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**MUTUELLE DE SECURITE SOCIALE
BENIN**

Methodology for developing a social marketing and communication plan for a
microinsurance scheme

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1. Introduction

1.1 Background and context of the microinsurance scheme

The *Mutuelle de Sécurité Sociale* (MSS) or Social Security Mutual Health Organization is a microinsurance scheme that was created in 1999 to provide social protection to informal economy workers in Benin. It was initiated by the Beninese Ministry of Civil Service and Labour based on a study carried out with the assistance of the International Labour Office (ILO) and the Belgian Cooperation in 1998. The scheme specifically targets informal economy workers and their families as well as all individuals who are excluded from existing formal social security systems, which make up nearly 85% of the country's population.

Currently, the MSS offers health insurance and old age pensions to members in the cities of Cotonou, Parakou, and Porto Novo. Each city's mutual health organization (MHO) was set up as an autonomous structure, but the three are in the process of merging into a single MHO based in Cotonou, with local branches in each major city.

In its first few years of operation, the MSS encountered serious difficulties in its administration and failed to develop as expected. In 2004, the Ministry of Labour and Civil Service requested support from the ILO's STEP Programme to formulate a strategy to revitalize the scheme. This led to a complete restructuring of the MSS' health insurance branch, which was implemented in the MSS of Cotonou in January of 2006 as a pilot experiment. Based on the growth experienced by the Cotonou branch over the past year, the results of the restructuring are encouraging, and will soon be implemented in Parakou and Porto Novo.

Insurance product and scheme administration

The MSS is unique in that its governance is entrusted to informal sector socioprofessional associations. These associations unite workers by profession (such as tailors, electricians, and taxi drivers) into associations in each commune of Benin that then form part of larger networks and federations.

The scheme favours membership through socioprofessional associations or small businesses. These organizations can register by paying an enrolment fee of 7,000 CFA F, thereby opening the right to participate to all of their members or employees. Subscription of individual members within a registered organizations remains voluntary, however. Individuals who are not members of a registered organization can also join the scheme by paying an enrolment fee of 3,000 CFA F for themselves and their dependents.

Premiums are set at 600 CFA F per person per month. The scheme uses a third party payment system which entitles members to 70% coverage for the majority of primary and secondary care treatments received from contracted health care providers. There are currently three health care providers in Cotonou: two are religious, one is public. In April of 2007, the MSS in Cotonou had 3,023 beneficiaries.

A General Assembly composed of representatives of member associations, individual members, and the MSS' partners acts as the main decision-making body. The Assembly elects a Governing Body composed of 10 scheme members and one representative of the Ministry of Labour and Civil Service for a three year term. A Supervisory Board of three elected scheme members monitors the scheme's management.

The technical administration of the scheme is managed by a secretariat of professional staff composed of a coordinator, an accountant, a marketing agent, a cashier and a liaison officer.¹

1.2 Background of social marketing and communication project

Following the restructuring of technical and organizational aspects of the scheme, the MSS has begun to focus on how to attract more members and ensure the loyalty of existing members. Although the insurance product offered by the MSS corresponds to a real need, after seven years of existence, the scheme has failed to attract significant numbers of members and remains virtually unknown among its target population.

Faced with this situation, the MSS, with support from the ILO's STEP Programme, initiated a pilot social marketing and communication project in its Cotonou branch in May of 2007, with the aim of increasing awareness on the scheme and improving the level of understanding of the health insurance product among current members.

The MSS' target population is not in the habit of buying health insurance. For people with very limited income, the advantage of paying for something that has no tangible or immediate benefits is not self-evident. Effective marketing and communication is expected to overcome some of these barriers to extending health coverage to informal economy workers.

1.3 Objectives of this document

Social marketing constitutes a new area of action research for the ILO's STEP Programme. This paper aims to document the process of developing a social marketing and communication plan for the Social Security Mutual Health Organization. It is meant to serve as a first step in building a generic methodology of social marketing for health microinsurance that can be applied to other contexts. It is important to note that this is not an evaluation of the outcomes of the project, as the activities recommended in the social marketing and communication plan were not yet implemented at the time of writing.

