FINAL TECHNICAL REPORT

IMPACT EVALUATION OF VISIONFUND ECUADOR'S INSURANCE AND HEALTH SERVICES

PREPARED BY EGES CONSULTORÍA E INNOVACIÓN LTDA.

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1. EXECUTIVE SUMMARY

1. INTRODUCTION AND GOAL OF THE STUDY

This document presents final findings from the impact evaluation of Familia Protegida (FP), a microinsurance product offered by VisionFund Ecuador (BVFE). The evaluation seeks to assess the product's contribution to the quality of life of clients and their families, particularly children. The study was conducted by EGES Consultoría e Innovación, which considers administrative data analysis with field research.

Launched in August 2021, FP is a bundled insurance product designed to protect low-income households through seven integrated services: telemedicine, virtual doctor consultations, free essential medications prescribed by physicians, psychological and legal assistance, accident-related medical expense coverage (up to $600), and an accidental death benefit ($3,250). Additionally, BVFE supports access through mobile health units (*Ambulancia Naranja*) and periodic visits to neighborhoods (*Brigadas Médicas)*.

As of June 2025, a significant share of BVFE credit clients is currently covered by *FP*. In fact, 42% of active loan clients were enrolled in FP.[1] However, approximately 20% of clients have used this insurance.[2] This distinction is central to the evaluation's analytical strategy.

2. EMPIRICAL STRATEGY AND DATA SOURCES

The evaluation utilizes a mixed-methods approach:

- Characterization factors associated with insurance participation with administrative data: It analyzes over 210,806 loans granted to 108,694 clients, with and without FP, between 2021 and 2025. The strategy includes multivariate regression analyses.

- Impact of FP in enhancing healthcare access with administrative data: It analyzes FP's compensations and services, covering the period from January 2022 to June 2025. The administrative data covers a total of 13,039 compensations, corresponding to 6,584 clients. The strategy includes multivariate analyses and Difference-in-Differences (DiD) techniques to estimate causal effects.

- Representative BVFE's client survey: Designed to include both insured and uninsured clients. The final sample comprises 1,215 valid cases, covering BVFE clients residing in Ecuador. The survey includes clients from various nationalities, including Ecuador, Venezuela, and Colombia, allowing for differential analysis. With a total sample size of N = 1,215, the approximate margin of error is ±2.8

[1] In line with the administrative data, the survey conducted in October 2025 indicates that 44% of surveyed clients declared having FP insurance.

[2] 20%" figure refers to the proportion of unique FP clients who appear in the administrative compensation database — that is, clients who used at least one FP-covered service. Specifically: 6,584 unique users appear in the compensation records. This represents approximately 20% who have activated at least one service during the period analyzed. It is not a claim ratio in the actuarial sense, but rather an activation rate based on service usage records. By contrast, in the representative survey, about 30% of FP-insured respondents reported having used at least one service. This slightly higher figure is likely reflected by: Self-reporting over a 12-month window; and inclusion of non-compensation services, such as telemedicine or medical brigadas.

percentage points at a 95% confidence level. National statistical representativeness is not inferred; the results are valid only for BVFE's credit clients.

- The data from the survey has been used for descriptive analysis and linear probability models that allow complement contribution and attribution impact analysis.

Our empirical strategy provides both rigorous causal inference (for insured clients) and broader descriptive insights (for the entire client base), enhancing the evaluation's depth and operational value.

3. KEY FINDINGS

Healthcare Access: Clients who actively use FP services experience, (users), significantly better healthcare access. During public health shocks (e.g., pneumonia outbreaks), utilization of telemedicine, medication, and compensation benefits increases substantially. Only 20.8% of users reported no medical consultation in the past year, versus 66.1% of non-users insured. Households facing well-being challenges (health, school, or mental health issues) are more likely to rely on FP services.

Financial Resilience: Active FP users are significantly more likely to save. Using the insurance increases the likelihood of saving by 8–16 percentage points. During health-related emergencies, 50% of users relied on savings, while 0% reported selling assets—compared to 12.8% of non-users.

Emotional Well-being: While emotional well-being remained stable for 87–92% of clients, the insurance showed no transformative effect. It acts more as a buffer than a sustained source of psychological relief.

Child Well-being: Families using FP report better pediatric healthcare access, especially in access to medicines (53% vs. 19%) and doctor visits (18% vs. 7%). However, impacts on education, nutrition, and housing remain limited, influenced more by structural factors than the insurance product.

Service Awareness and Perception: 66% of clients are aware of services like telemedicine, but only 30% used any service in the past year. Perceived financial relief is moderate: 40% reported no reduction in out-of-pocket spending, while only 22.4% of those who faced emergencies felt the insurance helped. Among clients who actually used the insurance, the results are much more favorable, over 70% perceived some level of financial relief thanks to FP coverage.

Inclusion of Women and Migrants: Although women—especially those with higher education—are less likely to enroll, 63% of insured clients are female. Migrant clients, particularly Venezuelans, are more likely to enroll and activate services. The product successfully reaches underserved and excluded groups.

High Satisfaction Among Users, with Positive Perceptions Extending to Non-Users: Clients who actively use FP report notably positive levels of satisfaction (43% versus 13% non-users), reflecting the program's effectiveness in delivering valued services. Among all surveyed clients, 28% expressed satisfaction, and 59% reported a neutral perception, indicating overall positive sentiment.

Summary of causal relationship:

- Users have significantly greater access to healthcare, special under health risk.
- Clients who use FP are more likely to save.
- Households facing well-being challenges (health, school, or mental health issues) are more likely to rely on FP services.

4. Opportunities for Improvement

- Strengthen communication and simplify procedures to increase service activation.
- Increase visibility of psychological assistance already included in the benefit package and consider adding more holistic psychosocial support (e.g., group sessions).
- Tailor outreach strategies for families with children and migrant clients to improve child-focused service use.
- Improve messaging around emergency assistance and financial protection benefits to reinforce client understanding.

FP is delivering measurable impact in improving access to care and strengthening household resilience. With targeted enhancements in communication, benefit use, and service delivery, BVFE has the opportunity to further position FP as a high-performing, inclusive microinsurance product aligned with international best practices.

RESUMEN EJECUTIVO

1 INTRODUCCIÓN Y OBJETIVO DEL ESTUDIO

Este documento presenta los hallazgos finales de la evaluación de impacto del Seguro "Familia Protegida" (FP), un producto de microseguros ofrecido por el Banco VisionFund Ecuador (BVFE). El objetivo de la evaluación es determinar la contribución del producto a la calidad de vida de los clientes y sus familias, especialmente de los niños. El estudio fue realizado por EGES Consultoría e Innovación, e incluyó el análisis de datos administrativos complementado con trabajo de campo.

Lanzado en agosto de 2021, FP es un seguro que integra siete servicios diseñados para proteger a hogares de bajos ingresos: telemedicina, consultas virtuales con médico, entrega gratuita de medicamentos esenciales prescritos, asistencia psicológica y legal, cobertura de gastos médicos por accidentes (hasta USD 600) y un beneficio por fallecimiento accidental (USD 3.250). Además, BVFE facilita el acceso a estos servicios mediante unidades móviles de salud (Ambulancia Naranja) y visitas periódicas a los barrios (Brigadas Médicas).

A junio de 2025, el 42% de los clientes activos con crédito estaban afiliados a FP[3]. Sin embargo, sólo cerca del 20% de estos clientes ha utilizado algún servicio del seguro, una distinción clave para el análisis de impacto[4].

2 ESTRATEGIA METODOLÓGICA Y FUENTES DE INFORMACIÓN

La evaluación utilizó un enfoque de métodos mixtos:

- Caracterización de determinantes asociados a la afiliación al seguro mediante datos administrativos: se analizaron más de 210.000 créditos otorgados a más de 108.000 clientes, con y sin seguro, entre 2021 y 2025, incluyendo análisis de regresión multivariada.
- Evaluación del impacto de FP en el acceso a servicios de salud con datos administrativos: se analizaron 13.039 registros de atención brindada a 6.584 clientes asegurados entre enero de 2022 y junio de 2025, utilizando análisis multivariados y técnicas de Diferencias en Diferencias (DiD).
- Encuesta representativa a clientes de BVFE: con 1.215 respuestas válidas de clientes residentes en Ecuador, incluyendo personas de nacionalidad ecuatoriana, venezolana y colombiana. El margen de

[3] Fuente: datos administrativos. Por otra parte, la encuesta realizada en octubre de 2025 indica que el 44% de los clientes encuestados declararon contar con el seguro FP

[4] La cifra del 20% se refiere a la proporción de clientes únicos de FP que aparecen en la base de datos administrativa; es decir, clientes que utilizaron al menos un servicio cubierto por FP. En concreto, 6584 usuarios únicos aparecen en los registros de compensación. Esto es el 20% de los clientes que activaron al menos un servicio durante el período analizado. No se trata de una tasa de siniestralidad en sentido actuarial, sino de una tasa de activación basada en los registros de uso del servicio. Por el contrario, en la encuesta representativa, alrededor del 30% de los asegurados de FP encuestados que informaron haber utilizado al menos un servicio. Esta cifra ligeramente superior probablemente se refleje a: Autodeclaración durante un período de 12 meses, e inclusión de servicios no remunerados, como la telemedicina o las brigadas médicas.

error estimado es de ±2,8 puntos porcentuales (95% de confianza). La muestra no es representativa a nivel nacional, sólo aplica para la cartera crediticia de BVFE.

