trained in the sale of the healthcare microinsurance product within the MFIs that are members of Djidjoho. However, to ensure better penetration of the product with MFI customers and regular monitoring of members, PlaNet Finance has proposed the creation of a sales force uniquely dedicated to the sale of the health microinsurance product and which carries out all of the activities associated with the distribution of the product (raising awareness of health microinsurance, managing membership and collecting premiums). The four dedicated agents employed since 2012 have made a significant contribution to facilitating access to health microinsurance for the beneficiaries.

At the end of May 2013, 3,259 MFI customers and their families, 3,848 individuals in total, were accessing high-quality, low-cost healthcare dispensed by the network of contracted healthcare centres. Although the number of members remains relatively low in relation to potential members, there has been a significant increase in awareness among populations regarding the services they obtain through health microinsurance. Disseminating the insurance principle and enabling better understanding of the notion of foresight is an important challenge given that the target population is characterised by low income – for whom healthcare costs do not appear to be a priority - a certain amount of illiteracy and a complete lack of knowledge of these concepts.

Through this project, the Djidjoho association, PlaNet Finance and Sanofi, have established a pilot initiative that may, in the future, enable health insurance to be provided to a whole section of the informal population in Benin, via a recognised distribution channel such as MFIs.

---

[11] Here and throughout the rest of the document, "PlaNet Finance" refers to the NGO and subsidiary of the Group specialising in health microinsurance, PlaNet Guarantee.
[12] The MFIs ALIDé, ACFB and Renaca are involved, representing a potential 120,000 individuals.

In Madagascar, creation of a mutual health insurance scheme targeting the customers of a partner MFI

In Madagascar, a feasibility study on the establishing of a health microinsurance system[13] carried out by PlaNet Finance in 2011 on members of an MFI, showed strong interest among these members in enrolling into a mutual health insurance scheme despite the low quality of healthcare services available to them. This study therefore led to the creation in May 2012 of the mutual health insurance scheme "Harena". This scheme offers healthcare coverage to microentrepreneurs (and their families) who are customers of the MFI OTIV Tana, i.e. 15,000 borrowers and 200,000 members within a network of 10 agencies in 5 regions of the highlands of Madagascar (Analamanga, Itasy, Bongolava, Vakinankaratra and Amoroni'Mania). The scheme is simple: any customer of OTIV Tana borrowing a sum equal to or exceeding MGA 1,000,000 (around EUR 350) must subscribe to the mutual health system Harena if he/she cannot provide evidence of healthcare cover at the time a loan is applied for. Other members of OTIV Tana (simple savers or small-scale borrowers) may subscribe voluntarily to the mutual health insurance scheme.

The product is also as simple as possible to ensure it can be easily understood by beneficiaries and easily managed by OTIV Tana staff. Premiums are annual and cover the entire family, costing EUR 9 for compulsory membership and EUR 10.5 per family for voluntary membership. In return for membership, members receive the following services:

(i) 70% cover for consultations and medicines;
(ii) 80% cover for hospitalisation, surgery and obstructed labour;
(iii) Third-party payment applies with all of the contracted suppliers[14].

One year after its creation, on 31 May 2013, the growth in the number of members is constant and the Harena mutual health insurance scheme covers 1,906 beneficiaries in and around the city of Antananarivo. Difficulties initially presented themselves among staff belonging to the OTIV Tana MFI who did not feel involved in this mutual health insurance scheme. The strategy was then changed with the hiring of two dedicated staff members for the scheme and the integration of the mutual health insurance scheme Harena into all of the OTIV communication tools. This strategy has shown rapid results in terms of adoption of the product by the MFI staff. After this one-year pilot phase limited to two agencies of the OTIV Tana MFI, the objective of the second phase of the project launched in May 2013 is to cover the whole network of this MFI from now until April 2016.

This scheme may therefore be replicated across a large part of Madagascar in the future. In fact, OTIV Tana is part of the national OTIV network, which comprises 6 MFIs throughout the country. The other OTIV MFIs present in the Sava, Diana, Boeny, Atsinana and Alaotro Mangoro regions represent over 20,000 borrowers and 120,000 members.

Lesson n°2: The subsidising of premiums by a third party is one solution to reduce the healthcare costs of beneficiaries

The model developed in Madagascar was quickly able to produce solid quantitative results owing to two main factors: the compulsory membership model and the subsiding of premiums by a third party.