Box 1 Definition of social marketing

Social marketing is the use of commercial marketing techniques to promote the adoption of a behaviour that will improve the health or welfare of the target audience or society as a whole.

Source: Promoting Health Micro-Insurance Schemes to Local Communities. Workshop Documentation. ILO/STEP 25-28 May 2004.

¹ Sources : *Mutuelle de Sécurité Sociale : Organisation et fonctionnement*, BIT/STEP Janvier 2007. *Mutuelle de Sécurité Sociale de Cotonou: Rapport de suivi 2006*, BIT/STEP Février 2007.

2. Project development

The MSS social marketing and communication project consists of five phases. The main activities of each phase are outlined in Table 1. At the time of writing, the first three phases had been completed.

Table 1: Social Marketing and Communication Project Activities

Phase 1: Research on target population (April – May 2007)
Questionnaires designed, pre-tested and finalized
Team of 10 external questionnaire administrators hired and trained
Questionnaires administered to scheme members and non-members
Heads of associations, small businesss, and HC providers selected and contacted for participation in the study
Heads of associations, small businesss and HC providers interviewed by MSS staff
Data entry and analysis of results
Workshop to present results to study participants
Phase 2: Design of social marketing and communication plan (June 2007)
Work sessions held with MSS Governing Body and staff to calendarize activities within Phase 2 and review existing communication practices
Work sessions held with 15 pilot associations to exchange on marketing and communication strategy
Work sessions held with contracted HC providers to plan their participation in sensitization activities
Communication plan drafted with timeline, budget, monitoring and evaluation tools
Communication plan presented to MSS Governing Body and staff for approval
Phase 3: Development of marketing materials (July 2007)
Logo, brochure, posters drafted
Marketing materials presented to elected members for feedback and approval
Marketing materials tested on members of the target population
Marketing materials finalised by graphic designer and printed for distribution
Phase 4: Implementation of social marketing plan (August 2007-July 2008)
Relay system implemented in 15 pilot associations, progressively extended to all member associations
HC providers trained to participate in sensitization activities
Calendar of sensitization activities for associations and HC providers implemented
Marketing materials distributed, theatre, radio and television producers contracted
Phase 5: Monitoring and evaluation (Ongoing)
Trimestral and annual reports produced by MSS staff
Database of current and prospective member associations maintained up-to-date, records kept of meetings and documents
Focus groups held regularly for relay persons
Progress of membership tracked in associations using the relay system
Questionnaires administered to new members to determine impact of marketing materials

2.1 Research on the target population

A research study was designed to better understand the target population's needs and perceptions regarding health insurance and health risk management. The study was used both as an opportunity to collect information on people's knowledge, attitudes and behaviours and to identify any problems within the microinsurance scheme itself that could constitute barriers to attracting or maintaining members.

The study consisted of surveys administered to the MSS’ target population (current members and non-members) as well as more in-depth interviews of heads of socio-professional associations, small businesses and contracted healthcare providers. In total, seven different versions of questionnaires were developed and administered.

Table 2: Participants in the study conducted on the MSS’ target population

	No. of participants
Informal economy workers currently enrolled in the scheme (“members”)	205
Informal economy workers <i>not</i> enrolled in the scheme (“non-members”)	96
Heads of socio-professional associations enrolled in the scheme	14
Heads of small businesses enrolled in the scheme	4
Heads of socio-professional associations <i>not</i> enrolled in the scheme	6
Heads of small businesses <i>not</i> enrolled in the scheme	5
Health care providers under agreement with the MSS	3