- Los datos de la encuesta fueron usados para análisis descriptivos y modelos de probabilidad lineal que permiten evaluar contribución y atribución de los impactos.

Nuestra estrategia empírica combina inferencia causal rigurosa (para asegurados) y perspectivas descriptivas amplias (para toda la base de clientes), enriqueciendo el valor operativo de la evaluación.

3 PRINCIPALES HALLAZGOS

Acceso a servicios de salud: Los clientes que usan activamente FP, (usuarios), tienen acceso significativamente mejor a servicios de salud. Durante picos sanitarios (ej. brotes de neumonía), aumenta el uso de telemedicina, medicamentos y compensaciones. Solo el 20,8% de los usuarios no tuvo consultas médicas en el último año, que contrasta con el 66,1% de los asegurados no usuarios sin consultas en el mismo período. Los hogares con desafíos de bienestar (salud, escuela o salud mental) son más propensos a usar los servicios de FP.

Resiliencia financiera: Los usuarios activos tienen una probabilidad significativamente mayor de ahorrar. El uso del seguro aumenta la probabilidad de haber ahorrado entre 8 y 16 puntos porcentuales. Ante emergencias de salud, el 50% de los usuarios recurrió a sus ahorros, y ninguno vendió activos, frente al 12,8% de los no usuarios que sí lo hizo.

Bienestar emocional: Aunque el bienestar emocional se mantuvo estable para el 87–92% de los clientes, el seguro no mostró un efecto transformador. Funciona más como un amortiguador temporal que como una fuente sostenida de alivio psicológico.

Bienestar infantil: Las familias que usan FP reportan mejor acceso pediátrico, especialmente en medicamentos (53% vs. 19%) y visitas médicas (18% vs. 7%). Sin embargo, los impactos en educación, nutrición y vivienda son limitados y responden más a factores estructurales que al seguro.

Conocimiento del producto y percepción: El 66% de los clientes conoce servicios como la telemedicina, pero solo el 30% utilizó algún servicio en el último año. El alivio financiero percibido es moderado: el 40% no sintió reducción en gastos de bolsillo, mientras que solo el 22,4% de quienes enfrentaron emergencias sintió que el seguro ayudó. Sobre aquellos clientes, que informaron usar el seguro, más del 70% percibió algún alivio financiero gracias a la cobertura de FP.

Inclusión de mujeres y migrantes: Aunque las mujeres—especialmente con mayor educación—tienen menor probabilidad de afiliación, el 63% de los asegurados son mujeres. Los migrantes, especialmente venezolanos, tienen mayor probabilidad de afiliación y activación de servicios. El producto logra alcanzar a poblaciones tradicionalmente excluidas.

Alta satisfacción entre usuarios, con percepciones positivas también entre no usuarios: Los usuarios activos reportan niveles notablemente altos de satisfacción (43% frente al 13% de los no usuarios), lo que refleja la

eficacia del programa. En general, el 28% expresó satisfacción y el 59% una percepción neutral, lo que indica un sentimiento positivo generalizado.

Resumen de relaciones causales:

- Los usuarios tienen mayor acceso a servicios de salud, especialmente en situaciones de riesgo sanitario.
- Los usuarios de FP tienen mayor probabilidad de generar ahorros.
- Los hogares con problemas de salud, educación o salud mental son más propensos a usar los servicios de FP.

4 REFLEXIONES Y OPORTUNIDADES DE MEJORA

- Fortalecer la comunicación y simplificar procedimientos para aumentar la activación de servicios.
- Aumentar la visibilidad de la asistencia psicológica ya incluida en el paquete de beneficios y considerar complementar con componentes psicosociales más amplios (ej. sesiones grupales).
- Diseñar estrategias específicas para familias con niños/as y para clientes migrantes, promoviendo el uso de servicios enfocados en la infancia.
- Mejorar el mensaje sobre beneficios en emergencias y protección financiera, reforzando el entendimiento del producto.

FP genera un impacto medible en el acceso a la atención médica y en la resiliencia económica del hogar. Con mejoras dirigidas en comunicación, uso de beneficios y calidad del servicio, BVFE tiene la oportunidad de consolidar a FP como un microseguro inclusivo y de alto desempeño, alineado con las mejores prácticas internacionales.

2. INTRODUCTION

This report presents the findings of an independent impact evaluation of VisionFund Ecuador's (BVFE) insurance and health service interventions, with a primary focus on the *Familia Protegida* product (FP). Introduced in august 2021, FP was designed to provide financial protection and facilitate access to essential services for low-income households, particularly during health-related shocks and emergencies. The motivation for this evaluation stems from BVFE's commitment to generating evidence of change in the lives of its clients and their families. Specifically, this study seeks to determine whether the insurance and associated services contribute meaningfully to improvements in well-being, resilience, and economic security—particularly among women and migrant populations, who represent a significant portion of the client base.

The general objective of this evaluation is to measure the impact of BVFE's insurance and health services, identifying their contribution to the quality of life of clients, their families—particularly children. More specifically, the evaluation aims to assess whether these services improve access to healthcare, reduce stress, and increase clients' sense of security; whether they enhance the well-being of children in terms of health, nutrition, education, and protection; whether they help clients protect income and assets during periods of crisis; and whether they enable faster recovery from adverse events. The study also explores whether outcomes differ significantly for Venezuelan migrant clients, whose access to traditional social protection mechanisms may be limited. In addition to these core questions, the evaluation investigates levels of client awareness and satisfaction, as well as opportunities to strengthen the program based on client experience.

To address these objectives, the evaluation employs a mixed-methods approach, combining the analysis of administrative data with the implementation of a structured client survey. Administrative records of 210,806 loans granted to 108,694 clients between January 2021 and June 2025 were used to describe the insured population and identify patterns of use and service delivery. A field survey with a stratified sample of 1.215 clients was conducted to collect primary data on client experiences, perceptions, and outcomes, both among users and non-users of the insurance product. The evaluation applies both contribution and attribution methodologies: the former to construct a coherent narrative of change based on triangulated evidence, and the latter to estimate causal effects using Difference-in-Differences. This dual strategy ensures a robust interpretation of results while acknowledging the complexity of the socio-economic context in which the program operates.

This document is organized to provide a comprehensive understanding of the evaluation process and its outcomes. It begins with an overview of the *FP* program, followed by a detailed description of the empirical strategies based on administrative and survey data. The results section presents the key findings across all impact dimensions, including quality of life, children's well-being, financial security, and resilience. The report concludes with a synthesis of the main insights and a set of actionable recommendations aimed at enhancing the effectiveness, scalability, and sustainability of BVFE's insurance model. As a final annex, this report includes responses to all comments and observations made by the client.

3. FAMILIA PROTEGIDA INSURANCE

FP is a bundled insurance product offered by BVFE since August 2021, designed to enhance the financial protection and resilience of microfinance clients and their families. The insurance covers both the credit holder and their nuclear family, providing a comprehensive set of services that go beyond traditional insurance schemes.

The product includes seven key benefits: telemedicine consultations, access to an e-doctor platform, basic medications, psychological support, legal assistance, coverage for medical expenses due to accidents (up to USD $600), and an accidental death indemnity of USD $3,250, which is distributed in the form of a funeral bonus, a food basket, and an educational scholarship. These services are intended to reduce the financial burden associated with health events and to provide holistic support in times of crisis[5].

Table 1 Services Offered by the FP Insurance Product

Service	Who is Covered	Description
1. E-Doctor	Credit holder and family	Remote medical consultations via digital platforms.
2. Telemedicine		Real-time medical attention through virtual channels.
3. Medicines		Free provision of basic medications following medical consultations.
4. Legal Assistance		Legal guidance and support on relevant matters.
5. Psychological Assistance		Access to mental health services and professional counseling.
6. Medical Expenses for Accidents		Coverage up to USD $600 for accident-related medical costs.
7. Accidental Death Indemnity	Credit holder only	USD $3,250 total: $250 cash bonus, $1,500 food basket, $1,500 education grant.

In addition to the insurance itself, BVFE clients benefit from two complementary health services implemented in partnership with external providers: *Ambulancia Naranja*, a mobile medical unit offering free consultations in rural and underserved areas; and *Brigadas Médicas*, which are periodic health campaigns offering general medicine, pediatrics, and gynecology, along with medication delivery. These services aim to extend access to preventive care and health information to communities that are often excluded from the public health system. Together, the insurance and health interventions form a unique package that integrates financial and non-financial components to promote well-being among low-income households.