Indeed, beyond this compulsory membership model developed with OTIV Tana, PlaNet Finance has developed a second model in the north of Madagascar. Two mutual health insurance schemes in the Diana and Madagascar regions have been launched with the support of the German multinational Symrise. These mutual healthcare schemes incorporate the model of many social security systems developed in the world with premiums paid by the employer (here Symrise, who is the purchaser of the products created by the insured producers) as part of business relationships. This company which

[13] *Feasibility study – OTIV Tana mutual health insurance scheme – June 2011.*
[14] *The suppliers contracted by the Harena mutual health insurance scheme include 29 doctors and dispensaries, 13 pharmacies and 4 hospitals.*

specialised in fragrances and aromas for the perfume and foodstuffs industry, sources its Bourbon vanilla from Madagascar. With the aim of developing a long term relationship with its farmer suppliers, Symrise has chosen to develop projects involving production diversification, education of local populations and most importantly, access to healthcare.

This healthcare component has resulted in the creation of two mutual health schemes, Tsihàrôfy and Mahavelona, in the north of Madagascar, in the Diana and Sava regions respectively. The development of these mutual health schemes has been a real challenge owing to their implementation in predominantly rural areas.

In fact, the rural environment is characterised by a dispersed target population, the high cost of transport, difficult access and the low quality of healthcare available. Consequently, support from an external structure such as Symrise has been vital. The automatic membership of all farmers receiving support from Symrise provides the mutual health insurance scheme with a minimum number of members and therefore facilitates the attainment of break-even point, but also a reduction (indeed the abolition) of contribution repayment costs. The Tsihàrôfy mutual health insurance scheme has 690 beneficiaries at the end of the one-year pilot phase and the Mahavelona mutual health insurance scheme is due to commence in August 2013 with around 2,500 beneficiaries. A portfolio of 7,000 beneficiaries would ensure the financial viability of the scheme.

This partnership, beyond the practical aspect of repayment being made easier for mutual health insurance schemes, creates a positive dynamic between the company and the beneficiary producers. In fact, this enables potential power struggles that are found within contractual agriculture to be avoided and establishes a sustainable relationship based on trust.

> *"Health is an invaluable asset – all around the world. However, whilst in many industrialized countries people are covered by public health insurances, smallholder farmers in Madagascar are facing severe challenges with regard to healthcare: The public health infrastructure is deficient, a social security system does not exist and any illness or injury can pose a life-threatening risk to people. By setting up a health-micro-insurance for smallholders and their communities, we are jointly enabling true step-change. If the farmers and their families are healthy, they can afford to focus on their farm and main source of income – which at the same time represents security of supply for us. All in all, this cause creates shared value – for all stakeholders involved."* (Clemens Tenge, Corporate Communications Symrise)

This model involving the subsidising of premiums by a company is particularly suited to the agricultural sector in which large companies employ individual workers who have no social protection. The company Symrise alone would enable around 4,000 farmers and their families to be covered in the future. This scheme therefore allows companies to create a network of trusted suppliers and farmers to access basic services in return for the sale of their produce.

Lesson n°3: It is in the interests of mutual health insurance schemes to share their resources, skills and efforts in order to increase efficiency.

One of the original features of the mutual health insurance scheme project in Madagascar is the creation of a management platform (Zina platform) shared by the different mutual health insurance schemes created as part of the project. The model is that of a network of mutual health insurance schemes which share specific skills to limit their costs and improve their management. A part of the premiums collected by the different mutual health insurance schemes is set aside for operating this structure nationally.

This platform run by PlaNet Finance during the project phase is made up of a coordinator, a medical officer and a training and communications manager. In the future, other employees may be added to assist with the workload and supplement the services offered to the mutual health insurance schemes. The intention is that **this platform be financially autonomous** after the withdrawal of PlaNet Finance

from the project and that it be accessible to all mutual health insurance schemes, whether already in existence or under development. Its services consist of 4 areas:

(i) Technical competence in insurance enabling feasibility studies to be carried out, the creation of economic models, pricing and the creation of health insurance products along with monitoring of the main insurance ratios;
(ii) Technical competence in healthcare to enable partnerships with health structures to be established, to monitor service quality, to establish statistics on the pathologies of beneficiaries and to monitor service statistics to avoid any risk of fraud or over-consumption;
(iii) Competence in terms of training and communication with the creation of branding, communication materials (posters, brochures etc.) and materials to raise awareness (flyers on health topics, an image library showing the value of a mutual health insurance scheme);
(iv) Sharing of a Management Information System (MIS) suitable for all the mutual health insurance schemes and which enables efficient management of the scheme and adequate monitoring by the Zina platform.

In the future, another advantage of the Zina platform may be exploited: the sharing of the network of healthcare providers between the different mutual health insurance schemes. This would enable members of mutual health insurance schemes living in the provinces to be covered for specialist services at Antananarivo University Hospital (Centres Hospitaliers Universitaires d'Antananarivo) in serious cases. In addition, members could continue to benefit from the services of their mutual health insurance scheme whilst travelling, for example during visits to families in other provinces.