Box 2. Some tips and suggestions for future use of questionnaires

- Because health insurance is complicated and literacy rates among the target population are low, the survey was designed to be administered by a team of trained researchers rather than self-administered.
- Although many of the questions appear as multiple choice to facilitate data entry of responses, whenever possible, survey administrators should ask the questions as if they were open-ended (without reading possible responses aloud) to avoid making respondents feel limited by the answer choices listed.
- Choose interview respondents carefully. While participants for the ‘member’ and ‘non-member’ surveys were chosen at random, the heads of member associations were chosen purposefully based on the criteria that there should be an even number of ‘very active’, ‘moderately active’ and inactive’ member associations, (based on the number of scheme members within the association) in order to ensure that a range of perspectives were represented.
- When conducting more in-depth interviews with partners such as heads of associations or health care providers, following the end of the formal interview, respondents should always be invited to make any other comments or suggestions they may have relevant to the microinsurance scheme. Often, this is when the most useful information is collected.
- When interviewing healthcare personnel, better information results from interviewing both a healthcare center director and a member of staff who has more direct contact with patients, such as a social worker or a head of staff. The two should be interviewed separately whenever possible to allow each the opportunity to speak freely.

Combining survey-type questionnaires of the target population with more in-depth interviews of other key stakeholders proved useful for getting a more complete picture of the experience of mutual members, particularly for more subjective areas such as the perception of the quality of health care providers. It also allowed us to cross check information gathered from one source with another to identify biases in responses.

Box 3. Creating incentives to participate in a study

Because the questionnaires were lengthy and often administered at respondents' place of work, a lottery was set up as a non-monetary incentive to participate. All respondents were entered in the lottery which awarded 4 prizes of free premiums for varying lengths of time (from 3 months to one year) for the winners and 3 of their dependents.

The following points summarize the key findings of the study:²

- Overall, the health insurance product offered by the MSS is appealing to its target population. Current members expressed high levels of satisfaction with the scheme's benefits and the quality of health care provided. Non-members, when presented with the product, expressed interest in subscribing.
- Respondents who had been members for over 2 years (prior to the restructuring of the scheme and its benefits in 2005) were less satisfied with the product than those who had joined more recently. Several claimed to be under the impression that they were now paying higher premiums in exchange for less benefits, as the original scheme did not require a co-payment and covered prescription medicine purchased in private pharmacies.
- The vast majority of non-member respondents have had no direct experience with insurance in the past and are not in the habit of taking steps to manage health risks.
- Although health risk management is not common practice, the majority of non-member respondents had some basic knowledge on insurance and mutual-type systems (due in part to experience with savings and credit mutual organizations). Male respondents had a stronger understanding of these concepts than female.
- To date, the majority of communication on the MSS occurs informally, by word-of-mouth. Testimonials of positive experiences with the MSS are an effective way to attract new members. Also effective are the use of arguments that show clearly the financial benefits of membership to the scheme.
- The majority of non-member respondents were unfamiliar with the MSS. When asked why they had never signed up for an insurance scheme, the reason most often cited was not having received any information on the subject.
- Among member respondents, certain gaps exist in their knowledge of the specificities of the scheme. This lack of information on the MSS was cited by respondents as the main barrier to promoting the scheme to friends and colleagues.
- Member socio-professional associations are very heterogeneous in terms of their internal dynamics, their structure and their mission. There does not seem to be a link between the overall level of activity of an association and its level of involvement in the MSS. However, those associations that receive information on the MSS from several different sources tend to be more active in promoting the scheme to their members than those who only have one source of information (usually MSS staff).
- There is a lack of communication between MSS staff and contracted health care providers, which negatively affects the quality of service provided to scheme members.

² For the full text of the study's methodology and findings, please refer to *Mutuelle de Sécurité Sociale - Rapport de synthèse d'enquêtes menées sur la population cible*, available online (in French only) at : <http://www.ilo.org/gimi/showpage.do?page=%2Fgimi%2Ffacteurs%2Fbenin%2Fhome.wiki>

- Internal communication between MSS staff and elected members is weak and the role of each actor in sensitization activities is not clear. In particular, there is confusion on the role and suitability of the marketing agent. Since the agent was hired, elected members and heads of associations have ceased to actively promote the scheme, as they consider it the sole responsibility of the marketing agent.

The results of the study were presented in a workshop to elected mutual members, MSS staff, heads of associations and small businesses and contracted health care providers. The discussion that followed allowed for participants to confirm that the results did indeed correspond to their perceptions of the scheme and to exchange on the strategy that should be adopted to rectify the problems identified (both those related to communication and to the operation of the scheme more broadly).