The underlying theory of change guiding this evaluation assumes that the integration of insurance and health services into BVFE's microfinance operations leads to measurable improvements in clients' lives. Specifically, the program is expected to reduce out-of-pocket health expenses, increase access to timely care, and enhance emotional and mental well-being. By protecting household income from health-related shocks and reducing the need to deplete savings or incur debt during emergencies, the program should also strengthen financial security and business continuity. Furthermore, by relieving financial and emotional stress on caregivers, the model anticipates indirect benefits for children, including improved nutrition, education, and housing conditions. This evidence is also found in migrants' vulnerable population. A cause–effect relationship table and a summary of the literature that supports these fundamentals could be found in Appendix 1 of this document.

To test these hypotheses, the evaluation draws on a structured set of assessment questions that are fully aligned with the program's theory of change. These questions are presented in Table 2 and serve as the foundation for the evaluation framework and methodology.

[5] It is important to note that the health insurance coverage is not designed for high-cost emergency situations, but rather for basic and preventive healthcare services.

Table 2 Assessment Questions

Specific Objective	Evaluation Question	Data Sources
Quality of Life	To what extent have BVFE's services improved clients' access to healthcare?	Primary data source: Client survey Secondary data source: Administrative data
	Have clients experienced reduced stress, greater peace of mind, or improved emotional well-being?	Primary data source: Client survey
Children's Well-Being	Has children's access to health, education, or nutrition improved due to BVFE's services?	Primary data source: Client survey
	Are there positive changes in children's security or housing because of insurance coverage?	Primary data source: Client survey
Economic Stability / Financial Security	Have BVFE's services helped clients protect income, savings, or business during emergencies?	Primary data source: Client survey
	Do clients feel more economically secure due to their insurance coverage?	Primary data source: Client survey
Resilience	Are clients able to recover more quickly after a health-related incident because of the services provided?	Primary data source: Client survey Secondary data source: Administrative data
	Do clients feel better prepared to handle future emergencies?	Primary data source: Client survey
Migrants (Venezuelans)	How do the outcomes of BVFE's services differ for Venezuelan migrants compared to Ecuadorian clients?	Primary data source: Client survey Secondary data source: Administrative data
	Have migrant clients experienced improvements in their well-being or protection due to participation?	Primary data source: Client survey Secondary data source: Administrative data

The evaluation applied two complementary analytical strategies to answer the assessment questions. First, contribution analysis will be devoted by primary source information, and attribution analysis will be developed with causal-effect analysis using administrative data. The next section will explain both empirical strategies.

4. EMPIRICAL STRATEGY: ADMINISTRATIVE DATA

To understand how the FP insurance product influences the lives of BVFE's clients, we conducted a detailed analysis of administrative data spanning from August 2021 to June 2025. A Comprehensive research document in Appendix No.2. This dataset includes 210,806 loans granted to 108,694 clients, providing a rich basis for evaluating the program's implementation and impact.

This part of the evaluation answers the following key questions raised by BVFE:

Are we contributing to an improved quality of life for our clients?

Are we helping clients gain access to healthcare services?

Does insurance provide economic protection for households and small businesses?

Do clients report greater peace of mind or a sense of security?

Are the results different for women or Venezuelan migrants, who may face greater barriers to social protection?

By analyzing administrative records, we can measure not only who enrolled in the insurance program, but also who used it, how frequently, and under what circumstances.

DATA SOURCES

We used two main types of administrative data:

Loan and Client Data: 108,694 clients from January 2021 to June 2025, covering demographic details (gender, age, location, nationality), credit characteristics (loan maturity, credit history), and socioeconomic indicators (employment, income, education).

Insurance Usage Data: complete database of FP compensations, covering the period from January 2022 to June 2025, with a total of 13,039 compensations corresponding to 6,584 clients[6]. This data allows information of insurance service records, such as: Medical consultations (telemedicine and e-doctor); Access to medicines; Psychological and legal support; Claims for health-related accidents and compensation[7].

External source: We also introduced a secondary national source statistics from Ministry of Public Health of Ecuador. Specifically, hospital discharge databases for the years 2022, 2023, and 2024, which provide detailed information on diagnoses, age, province of residence, and other health indicators about province-level panel such as pneumonia cases to study the role of insurance in times of heightened health risk. This database allows us to identify monthly peaks of infection and higher concentrations of cases in specific provinces[8].

CLIENT CREDIT DATA WITH AND WHITHOUT FP: DESCRIPTIVE OVERVIEW

Clients with FP tend to be slightly older (average age 39.2 vs. 36.9) and more likely to be women (62.5% vs. 59.2%) compared to those without the insurance. They are less likely to be single (59.5% vs. 70.8%) and slightly more educated at the primary level, although they have lower university completion rates. While both groups are overwhelmingly Ecuadorian, clients with FP show a slightly higher share of Ecuadorians (97.2% vs. 96.3%) and a lower proportion of Venezuelan and Colombian migrants. They also tend to have longer loan maturities, higher incomes and equity, and are more likely to hold a savings account (98% vs. 85.2%), but less likely to use other financial instruments. These differences suggest that clients with FP exhibit a more stable and financially integrated profile.

Table 3 Descriptive Statistic Without and With FP (n=108.694)

Category	Mean Without FP (Points/100)	Mean With FP (Points/100)
Applicant characteristics		
Age (years)	36.877	39.164

[6] For insurance usage, data is only available from 2022 onward, because compensations and services take time to appear in the system after enrollment.

[7] This dataset does not represent the full universe of insured clients, but rather the subset of insured clients who triggered or activated a service — such as telemedicine, pharmacy, compensation claims, or legal/psychological assistance.

[8] External source secondary data is monthly base, and it is consistent with the insurance data range.

Category	Mean Without FP (Points/100)	Mean With FP (Points/100)
Women	0.592	0.625
Single	0.708	0.595
Primary education	0.403	0.467
Secondary education	0.505	0.454
University education	0.057	0.048
Nationality		
Venezuelan	0.008	0.007
Colombian	0.029	0.021
Ecuadorian	0.963	0.972
Other	0.029	0.021
Loan characteristics		
Maturity (months)	15.091	18.666
Delinquent	0.11	0.121
Matured	0.489	0.823
Income and wealth		
Income (US$)	1.237	1.543
Equity (US$)	12.256	15.442
Financial inclusion		
Seniority (years)	2.855	3.099
Savings account	0.852	0.98
Other financial instruments	0.71	0.601

Clients with FP also demonstrate slightly greater seniority in their relationship with BVFE, with an average of 3.1 years compared to 2.9 years for those without the insurance.

INSURANCE USAGE DATA: DESCRIPTIVE INSIGHTS

To assess how clients interact with the FP insurance product, we analyzed detailed administrative records for 6,584 insured clients who used at least one service between August 2021 and June 2025. These records help us understand the extent of insurance usage, the profile of beneficiaries, and the types of services most frequently accessed.

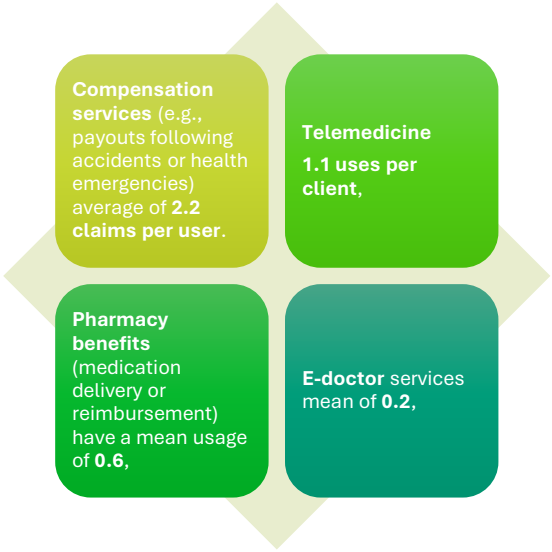
Types of Services Used

The data reveals that clients are actively using a range of insurance benefits:

- **Compensation services** (e.g., payouts following accidents or health emergencies) are the most utilized, with an average of 2.2 claims per user.
- **Telemedicine** consultations, a key part of the FP offering, show solid uptake with 1.1 uses per client, reinforcing the value of remote healthcare access.
- **Pharmacy benefits** (medication delivery or reimbursement) have a mean usage of 0.6, suggesting that not all consultations result in prescriptions or that clients may access medications through other means.
- **E-doctor** services (digital medical interactions) are used less frequently, with a mean of 0.2, but some clients used this service intensively (up to 16 times).

These patterns demonstrate the insurance product's multi-dimensional utility, with clients accessing both financial protection and direct health services.

Figure 1 Type of services



User Demographics and Family Involvement

The insurance not only covers the credit holder but also their nuclear family, especially children:

- On average, clients had 1.4 children, and 0.7 medical attentions were provided to children per FP-insured client, with some households receiving up to 10 services for their children.
- Adult clients (holders) used approximately 0.9 services on average.
- 70% of insured users were women, highlighting a strong gender focus in both enrollment and utilization.
- The average age of insured clients was 37.3 years, with a wide range from 19 to 77 years, confirming the program's relevance across working-age adults and caregivers.