This innovative model aims to incorporate as many mutual health insurance schemes as possible in order to maximise the benefits of sharing costs and skills. It also enables well-established models to be replicated easily within new regions and target populations. By April 2016, at the end of the 2nd phase of the Zina project, the two mutual health insurance schemes in the north should each cover 7,500 beneficiaries and the Harena scheme should cover 30,000 beneficiaries. **With 45,000 beneficiaries, the mutual health insurance schemes and the Zina platform will reach their economic viability threshold**.

Lesson n°4: The viability of health microinsurance systems requires an improvement in the quality of the care offered and acknowledgement of local healthcare practices

In Benin, a study has revealed several obstacles to membership and retention of customers

In order to better understand the health microinsurance membership and retention mechanisms, in November 2011 PlaNet Finance and Sanofi commissioned an anthropological and epidemiological study[15] with the Research Institute for Development (Institut de Recherche pour le Développement - IRD).

This research had two objectives:
(i) To improve knowledge of health needs and understanding of population practices when choosing therapeutic treatments and costs associated with healthcare;
(ii) To evaluate perceptions of microinsurance among health populations and to gather their assessment of the product to improve the financial and social sustainability of the Djidjoho model and to enrich knowledge for the replication and extension of the project.

The main obstacles to the development of the health microinsurance product identified during the study with customers of MFIs who are members of Djidjoho are the following:

Self-medication. Self-medication, both preventative and curative, is extremely widespread in Benin[16],

---

[15] *Source: Microinsurance: Améliorer l'adhésion et la fidélisation des populations au Bénin, Jean-Yves Le Hesran, Carine Baxerres, Anne-Lise Le Hesran, UMR 216, IRD, November 2012.*
[16] *The study reveals that 85.8% of families in Cotonou use self-medication, and 83% in Agon.*

whether via pharmaceutical medicines or traditional remedies. Self-medication is most often used in the first instance to treat simple symptoms – fever, headaches, stomach ache, soreness – and especially for cases of self-diagnosed malaria. These different symptoms or illnesses, such as malaria, are mainly treated with antipyretics and antimalarials, the latter accounting for around 30% of treatments. These treatments, which families see as cheap and appropriate, give them autonomy with regard to the formal healthcare system, for everyday problems. Their real interest in the health microinsurance product appears to be when things go "beyond", following a relatively rare event (accident, pregnancy) which requires payment for expensive care. It is very important to take into account the therapeutic treatment of beneficiaries when setting up a health microinsurance project. In Benin, for example, health problems are always a source of exchange and advice among individuals, particularly owing to the proximity within concessions. Each vehicle in its entourage the positive or negative perceptions of the health centres that it has frequented and therefore influences the choice of consultation site.

Accessibility of healthcare offering. In rural areas, this phenomenon is more noticeable owing to the distance from health centres. Populations are reticent about making long journeys, which are costly in terms of time and money, to obtain treatment for minor health issues.

Lack of awareness of the benefits of health microinsurance. Hesitancy over contributing to a scheme results from lack of awareness of the benefits provided by the health insurance product. The concept of mutual health insurance is complex and different from that of the usual social solidarity systems. In addition, for the two reasons mentioned above, few people are able to try the service provided by the mutual health insurance scheme, yet this would constitute the strongest argument for disseminating the product among the population.

These results coincide with the experiences of other health microinsurance projects in the world[17] and confirm the **need for joint intervention between governments, lenders, the private sector and civil society in light of dissemination of health coverage among populations, particularly in the informal sector**.

The results of this study have enabled to identify two conditions necessary for the development of health microinsurance

Improving the quality of the healthcare offering. The populations have organised their access to care based on the available offerings and their economic capacities. Health microinsurance must therefore position itself as a positive alternative to a system which is already in place, by offering a service that goes beyond simple "access to care".
Thus, the success of a health microinsurance project depends largely on improving the quality of the reception and cover in health centres.

*Offering health education***.** The success of the project depends upon certain changes in the behaviour of individuals. Although these individuals understand that health microinsurance permits access to a large range of care and better quality of care, they do not necessarily see the value of better diagnoses. Promotion of the product should therefore be linked to targeted health education on everyday issues, in collaboration with health professionals. Families must be made aware of the need for an accurate diagnosis and appropriate treatment early on, resorting to specialists where necessary, to avoid any secondary complications from poorly treated pathologies. Those individuals who have taken out microloans with MFIs are an ideal target population for monitored health education.

OUTLOOK

National strategies in favour of universal health coverage

[17] *Évaluation de l'impact du programme SKY au Cambodge 2010, Expost n°9, AFD, April 2013*

Health microinsurance can contribute significantly to improving access to healthcare for vulnerable populations, and more generally to improving their income and their living conditions, especially in Africa where social security systems are sometimes only just being established. Nevertheless, health microinsurance can only be developed with considerable support and commitment from public authorities (both in terms of infrastructure as well as investment).