2.2 Design of the social marketing and communication plan

Following the presentation of the results of the study, work sessions were held with key stakeholders (member associations, health care providers, MSS staff and Governing Body) to jointly formulate the marketing and communication strategy.³ Specifically, for each stakeholder, the sessions aimed to:

- better understand their current practices relevant to marketing and communication on the scheme;
- define more clearly the role and level of participation in the promotion of the scheme that could be expected from each stakeholder;
- identify their training and support needs to enable them to effectively communicate and promote the scheme.

Member associations

Of the approximately 90 member associations and small businesses currently members of the scheme, 15 were chosen to work closely with MSS staff to formulate the marketing and communication strategy and would later act as pilot organizations for implementing the strategy.

Although the structure of the MSS relies heavily on the dynamics of its member associations to channel information to its beneficiaries, it has not invested in training associations to communicate to their members on the scheme. In addition, contact between MSS staff and member organizations has tended to be irregular. As a result, member associations varied widely in their attitude and level of commitment to the MSS. While some associations saw clearly the benefits of the scheme for their members and actively promoted it, others were not convinced that the health insurance product was attractive or that they had any role to play in its promotion. Still others seemed to have ‘forgotten’ about the existence of the scheme entirely.

Individual and group working sessions were held with association heads to discuss ways of creating a greater sense of responsibility among the associations for managing the scheme. The group sessions were particularly useful in sharing best practices in managing scheme membership within associations, which helped to convince those association heads who were reticent to take on what was seen as extra work in the name of the mutual. Through these

³ The social marketing and communication plan for the MSS is available online (in French only) at <http://www.ilo.org/gimi/showpage.do?page=%2Fgimi%2Ffacteurs%2Fbenin%2Fhome.wiki>

sessions, it was decided that, in order to facilitate assigning responsibilities to associations, one person would be designated within each association to act as the 'relay person' between the MSS and association members. This person would be responsible for passing information between the scheme and its beneficiaries in the association and would be provided with the necessary training and written materials to aid him in his tasks.

Although this represents a step forward in creating and maintaining open communication channels with scheme beneficiaries, association heads were not able to reach a consensus on some of the more specific responsibilities of the relay person. For example, there was some resistance to the idea of introducing quantitative objectives for each relay person for the number of scheme members within their association. Also, several association heads were strongly opposed to the idea that the relay person would also be responsible for collecting monthly premiums from association members, citing trust issues with handling money. However, some associations currently delegate premium collection to one member and find it the most effective for ensuring a high rates of premium payment. Efforts to harmonize premium collection methods were finally dropped until a solution was found to decentralize the MSS premium collection point to facilitate payment.

Contracted healthcare providers

A team of MSS staff and members of the Governing Body met with each of the three health care providers to discuss how to involve the health care personnel in sensitizing the target population. All three of the hospitals had prior experience with social marketing on health topics, such as HIV/AIDS or vaccination campaigns. Based on these experiences, the hospital administrators were able to assist the MSS in identifying the most appropriate ways to communicate their message to patients, namely:

- which members of the staff were best positioned to talk to patients about health insurance and should thus be trained to do so;
- the times of day and hospital services that experienced the most affluence in order to schedule awareness-raising sessions during those times;
- the types of audiovisual aids that would be most effective .

Once hospital administrators had identified the staff members that would be asked to participate in trainings on raising awareness on the MSS (approximately 2 staff members per hospital service), MSS representatives met with the staff to introduce the concept of a social marketing campaign on health insurance. While hospital administrators reacted positively to the idea of working in collaboration with the MSS to actively promote the scheme to patients, hospital staff were initially more wary, fearing it would increase their workload. Up to then, selected staff had received training on only the administrative aspects of the MSS, and often considered the paperwork to be rather onerous. It is not surprising then, that they were reticent to take on what they viewed as more work 'for free' for the MSS.

The introductory sessions held with the staff thus sought to emphasize the social and financial benefits for the health care provider of increasing the numbers of patients that were insured as well as to reassure staff that promoting the scheme would not require a significant increase in their workload.