Migrant Participation

Approximately 8% of insurance users were Venezuelan migrants, a group of particular interest due to their limited access to public health systems. The presence of migrant clients in service usage data indicates that FP is effectively reaching excluded populations, consistent with VisionFund's inclusion goals.

METHODS USED

We applied rigorous econometric techniques that are common in international impact evaluation that is detailed in the research paper in Appendix 2, the approaches were:

Determinants of Enrollment: Using linear and panel data models, we examined which clients were more likely to enroll in the insurance program. This helps us understand if vulnerable groups are being reached.

Difference-in-Differences (DiD) models: To identify how insured and uninsured clients differ in their access to health services during health crises.

Usage Analysis: We explored whether people used insurance services more intensively during periods of high health risk (e.g., increased respiratory infections), an indicator of enhanced resilience using correlation analysis.

Subgroup Analysis: Special attention was given to female clients and Venezuelan migrants.

KEY FINDINGS

1. Improved Access to Healthcare

(To what extent have BVFE's services improved clients' access to healthcare?)

Clients enrolled in FP demonstrate significantly better access to healthcare services. Administrative data show that insured individuals make more frequent use of telemedicine, medications, and compensation services—especially during periods of heightened health risk (e.g., pneumonia outbreaks). This confirms the program's central promise: to reduce barriers to timely, affordable health care for low-income households.

2. Enhanced Household Resilience and Financial Protection

(Does the insurance help protect the family economy or business during emergencies?)

Clients with insurance are more likely to respond quickly to health shocks. They rely on services instead of resorting to asset sales or emergency borrowing. This is particularly evident during spikes in respiratory illnesses, when service usage increases significantly. FP effectively serves as a protective mechanism during unexpected health events, providing both financial support and access to medical services when aggregate health conditions deteriorate.

3. Inclusion of Women Despite Lower Enrollment Probability

(Are women benefiting from the insurance, and are results different for them?)

Although 63% of insured clients are women, statistical analysis shows that being female is associated with a lower likelihood of enrolling in the insurance. Additionally, older age and university-level education are also negatively correlated with participation. This suggests that enrollment is not uniformly distributed across demographic groups.

However, once enrolled, women—particularly single women—tend to use the insurance to benefit their children and families, even if their own personal use of services is lower. This underscores the indirect impact of the insurance through caregiving roles, rather than individual usage alone.

4. Family Status and Financial Behavior Shape Participation

(Is the insurance truly beneficial, and who chooses to enroll?)

Formal employment, single marital status, and ownership of a savings account are all positively associated with enrollment. The effect of having a savings account is especially strong, increasing the probability of insurance uptake by 25 percentage points. This reinforces the importance of financial inclusion infrastructure as a driver of insurance participation. The term of the credit is also positively associated with higher enrollment, suggesting that clients employ insurance as a protection tool for the medium and long term rather than as a tool for short-term shocks.

5. Migrant Inclusion is Effective and Measurable

(Are the results different for Venezuelan migrants?)

Being Venezuelan is a strong predictor of enrollment. Venezuelan clients are 6.5 percentage points more likely to enroll in FP compared to Ecuadorians. Despite their often-precarious situation, this population is actively participating, suggesting that the product effectively reaches excluded and underserved groups, as well as those more exposed to adverse shocks.

6. Income and Wealth Are Not Barriers—Inclusion Persists

(Is the product inclusive in practice?)

Interestingly, higher levels of income and wealth, as well as ownership of financial instruments, are negatively associated with insurance enrollment. This implies that Familia Protegida is not attracting only higher-income clients, who are typically covered for more sophisticated, expensive instruments. On the contrary, Familia Protegida is more attractive to lower-income households, which have traditionally been unserved by traditional financial products and institutions. This suggests the pro-poor, inclusive design of the FP insurance.

7. Determinants of Familia Protegida Enrollment

A combination of demographic, socioeconomic, and behavioral factors influences enrollment in the Familia Protegida insurance program**.** Women, self-employed individuals, and clients with a history of more extended engagement with VisionFund Ecuador are more likely to be enrolled. Clients with Familia Protegida also demonstrate slightly greater seniority in their relationship with VisionFund Ecuador, with an average of 3.1 years compared to 2.9 years for those without the insurance. Clients residing in rural or underserved areas, as well as Venezuelan migrants, exhibit higher participation rates, indicating that the insurance meets the needs of populations with limited access to traditional healthcare services. Additionally, factors such as having children, lower educational attainment, and prior exposure to health shocks are associated with a greater likelihood of uptake. These patterns reflect both the demand-side needs for protection and the supply-side targeting strategies employed by VFE. Understanding these determinants is crucial for refining outreach and ensuring the insurance reaches those most in need.

These findings confirm that FP is achieving a broad and inclusive impact across different client segments. While certain groups (such as formally employed or educated women) are less likely to enroll, BVFE has implemented effective strategies to compensate for structural inequalities—ensuring strong participation by women, single mothers, and migrants. Once enrolled, these groups use insurance in ways that reflect their caregiving priorities. Insurance especially benefited clients during adverse health shocks, with evidence showing higher service utilization when pneumonia incidence was elevated, indicating that coverage enhanced resilience and responsiveness during critical health periods.

5. EMPIRICAL STRATEGY: REPRESENTATIVE SURVEY

To assess the effects and satisfaction associated with the FP, we designed a purpose-specific survey targeting clients of BVFE. A structured sample of clients—both with and without FP—was selected to enable comparative analysis. The survey was conducted over a five-week period between September and October 2025 and included retrospective questions comparing 2024 to 2025 (e.g., income comparisons). These comparisons were self-reported by respondents within the same instrument.

The survey was organized around six core dimensions:

1. Sociodemographic and household characteristics
2. Effective use of BVFE services
3. Perceived quality of life and well-being
4. Children's well-being

5. Financial resilience and economic stability
6. User experience, awareness, and suggestions for improvement

The average duration of the survey was approximately 8 minutes per respondent. The questionnaire was carefully designed to be concise yet comprehensive, balancing quantitative measurement with meaningful insights into client experience. It included closed-ended questions—such as Likert scales, dichotomous (yes/no), and multiple-choice formats—as well as a few open-ended prompts for suggestions and qualitative feedback. Language was adapted for regional and cultural appropriateness, using clear and accessible phrasing across the different provinces surveyed.

Pollsters received specialized training to ensure uniform implementation of field protocols. These standardized procedures were supported by a practical manual that guided pollsters through key aspects of the survey, including how to approach clients, handle sensitive questions (e.g., income or health-related topics), and ensure consistent and accurate data entry.

The survey was administered via digital devices using LimeSurvey, an online-compatible platform that allowed for real-time data quality monitoring. Dashboards and survey indicators were regularly reviewed by the quality assurance team in coordination meetings throughout the survey period, ensuring that sampling quotas and representativeness goals were being met.

As detailed in Appendix No. 3, the sample was drawn from BVFE's administrative database, using stratified random sampling to ensure proportional representation across:

1. Insurance status (with vs. without FP)
2. Gender (male/female)
3. Migrant status (Ecuadorian vs. Venezuelan)

Additional eligibility filters were applied to define the survey population:

4. Clients active between January 2024 and December 2025[9]
5. Only one client interviewed per household
6. Age between 18 and 65 years
7. Only current loan holders were included (up-to-date, overdue, or fully overdue loans); clients with cancelled, written-off, or foreclosed loans were exclude
8. Clients must have had all their loans either with or without FP coverage, to ensure clear categorization
9. The most representative nationalities—Ecuadorian, Venezuelan, and Colombian—were included in the sample

Prior to and during data collection, information and awareness campaigns were deployed to encourage client participation. These messages were distributed through BVFE's official social media channels such as Facebook.

REPRESENTATIVE SURVEY RESULTS

SURVEY RESPONSE RATE AND SAMPLING FRAMEWORK

The survey followed a stratified sampling framework shown in Appendix 3 to ensure representativeness across client gender, nationality, and FP insurance status. The final sample consists of 1,215 valid cases, with national coverage across Ecuador, and includes identification of country of origin (Ecuador, Venezuela, Colombia) for

[9] Clients enrolled in the FP program must have maintained uninterrupted insurance coverage during the entire study period.

disaggregated analysis. With a sample size of N = 1,215, the estimated sampling error is approximately ±2.8 percentage points (with 90% confidence level and a 7% margin of error).

Survey completions were distributed as follows:

- Clients without insurance: 675 surveys
- Clients with insurance: 540 surveys
- Women: 697 surveys (57%)
- Men: 518 surveys (43%)

While certain segments, such as Venezuelan and Colombian clients, were underrepresented in relation to their targets, key demographic strata such as Ecuadorian women and men—both with and without insurance—achieved or exceeded 90% of their sampling goals. This enables reliable subgroup analysis for the largest client segments.