Governments need to establish an appropriate institutional framework, invest in infrastructures and implement subsidised programmes for the benefit of the most deprived. These conditions are a prerequisite for the establishment of Public Private Partnerships (PPP) and the intervention of a multitude of stakeholders, including lenders, commercial insurers, NGOs and private partners.

Consequently, a growing number of governments in West Africa are moving towards the establishment of a universal health coverage system (Régime d'Assurance Maladie Universelle - RAMU). However, these still fragile initiatives require sustainable support, both technical and financial, to result in long-lasting, efficient schemes. In this context, microfinance institutions and NGOs can contribute significantly to these efforts, as is the case in Benin with the dissemination of health microinsurance via the MFI association Djidjoho.

Focus on Benin

The project led by PlaNet Finance is part of the current national policy of the State of Benin, which aims to establish a universal health coverage system which will result in a social welfare system designed to protect all social classes within the population from the financial consequences of health risks. The universal health coverage system, currently being adopted, will be based on existing mutual health insurance schemes and their experiences of selling health microinsurance products. In this context, an MFI association such as Djidjoho which benefits from direct access to the target population and expertise in training and raising awareness of health microinsurance would be a strategic partner for the State when implementing national policy.

Focus on Madagascar

The State of Madagascar has included social protection and in particular mutual health insurance scheme in its national health policy (particularly through community health policy). Despite these intentions, there has been no true implementation of this social protection for all. In fact, the recession suffered by Madagascar since 2009 has deprived institutions of the resources required to implement such a programme. A programme such as the universal health coverage system in Benin can only be implemented after constitutional order has been restored, which is determined by the return of international lenders. For now, public institutions are limited to actions such as appointing public health providers for mutual health insurance schemes (as is the case for the 3 mutual health insurance schemes in the Zina project) or the creation of networks of social protection stakeholders (P4H network launched in 2012).

CONCLUSION

Access to healthcare is a major challenge to which health microinsurance must respond immediately, particularly in Africa where there are few efficient social security systems.

Through two pilot projects in Benin and Madagascar, PlaNet Finance and Sanofi wished to facilitate access to health microinsurance for a population which is vulnerable in terms of health coverage, thereby helping to reduce poverty in these countries. **The lessons from these two projects favour a greater synergy between MFIs and health microinsurance and the establishing of partnerships with companies or organisations that subsidise and facilitate the payment of premiums.** It is essential to involve staff from partner institutions (MFIs, farmers' organisations or companies) as much

as possible, as well as members of mutual health insurance schemes as the success of health microinsurance projects is based on the membership of these key individuals in their mutual health insurance scheme. Moreover, **the choice of a compulsory membership model and the establishing of a technical platform are crucial factors in achieving satisfactory membership and retention rates**. The anthropological and epidemiological study carried out by the IRD in Benin has enabled new light to be shed on this type of project and has identified potential solutions for responding more successfully to population demands. It would appear fundamental to adapt the healthcare offering to the specific needs of beneficiaries, depending on their cultural characteristics, whilst raising awareness of health microinsurance products and prevention against health risks on a long-term basis.

Finally, significant commitment from governments and lenders to support health microinsurance for the most vulnerable populations is crucial, and more generally to support the establishing of universal health coverage.

REFERENCES

Jean-Yves Le Hesran, Carine Baxerres, Anne-Lise Le Hesran, UMR 216, IRD, November 2012, "*Microassurance: Améliorer l'adhésion et la fidélisation des populations au Bénin".*

Alain Letourmy and Aude Pavy-Letourmy, AFD, "*La microassurance de santé dans les pays à faible revenu".*

"Protecting the Poor: A microinsurance compendium*. Vol. II",* published by BIT and the Munich Re Foundation.

Michal Matul, Michael J. McCord, Caroline Phily, and Job Harms, Fonds pour l'innovation en microassurance, BIT, October 2009, "*Etats des lieux de la microassurance en Afrique".*

Ibid, p.6.

"Etude de Faisabilité sur la mise en place d'une assurance maladie pour les IMF au Bénin", by PlaNet Finance, BIT and STEP.

"Briefing note, The landscape of microinsurance in Africa 2012", published by Making finance work for Africa and Fondation Munich Re.

Metcalfe et al, 2012.

"Innovations et barrières en microassurance santé", Sheila Leatherman, Lisa Jones Christensen and Jeanna Holtz, October 2010.

"SIGMA, Microinsurance - Risk protection for 4 billion people", N°6/2010, published by Swiss Re, 2010.

PlaNet Finance

44, rue de Prony, 75017 Paris

Tel: +33 (0)1.49.21.26.26

www.planetfinance.org