MSS Staff and Governing Body

Several working sessions were held with the MSS staff and members of the Executive Office of the Governing Body to analyze current internal and external communication practices and ways they could be improved.

Through these sessions, the following ‘problem areas’ were identified for improvement:

- There is a lack of clear roles and responsibilities among members of the MSS staff and Governing Body in regards to sensitization activities, and more generally, a lack of sense of accountability among MSS staff to the Governing Body (who is reporting to who);
- Due in part to this lack of clear roles, to date, sensitization activities have been carried out somewhat sporadically, with little or no coordination between actors and often insufficient follow-up of prospective member associations;
- There is very little data collection on member associations. Basic information, such as the total number of members in an association or the frequency of meetings is unknown by staff. Because such information is not systematically collected from each association, it is difficult to target ‘problem’ associations for marketing and communication or to learn best practices from others (for example, effective systems for premium collection within associations).

Based on this analysis, MSS staff and Governing Body members agreed to jointly implement the following practices:

- Regular reporting on sensitization activities, such as field visits to associations and meetings with healthcare providers, to create greater accountability among staff and facilitate follow-up;
- Collecting data on current and potential member associations to better target sensitization activities;
- Holding regular internal meetings to review progress towards objectives, assign responsibilities for tasks, and improve the coordination of sensitization activities.

2.3 Developing marketing and communication materials

To date, virtually all communication on the MSS had been conducted orally, with the exception of a brochure created by MSS staff. While oral communication can be very effective for reaching low literacy audiences, because the specifics of a microinsurance scheme can be complicated, it was decided that more written materials were needed to reinforce messages conveyed through word-of-mouth. Also, actors involved in sensitizing, in particular healthcare providers and member associations had requested written materials to act as reference sheets. And finally, the presence of written materials, even among illiterate or semi-literate audiences, appears to build confidence in the scheme’s durability as an organization among those unfamiliar with or new to the scheme.

The following steps summarize the approach taken to develop written social marketing and communication materials for the MSS:

1. For each stakeholder or segment of the target population (heads of member associations, healthcare providers, members, non-members...), the following was identified:
 - their role in the microinsurance scheme relative to marketing and communication (promoter of the scheme, potential purchaser of insurance...)
 - the information they need to fulfill this role
 - key messages to be conveyed to them

2. Once the message concepts were developed in rough form, the format of the materials (brochure, poster, etc.) to be developed were chosen, taking into account practical issues such as literacy levels, the distribution channels available and budget constraints.
3. Draft versions of the material were developed, using different slogans and types of appeal. For example, a poster targeting members of socio-professional associations aimed to appeal to the audience's sense of solidarity using pictures of people working and the slogan "Together, good health is within everyone's reach"
4. The drafts were presented to the MSS staff and Governing Body for pretesting. Pretests were also conducted informally on both members and non-members of the scheme to gauge their understanding and perception of the material.
5. Once the changes suggested by the pretesting groups were integrated, the materials were sent to a graphic designer to be finalized.

Some thoughts on using the media

In deciding to use mass media channels such as radio and television, several considerations have to be weighed. On one hand, mass media has the potential to reach large sections of the target population on a scale that word-of-mouth or face-to-face sensitization activities cannot. Also, both scheme members and funders (in this case, the Ministry of Labour and Civil Service) tend to favour high profile activities such as television commercials, as it is a very public way of showing that they are 'doing something.'

On the other hand, using the mass media is expensive and often too poorly targeted to affect the perceptions and behaviours of the target population. As the study conducted in Phase 1 showed, much of the scheme's target population is entirely unaware of the MSS' existence and has only basic knowledge of the concept of insurance. It is therefore unlikely that exposure to an advertisement on the MSS will incite people to subscribe to the scheme. There are still several steps between awareness of the insurance product and purchase (see Box 4 below).

Box 4. Stages of Behaviour Change

1. Awareness

It is possible that the target audience has little or no awareness either of the concept of insurance or of the specific insurance product. The communicator must therefore try to build awareness, often best done through repetition of simple messages to build name recognition.