The final achieved sample supports strong analytical power for the overall population and core subgroups, ensuring meaningful comparisons between FP-insured and non-insured clients.

MAIN FINDINGS

The following section presents a summary of responses to the questions organized across the six dimensions of the survey instrument. For more detailed information, please refer to Appendix No. 4.

I. SAMPLE CHARACTERIZATION (N=1,215)

- FP: 44.4% with FP insurance and 55.6% without FP.
- Gender: 57.3% women and 42.7% men.
- Age: 37% between 25–35; 23.1% between 36–45; 19% between 46–59; 16% between 18–24; 4.8% aged 60+.
- Children aged 0–23: 61.3% have children (54.3% with 1–3; 7.0% with 4+).
- Marital status: 62.5% single; 19.9% married; 11.1% in a common-law union.
- Nationality: 74.9% Ecuadorian; 17.6% Colombian; 7.0% Venezuelan.
- Education: 47.8% secondary; 31.5% primary; 11.5% university; 6.7% technical.
- Occupation: 72.2% self-employed/business owner; 23.8% employee. Sectors: 35.8% agriculture; 26.4% commerce; 10.5% services.
- Income variation: 44.3% report an increase; 39.4% the same; 16.3% decreased.
- Key insights: prevalence of self-employment, agro-commercial sector, and households with children; FP coverage reaches 4 out of 10.

II. USE OF FP SERVICES (INSURED ONLY, N = 540)

- Awareness: Highest for Telemedicine and Pharmacy (66%) and accidental death benefit (61%); lower for family income support (23%), scholarship (21%), and Medical Brigades (Brigadas Médicas) (24%).
- Use in the past 12 months: 30% of insured clients have used at least one of the services. Most used services were Ambulancia Naranja (Orange Ambulance) (44%) and Telemedicine/Pharmacy (38%); the rest ≤21%.

- Valid reasons for non-use: 55.9% "didn't need it"; 12.6% didn't know they could use it; 9.7% received care elsewhere; 7.6% tried but couldn't.
- Key insights: high recall of telemedicine/ambulance, but low overall activation and gaps in information/management[10].

III. PERCEIVED QUALITY OF LIFE AND WELL-BEING (GHQ-5, 2025 VS 2024, N=1.215)

- Stable balance: Between 87%–92% reported the same status in sleep, stress, daily activities, mood, and happiness.
- Net improvements (Better – Worse): Sleep +1 p.p. (6.0% vs 7.2%), Stress ~0 (5.5% vs 5.7%), Activity +0.2, Depression −1.4, Happiness +2.5.
- Subgroup Findings: Modest improvements are most noticeable among those who experienced an increase in income and, to a lesser extent, among insured clients. Specifically, 4.8% of insured individuals reported lower emotional distress compared to 2024; within this group, 3.4% of those who used FP services, (users), showed improvement.
- Key Takeaways: Well-being has remained stable overall, with slight emotional improvements observed. A recent increase in income stands out as the strongest positive factor—54.8% of insured individuals reported income growth, compared to 35.9% of the uninsured. Among those who used FP services (users), 65.4% saw income increases, versus 50.4% of non-users. These results underscore the potential of insurance coverage and service utilization to contribute to financial and emotional well-being.

IV. CHILDREN'S WELL-BEING AT HOME (INSURED)

N = From the total sample (n=1,215), 745 individuals reported having children between 0 and 23 years old, representing 61.3% of the total. Within this subgroup of caregivers/parents, 350 are covered by the FP insurance.

- Reported access: The utilization of the FP microinsurance leads to significantly improved health access for children in insured households, particularly when compared to insured clients who do not activate or use the services.
    - Access to Medicines: Households that use the FP services are significantly more likely to report that their children have more access to medicines. 53% of users declared this improvement, compared to only 19% of non-users. This is the most marked difference in perceived benefits related to child well-being.
    - Easier Doctor Visits: Users report that their children can go to the doctor with more ease when they are sick (18% of users reported this benefit) compared to only 7% of non-users. This demonstrates that the activation of insurance is associated with a clear perception of better access to effective medical attention.

[10] While survey results indicate relatively high awareness of services like telemedicine and pharmacy benefits (66%) and reported use of Ambulancia Naranja (44% among insured users), open-ended suggestions frequently pointed to gaps in information and service use. This finding is consistent with other survey sections that reveal knowledge gaps, suggesting that awareness does not always translate into clear understanding or effective activation. Awareness does not necessarily equal understanding or effective use. Clients may have heard of a service but still lack clarity on how to access it, what it covers, or when it applies.

- Actual Utilization of Health Services: The use of specific pediatric benefits bundled in the FP product is highly concentrated among clients who activate the insurance, effectively linking utilization to access:

Table 4 Healthcare Service Utilization

Service Utilized by Child	Users of FP Services	Non-Users of FP Services
Ambulancia Naranja (Mobile Health Unit)	47.3%	13.5%
Telemedicine (Virtual Doctor Consultations)	35.1%	8.1%
Brigada Médica (Medical Brigades)	14.9%	5.4%

- Contrast in Non-Utilization: Among insured households that do not use the FP services, 84.0% reported that their children did not utilize any of the FP's services. This indicates that in households where the parent does not activate the insurance, the children are largely excluded from the benefits package

V. FINANCIAL RESILIENCE AND STABILITY (N=1.215)

- Savings: 64.4% managed to save something; 33% did not save; among the insured, fewer reported "no savings at all." Greater saving capacity is observed among those who use the FP—85.5% of individuals who have used insurance services report having been able to save "a lot" or "some" money over the past 12 months.
- Emergencies: 30.2% faced a financial emergency; higher incidence in households with children and without FP.
- How it was handled (multiple responses): loans (37.6%), savings (33.2%), family help (27.0%); selling assets (7.9%); unable to cover it fully (9.0%).
- Health emergencies: mostly resolved through the public system (49.6%); private (21.8%); BVFE services (2.7%).
- 80% of those who resolved a health emergency through BVFE's medical services (brigades, ambulance, or telemedicine) were active users of the insurance, while non-users relied primarily on the public or private healthcare system
- Evaluation of FP during economic emergencies (N = 138 only FP and emergencies): 22.4% said it helped (a lot/somewhat); 34.1% said it didn't help; 26.8% didn't use it or it wasn't useful; 16.7% were unaware it could help.
- The difference between clients who actively used the FP services ("Users") and those who were enrolled but did not use the services ("Non-users") is substantial across perception, financial stability

Table 5 Financial Resilience

	Users of FP Services	Non-Users of FP Services	Key Difference
Ability to Save (Algo/Bastante)	86%	66%	Users exhibit a greater capacity to save.
Use of Savings to Cope with Emergency	50% used own savings	29.8% used own savings	Users rely more on their financial cushion.

Sale of Assets to Cope with Emergency	0% sold assets	12.8% sold assets	Users avoid erosive strategies like selling assets.

- Key insights: main coping mechanisms during shocks are credit, savings, and family. The dichotomy highlights that for the FP to be an effective financial and health protection tool, its activation and subsequent service delivery is an active resource for resilience

VI. GENERAL ENGAGEMENT AND SATISFACTION

- In general terms, the comparison between those who use and those who do not use the Insurance (FP) shows that it only makes a difference when it is actually activated. Users are more aware of the benefits, report better access to health services, some reduction in expenses, and greater savings capacity, and their positive evaluations of the insurance are concentrated in emergency situations. In contrast, those who do not use it are very similar to those without it: a lower perception of support, minimal reduction in expenses, and little appreciation of the insurance as a tool for coping with crises.
- At the same time, the differences in psychological well-being (GHQ-5) are small and not systematic, suggesting that the insurance primarily serves as a means of providing occasional health and financial support, rather than a profound transformation of psychosocial distress. In short, the added value of the FP is realized where there is actual use, while mere possession without activation generates very limited benefits.

Table 6 Comparison of Key Outcomes

Indicator	Users of FP Services (%)	Non-Users of FP Services (%)	Difference
Knowledge of benefits	95	80	15
Perceived improvement in health access (yes, yes a lot)	40	15	25
Perceived reduction in expenses (a bit, a lot)	17	9	8
High Satisfacción (satisfied, very satisfied)	51	18	33
Ability to save (some, a lot)	86	66	20
Faced an economic emergency (yes)	28	25	3
Emergency solved with insurance	2	0	2
Positive evaluation of insurance in emergency (some, a lot)	43	13	30
GHQ-5: Sleep (improved)	7	5	2
GHQ-5: Stress (improved)	7	6	1
GHQ-5: Activities (improved)	3	5	-2
GHQ-5: Depression (improved)	3	4	-1

VII. FP´S ROLE IN SHAPING HOUSEHOLD BEHAVIOS AND WELFARE

This study demonstrates that FP not only enhances access to healthcare, but also actively influences household financial and behavioral responses to risk, in line with the hypotheses outlined in the Theory of Change of this study and presented in Appendix 1. These findings are based on a linear probability model applied to representative survey data, detailed in Appendix 2.

- As observed in the administrative data, insured households report greater utilization of health services—particularly during periods of heightened health vulnerability, such as pneumonia outbreaks. Complementary survey and model-based evidence further indicate that insurance coverage and active use are significantly associated with higher household savings and more frequent medical consultations.
- The study finds that it is the active use of insurance services—rather than passive enrollment—that drives these positive outcomes. Linear regressions reveal that using FP increases the probability of saving in the past year by 8 to 16 percentage points, highlighting its meaningful contribution to financial resilience. These results remain robust after accounting for a wide range of client, household, and agency-level factors.
- The analysis shows a positive and statistically significant association between well-being challenges (such as health, educational, and mental health issues) and the likelihood of using FP services. In particular, families facing mental health difficulties are notably more likely to activate insurance benefits, even after controlling for a comprehensive set of covariates. This underscores FP's role as a support mechanism for vulnerable households confronting complex, interrelated welfare issues.

Taken together, the findings suggest that microinsurance like FP functions not only as a financial safety net but also as a behavior-shaping instrument. It encourages preventive healthcare use, promotes household-level savings, and facilitates access to integrated health and social services. These pathways highlight the potential of microinsurance to bridge financial inclusion with public health goals, and to serve as an effective policy tool for improving the resilience and well-being of underserved populations.

6. CONCLUSIONS

The evidence draws from both administrative utilization data and survey client-reported perceptions of change in access. The next section will answer each of the evaluation questions as follows:

TO WHAT EXTENT HAVE VFE'S SERVICES IMPROVED CLIENTS' ACCESS TO HEALTHCARE?

BVFE 's FP microinsurance program demonstrably improves clients' access to healthcare, particularly when clients actively utilize the services, fulfilling the program's promise of reducing barriers to timely care for low-income households. Administrative data confirms that insured individuals experience greater improvements in service utilization. This enhanced access is especially pronounced during periods of public health risk, as increases in pneumonia cases across provinces are strongly associated with a higher use of FP services, including compensation payments, telemedicine, and medication benefits. Moreover, the evaluation found that FP coverage and use are positively and significantly associated with a higher intensity of medical attention. When comparing clients who actively used FP services to insured non-users, 40% of users perceived an improvement in health access, versus only 15% of non-users.

The FP insurance acts as a critical catalyst for primary health contact, facilitating utilization that would otherwise not occur. Among clients who actively used FP services, only 20.8% had no health consultation in the last 12 months, whereas 66.1% of insured non-users had no attention during that same period.

The findings confirm that women with formal employment or with university education, are statistically less likely to enroll, BVFE has successfully implemented strategies to compensate for structural inequalities. For example, being female is associated with a lower enrollment probability, yet 63% of insured clients are women. Once enrolled, these groups utilize the insurance in ways that reflect their caregiving priorities: women, especially single women, tend to use the insurance principally for the benefit of their children and families.

HAVE CLIENTS EXPERIENCED REDUCED STRESS, GREATER PEACE OF MIND, OR IMPROVED EMOTIONAL WELL-BEING?

Clients generally reported high stability in their emotional and psychological well-being between 2024 and 2025, although the Seguro FP did not appear to cause a marked or sustained improvement in emotional well-being, stress reduction, or peace of mind. The GHQ-5 indicators (measuring sleep, tension, activity, depression, and happiness) showed high stability, with between 87% and 92% of respondents reporting their well-being remained stable or improved during that period. Perceptions of improvement were particularly notable among clients who experienced increased income and those who were covered by the insurance, but these associations were not definitively causal. The analysis concluded that the FP insurance primarily functions as a source of occasional health and financial support, rather than generating a profound transformation of psychosocial distress.

The comparison of psychological well-being between clients who actively used the FP services and those who did not showed differences that were small and not systematic. For instance, while active users showed slight signals of improvement in areas like sleep (7% improved for users vs. 5% for non-users) and happiness, these improvements were often offset by a slightly higher proportion of users reporting temporary deterioration. In domains like depression and the ability to enjoy activities, the differences in reported improvement between users and non-users were statistically minimal, suggesting that the FP insurance serves a role of contention against malestar rather than creating sustained psychological improvement.

HAS CHILDREN'S ACCESS TO HEALTH, EDUCATION, OR NUTRITION IMPROVED DUE TO VFE'S SERVICES?

Children's well-being and access to health services have shown modest but clear improvements attributable to the use of BVFE's FP microinsurance services, primarily in the domain of health access. These positive changes are concentrated almost exclusively in households that actively utilize the insurance, rather than merely possessing it.

Health Access (Improved): Households that used FP services reported significantly greater improvements in pediatric health access compared to insured non-users:

- Access to Medicines: 53% of users reported that their children had more access to medicines, versus only 19% of non-users.
- Easier Doctor Visits: 18% of users reported that their children could go to the doctor with more ease when sick, compared to 7% of non-users.
- Services like telemedicine (26% utilization) and ambulance services (36% utilization) were the most used services for children. The use of these services for children is strongly concentrated in households where the insured adult activates the service.

Education and Nutrition (Limited/Modest Impact): FP showed limited influence on educational and nutritional dimensions, which are more structural in nature:

- Schooling: Modest advances were reported in school attendance (continuity escolar/formación). However, analysis showed that difficulties in school attendance increased slightly overall from 10.0% (2023–2024) to 12.9% (2024–2025).
- Nutrition, Housing, and Sanitation: Perceived improvements in accessing more nutritious and varied foods, improved housing conditions, and better access to water/saneamiento were very low and showed minimal difference between users and non-users of the insurance.

These outcomes are viewed as structural determinants that largely exceed the direct scope of the FP insurance

ARE THERE POSITIVE CHANGES IN CHILDREN'S SECURITY OR HOUSING BECAUSE OF INSURANCE COVERAGE?

There is limited evidence of positive changes in children's security or housing conditions directly attributable to the FP microinsurance coverage. These factors are considered structural determinants that largely exceed the direct scope of the FP insurance.

While the evaluation sought to measure perceived improvements in these dimensions:

- Housing: Perceived improvements in housing conditions were very low. The survey found minimal difference in improved housing conditions between users and non-users of the insurance. The modest improvements that were observed are likely due to economic factors (such as increased income or liberation of healthcare spending) rather than a direct benefit of the insurance.
- Security (General): The FP insurance did not appear to modify the burden of work (child labor) in the home or business, with both users and non-users marking 6% improvement. Furthermore, perceived improvements in accessing more nutritious and varied foods and better access to water/sanitation were also very low and showed minimal difference between users and non-users.

The clearest positive impact of FP on children's well-being is seen in health access (e.g., access to medicine, doctor visits), not in structural areas like housing or sanitation

HAVE BVFE'S SERVICES HELPED CLIENTS PROTECT INCOME, SAVINGS, OR BUSINESS DURING EMERGENCIES?

VFE's FP microinsurance services have shown positive effects on protecting clients' financial stability, primarily by enhancing their savings capacity and acting as a protective mechanism during health shocks, rather than being used directly to cover general business or income losses.

Protection of Savings and Resilience:

The FP insurance is positively and significantly associated with the likelihood that households save. The study found that insurance users exhibit a notably larger effect on promoting savings behavior than those with coverage alone. Specifically, using the insurance increases the probability of having saved in the past 12 months by approximately 8 to 16 percentage points. This suggests FP enhances financial resilience by reducing uncertainty and potentially freeing up liquidity that would otherwise be held in precautionary reserves. Furthermore, when facing an emergency, clients who used FP services relied more on their own savings (50%) compared to non-users (29.8%) and avoided erosive strategies, with 0% of users reporting selling assets compared to 12.8% of insured non-users.

DO CLIENTS FEEL MORE ECONOMICALLY SECURE DUE TO THEIR INSURANCE COVERAGE?

Clients experience greater economic security due to their insurance coverage, primarily through an enhanced capacity to save and protection against asset depletion during health crises, although the perceived direct financial relief is mixed and its use for general economic emergencies is marginal.

The insurance serves a crucial role in preventing financial erosion during shocks: 0% of active users reported selling assets to cover emergency costs, compared to 12.8% of insured non-users. However, clients' perception of direct financial relief remains moderate: 40% of surveyed clients felt FP did not help reduce out-of-pocket expenses, and only 22.4% of those insured who faced an emergency felt that FP helped. The

insurance is rarely used as a direct tool for non-medical economic emergencies (1.1%), indicating that while it strengthens financial resilience through savings and shock mitigation, its scope is narrowly focused on health, limiting its perceived security against general economic crises.

ARE CLIENTS ABLE TO RECOVER MORE QUICKLY AFTER A HEALTH-RELATED INCIDENT BECAUSE OF THE SERVICES PROVIDED?

Yes, clients are able to recover more quickly after a health-related incident, particularly during aggregate health shocks, because the services provided by BVFE 's FP microinsurance ensure timely and sustained medical attention.