2. Knowledge

The concept of insurance is relatively complex. The target audience may be aware of its existence, or of that of a particular scheme, but know little else. Here, educating the public on insurance and on specific products available is the communicator's task. Education campaigns can be done in partnership with other actors, such as government institutions or donors.

3. Liking

Once target audience members know the product, communication should aim to influence how they *feel* about the product. They may have negative attitudes towards the concept of insurance or feel distrust for the scheme or based on bad experiences in the past. These should be addressed through counter-arguments and positive messages.

4. Preference

The target audience may like the product, but may not prefer it to other insurance mechanisms, whether other schemes or more informal practices they currently rely on. The communicator must identify the advantages of the product that are most appealing to the audience, for example in terms of price or quality, and promote these.

5. Conviction

The target audience may prefer one insurance product over others available, but this does not mean they are convinced that buying it is the right thing to do. They may, for example, think it wiser to invest in something else with more immediate perceived benefits.

6. Purchase

Once a potential scheme member has conviction, he or she may decide to wait for more information or plan to act later. It is the communicator's job to lead the client in making the final step to sign a contract and pay premiums, for example through enrolment campaigns.

Adapted from

Taking into account the arguments for and against using mass media, the following strategy was adopted:

- Initially, focus primarily on developing effective written and print communication materials, such as brochures and posters that can be used to support face-to-face sensitization activities;
- Gradually invest in media, starting with less costly forms of communication, such as street theatre and radio. Measure their impact before investing in television;
- Use the media to raise public awareness and educate on health insurance concepts, rather than to try to incite people to sign up for the MSS specifically.

3. Lessons learned

A social marketing and communication plan should be integrated into the initial setup of the scheme and invested in throughout the scheme's lifetime.

This avoids conducting redundant research – research specific to designing a communication plan (such as where the respondent spends his leisure time, his literacy level, etc.) can easily be integrated into a household survey conducted during a feasibility study prior to the microinsurance scheme's setup. Once the scheme is in operation, a shorter 'member satisfaction survey' can be administered periodically to guide the ongoing communication strategy as well as identify any problems in the scheme's operation.

Any changes in the insurance product or scheme's structure made once the scheme is in operation should be accompanied by a communication campaign to ensure that all members are informed of the changes. In the case of the MSS, the changes in the insurance product made in 2005 that resulted from the ILO/STEP recommendations were not accompanied by sufficient communication. This left many of the longer standing members with the impression that they were paying higher premiums in exchange for less benefits. To date, these members continue to voice their dissatisfaction with the changes, creating negative publicity for the insurance product. More effective communication on the reasoning behind the changes at the time of their implementation could have avoided this.

If a social marketing plan is to be developed for an existing scheme, to the extent possible, the major technical issues of the scheme should be resolved before investing in marketing.

If these issues are not resolved, they risk becoming a barrier to attracting and maintaining members, thereby rendering all marketing efforts null. For example, MSS scheme members are frustrated by the lack of decentralized premium collection sites and the insufficient stocks of medicine in hospital pharmacies. These issues negatively affect their perception of the scheme, and because word-of-mouth is the principle method for attracting new members, could also undo any positive effects of social marketing activities.

A social marketing and communication plan should also target staff and partners.

When relying on existing networks (such as socio-professional associations) to act as the link between the scheme and its beneficiaries, the scheme needs to invest in training intermediaries (in the case of the MSS, association leaders) on how to communicate to beneficiaries. It should not be assumed that existing internal dynamics will mean that communication on the scheme will 'take care of itself' or that those responsible for promoting the scheme will immediately see its benefits. Even if the insurance product is well-adapted to the target population's needs, if the communicator is not well-informed of the product or convinced of its quality, members will lose confidence in the scheme.

Staff must also be convinced of the product they are promoting and have a well-functioning internal communication system if they are to work as a team to implement an external communication strategy. In the case of the MSS, the significant internal problems between staff and members of the Governing Body were standing in the way of effectively sensitizing the target population. Such problems have to be addressed before any large-scale social marketing or communication campaign can be undertaken.