Statistical evidence confirms that the insurance enhances resilience to adverse aggregate health shocks. When respiratory illnesses, such as pneumonia cases, rise across provinces, insurance holders significantly more often use compensation payments, telemedicine, and medication benefits. This increased utilization suggests a quicker and more effective response during critical periods. This responsiveness enhances not only individual health outcomes but encourages earlier treatment and reduces delays in seeking care. For insured clients who faced a health-related emergency, those who used FP services were far more likely to resolve the emergency through BVFE's medical services (such as Brigade, Ambulance, or Telemedicine) (18.2%), compared to non-users (1.1%) or those without insurance (0.4%). This direct and rapid channeling of care via the insurance network facilitates faster recovery.

DO CLIENTS FEEL BETTER PREPARED TO HANDLE FUTURE EMERGENCIES?

Clients show mixed feelings regarding their preparation for future emergencies due to the FP microinsurance, as its effectiveness is primarily perceived in health crises, but its role in general economic shocks remains low.

The FP insurance contributes to preparedness by fostering financial stability: 86% of active users reported an ability to save "algo" (some) or "bastante" (a lot) of money, compared to 66% of insured non-users. This greater saving capacity and utilization of savings during shocks suggests enhanced financial resilience. Furthermore, active users avoid highly erosive strategies like selling assets (0% of users) when facing an emergency, compared to 12.8% of insured non-users, indicating better protection of assets and thus, better future preparation.

However, the perceived impact of the insurance on general emergency preparedness is moderate due to utilization gaps:

- Among all insured clients who faced an emergency (N=138), only 22.4% felt that FP helped (mucho or algo).
- A significant portion of insured clients were unaware of the insurance's potential role, with 16.7% reporting they "no sabía que podía ayudar en ese tipo de situaciones".
- The insurance is rarely used as a direct tool for non-medical economic emergencies (1.1%)[11].

Overall, while the insurance strengthens clients' financial cushions and their ability to handle *health-related* shocks through timely service use, a large segment of insured clients experiences subutilization by unknown factors and by the limited scope of coverage. This limits the overall feeling of being fully prepared for a range of future crises.

HOW DO THE OUTCOMES OF BVFE'S SERVICES DIFFER FOR VENEZUELAN MIGRANTS COMPARED TO ECUADORIAN CLIENTS?

[11] It's worth noting that FP Insurance, by design, has limited coverage, so high-cost emergencies are not covered.

Venezuelan migrant clients of BVFE exhibit distinct behaviors and outcomes related to the FP microinsurance compared to Ecuadorian clients, particularly concerning enrollment and utilization of specific services.

Enrollment: Venezuelan nationality is a strong predictor of enrollment in the FP microinsurance. Venezuelan migrants show a 6.5 percentage point higher likelihood of enrollment compared to Ecuadorian nationals. This elevated participation underscores the program's reach within vulnerable migrant populations who are often excluded from traditional financial systems.

Service Utilization and Access to Health: Once enrolled, there are measurable differences in how Venezuelan clients utilize the services compared to Ecuadorian clients, especially during public health shocks:

- Targeted Use during Shocks: Venezuelan holders are more likely to use telemedicine and medicine compensations than Ecuadorians when controlling for structural differences across provinces. This suggests that FP plays a crucial role for migrants in providing quick assistance during illness peaks.
- Holder vs. Child Attention: Attention requested by the insurance holder (the adult client) is more frequent when the holder is Venezuelan. However, the use of services for children (NNA) is low in almost all items for Venezuelan clients, potentially requiring specific messaging or a review of documentary barriers.
- Telemedicine Preference: Venezuelan clients demonstrate a higher use of telemedicine compared to other remote services.

HAVE MIGRANT CLIENTS EXPERIENCED IMPROVEMENTS IN THEIR WELL-BEING OR PROTECTION DUE TO PARTICIPATION?

Migrant clients, specifically those of Venezuelan nationality, exhibit improved protection and well-being primarily through enhanced enrollment and targeted health service utilization via the FP microinsurance, although the overall perception of financial relief is less clear compared to Ecuadorian clients.

Perceived Economic Security:

- Savings: Venezuelan clients show a less palpable perception of financial relief and saving capacity compared to the dominant Ecuadorian group, although the sample size for this group is smaller.
- General Perception: Overall, while the FP program effectively reaches Venezuelan migrants, their responses regarding satisfaction and financial relief tend to show lower levels of satisfaction and more neutrality compared to the larger Ecuadorian segment, likely reflecting different expectations and potential frictions in access.

7. RECOMMENDATIONS

1. **To what extent have BVFE's services improved clients' access to healthcare?**
   - To maximize the impact of FP, BVFE should prioritize strategies that promote the active use of insurance services, not just enrollment. This presents a strategic opportunity to increase healthcare access, strengthen client engagement, and enhance the program's social impact, while maintaining its sustainability.
   - Expand client education campaigns on service availability and activation procedures, especially during health risk periods.
   - Keep outreach to less educated or informally employed women to promote equitable access.
2. **Have clients experienced reduced stress, greater peace of mind, or improved emotional well-being?**
   - Strengthen the visibility and uptake of existing psychological assistance services by implementing targeted communication strategies that raise awareness among clients.

- Monitor and assess client expectations vs. service outcomes to adjust messaging and improve satisfaction.

3. **Has children's access to health, education, or nutrition improved due to BVFE's services?**
   - Strengthen communication to highlight child-related benefits, especially in households where the insured adult may not recognize available services.
   - Prioritize expansion of child-focused health services within the insurance, such as telemedicine for pediatric cases and accessible medication delivery.
   - Explore pilot programs that link insurance with school health campaigns or nutrition awareness through Ambulancia Naranja/Brigadas Medicas services.
4. **Are there positive changes in children's security or housing because of insurance coverage?**
   - Collaborate with complementary social programs to address structural determinants such as housing, nutrition, and sanitation.
5. **Have BVFE's services helped clients protect income, savings, or business during emergencies?**
   - Reinforce FP's role as a financial resilience tool through financial literacy programs that help clients manage savings and emergencies.
   - Documenting and promoting positive behaviors (e.g., clients saving instead of selling assets by social media) as case studies for peer learning.
6. **Do clients feel more economically secure due to their insurance coverage?**
   - Expand communication around the economic value of the insurance, not just the health aspects.
   - Address knowledge gaps regarding the use of the insurance for economic emergencies, especially among users who were unaware of its utility.
   - Explore new coverage innovation to include modest, flexible benefits for non-medical emergencies.
7. **Are clients able to recover more quickly after a health-related incident because of the services provided?**
   - Maintain and scale up services like telemedicine and Ambulancia Naranja, which have shown strong performance during health shocks.
   - Enhance early detection and follow-up protocols, especially in times of elevated public health risk.
   - Establish partnerships with local health providers to expand access during crises.
8. **Do clients feel better prepared to handle future emergencies?**
   - Conduct targeted education campaigns on how FP supports preparedness, especially financial resilience.
   - Investigate reasons behind service underuse and develop user-centered solutions (e.g., simplified processes, reminders).
9. **How do the outcomes of BVFE's services differ for Venezuelan migrants compared to Ecuadorian clients?**
   - Maintain and strengthen inclusive enrollment strategies for migrants.
   - Address gaps in child-focused service utilization among migrant families, possibly through improved messaging or reduced documentation barriers.
   - Tailor communication to emphasize services that migrants are more likely to use, such as telemedicine.
10. **Have migrant clients experienced improvements in their well-being or protection due to participation?**
    - Conduct qualitative follow-ups with migrant clients to better understand satisfaction levels and hidden barriers.
    - Reinforce migrant-focused financial education, emphasizing how insurance contributes to stability and resilience.

General recommendation

The impact evaluation study conducted for VisionFund Ecuador provides a rich and comprehensive dataset that represents an asset for continued analysis. The information collected not only supports the current findings but also holds significant potential for future research and learning that can inform strategic decisions, both within the institution and across the broader financial inclusion and health service sectors in Latin American Countries. It is important to note that all data regarding the users of the Ambulancia Naranja and Brigadas Médicas services were gathered exclusively through the structured survey instrument applied during the fieldwork phase. We strongly recommend investing in the development of administrative data systems for these services to improve real-time monitoring, facilitate impact measurement, and support continuous improvement in service delivery.

APPENDIX

APPENDIX 1

THEORY OF CHANGE

CAUSE – EFFECT RELATIONSHIP

Sphere of Control	Narrative	Cause–Effect Relationship	Assumptions or Contextual Influences	Validation of Assumptions by evidence gathered in this study.
Impact	Enhance emotional and mental well-being among vulnerable populations.	**If** families access health services and compensations, **then** they reduce stress and improve their well-being.	Structural barriers (poverty, weak public health systems) are mitigated.	It functions effectively when public health conditions deteriorate.
Outcome	Increase access to timely care and improved household economic behaviors.	**If** the insurance is understood and accessed, **then** the use of health services and financial resilience improves.	The household recognizes the benefits of the insurance and knows how to activate them**;** there is trust in BVFE**.**	Inclusive and effective in promoting financial resilience, though some gaps remain in effective use.
Outputs	Access to FP Services: • E-Doctor • Telemedicine • Medicines • Legal Assistance • Psychological Assistance • Medical Expenses for Accidents • Accidental Death Indemnity.	**If** clients enroll and services are available, **then** households acquire protection tools.	Families have clear information**,** accessible channels**,** and culturally appropriate care**.**	Benefits are obtained, but there are some communication gaps regarding how to access them..
Activities	FP clients enrollment	**If** the activities are implemented as planned, **then** the expected outputs are generated.	There is operational capacity for coverage**,** functional referral protocols**,** and trained staff**.**	
Inputs	Financial resources for transfers, trained personnel, coordination mechanisms.	**If** adequate resources are mobilized, **then** the activities are carried out as planned.	There is sustained financing**,** a stable insurance partner**,** and trained personnel and logistical support with the capacity to respond to clients	

SPECIFIC OBJECTIVE	REFERENCE	RESULTS	JUSTIFICATION
Quality of life	• Dhungana (2023), "Microfinance and Maternal and Child Health in Nepal", p. 79 • Leatherman et al. (2012), "Integrating microfinance and health strategies", p. 94 • Blanchard-Horan, C. (2007). Health microinsurance in Uganda: Affecting malaria treatment seeking behavior. 30(8–9), p. 765–789.	• Improvements in maternal and child health, lower mortality and violence • Changes in health knowledge and behaviors • Reduced vulnerability and better risk management	• Participation in microfinance improves health and reduces key vulnerabilities • Integrating health and microfinance can lead to measurable health improvements • Microinsurance helps manage risks, enhancing overall quality of life
Children's well-being	• Lorenzetti et al. (2017), "Systematic review on microfinance and health", p. 12 • Hamad et al. (2011), cited in Lorenzetti et al. (2017) "Evaluating the effect of integrated microfinance and health interventions", p. 741 • ILO (2010), "Protecting the Poor: Microinsurance Compendium Vol. 1", p. 50	• Increase in institutional delivery, early breastfeeding and immunization • Reduction in incidence of childhood diarrhea • Improved height-for-age scores	• Integrated programs improve knowledge and childcare practices • Specific interventions prevent illness and improve child health • Health education linked to microcredit impacts children's physical development
Economic stability or financial security	• Leatherman et al. (2012), "Integrating microfinance and health strategies", p. 57 • Chuma et al. (2007), cited in Leatherman et al. (2012), p. 56 • Blanchard-Horan (2007), "Health microinsurance in Uganda", p. 775	• Reduced need to sell assets or take high-interest loans • 30% faced catastrophic health costs • Lower hospitalization among insured individuals	• Integrated services help face emergencies without harming economic stability • Lack of protection can reverse family economic gains • Microinsurance reduces indirect costs and income loss
Resilience	• Blanchard-Horan (2007), "Health microinsurance in Uganda", p. 776 • McCord (2001), "Health microinsurance case studies", p. 9 • Cohen & Young (2007), Mosley (2015), cited in Access to Insurance Initiative (A2ii), (IAIS), & Munich Re Foundation. (2021). "Microinsurance on Financial Inclusion", p. 45	• Earlier seeking medical care • Lower need for extreme measures post-crisis • Reduction in precautionary savings usage	• Insurance encourages early attention, reducing disease severity • Insurance prevents harmful decisions such as selling assets or school dropouts • Insurance boosts confidence in facing shocks, enhancing recovery
Migrants	• Bowser et al. (2025), "The impact of regularization policies on health access", p. 18 • Konig et al. (2024), "Health insurance access for migrants in Thailand", p. 9 • Pudpong et al. (2019), "Migrant health insurance in Thailand", p. 8	• Stabilized healthcare use during shocks • Increased medical service use by migrants in Thailand • Lower financial burden on hospitals and higher health awareness	• Insurance protects access in crisis contexts for migrants • Microinsurance improves healthcare access among migrants • Insurance enhances protection and reduces migrants' expenses
Awareness	• Hadi (2001), cited in Lorenzetti et al. (2017), p. 13 • ILO (2010), "Protecting the Poor: Microinsurance Compendium Vol. 1", p. 50 • Blanchard-Horan (2007), "Health microinsurance in Uganda", p. 783	• Greater maternal knowledge and service use • Insurance use depends on understanding its function • Greater willingness to seek early care	• Combining microcredit and health strengthens knowledge and service use • Impact depends on users understanding and using insurance effectively • Knowledge of insurance influences healthy behaviors

APPENDIX 2

MICROINSURANCE AND HEALTH RESILIENCE: DETERMINANTS OF UPTAKE AND EFFECTS OF FP IN ECUADOR

Summary

Objective: This study investigates the determinants of enrollment in BVFE's FP microinsurance program. It evaluates its impact on access to health services and resilience to adverse aggregate health shocks. Finally, it explores the relationship between well-being problems, insurance use, access to health, and household savings.

Data: It analyzes a comprehensive administrative dataset and a representative survey. The data integrates information on microcredit transactions, health insurance uptake, utilization of health services, and household savings. It also employs a province-level panel of pneumonia cases to examine the program's effectiveness under varying health risk conditions.

Method: It estimated linear, panel data, and difference-in-difference models to estimate the determinants of insurance uptake, the determinants of the intensity of the usage of the insurance, the resilience to adverse shocks, the effect of the use of the insurance on household savings and access to medical attentions, and the relationship between well being issues and access to help through the insurance.

Results: Using administrative data, the study identifies key factors linked to insurance participation and shows that microinsurance enhances healthcare access, with insured individuals experiencing greater improvements in service utilization—particularly during periods of heightened pneumonia incidence. Survey evidence further indicates that insurance coverage and use are positively and significantly associated with households' likelihood of saving and with a higher intensity of medical attention. The results also show that households facing well-being challenges make greater use of insurance services, underscoring the role of microinsurance in supporting vulnerable populations through integrated health-related benefits.

Conclusion: These results have important implications for the strategic expansion and targeted promotion of microinsurance programs, especially in underserved regions and among vulnerable populations typically excluded from formal financial systems. The study highlights the potential of microinsurance as a policy instrument to strengthen health system resilience and reduce disparities in healthcare access.

1. INTRODUCTION

Microinsurance products bundled with microcredit services have the potential to enhance financial protection for vulnerable populations, especially when designed considering the social and economic conditions of the context (ILO, 2010; Leatherman et al., 2012). The literature has highlighted three main conditions to ensure a positive effect of microinsurance on well-being. First, microinsurance design should be carefully adapted to the specific needs and preferences of the target population, with particular attention to effective field implementation and the selection of appropriate distribution channels (Lorenzetti et al., 2017; McCord, 2001). Second, microinsurance programs must emphasize the critical role of guaranteeing high-quality service provision to achieve the intended health and financial outcomes (Blanchard-Horan, 2007). Finally, providing precise, clear, and actionable information to beneficiaries is essential to facilitate understanding and promote higher utilization of insurance benefits, as broadly discussed by the International Labour Organization and the World Health Organization in their conceptual frameworks on social protection (ILO, 2010; WHO, 2010). Despite its potential, the study of how low-cost, low-coverage insurance products can promote resilience and well-being remains in its early stages, particularly in Latin America (Dhungana, 2023).

BVFE offers the FP insurance, a low-cost life and health insurance product available to its credit clients. However, the factors influencing insurance enrollment across diverse client segments, as well as the impact of this insurance on access to health care and resilience to health shocks, are still not fully understood. Previous studies show that enrollment decisions are associated with both demographic and economic factors, including gender, education level, income, and financial stability (Lorenzetti et al., 2017; K¨onig et al., 2024). This study analyzes the determinants of insurance uptake using administrative data on 210,806 loans (with and without health insurance) granted to 108,694 clients by BVFE between August 2021 and June 2025. It also employs administrative data on 13,039 compensation and health insurance services used by insurance holders and their beneficiaries, aligning with evidence that the utilization of microinsurance depends on institutional trust and accessibility to health services (Pudpong et al., 2019).

We begin by characterizing the demographic, socioeconomic, and credit-related variables associated with the likelihood of insurance enrollment. We also examine key interaction effects to identify heterogeneous adoption patterns across subgroups, following the methodological approaches of studies such as Leatherman et al. (2012), which link financial inclusion to preventive health. We then analyze how specific characteristics are associated with the likelihood of using the insurance benefits, including monetary compensation, telemedicine consultations, access to medicines, and e-doctor services—a dynamic also observed in Asian and African experiences (McCord, 2001; König et al., 2024). We pay particular attention to four characteristics of the insurance holder and their family: gender, number of children, age, and nationality. Furthermore, we explore the characteristics of the holder and their family that influence how different household members use the insurance's compensations and services with varying levels of intensity. Finally, we assess whether the insurance makes clients more resilient to aggregate health risks by using the insurance services more intensively during periods with high levels of respiratory disease contagion, as suggested by WHO's evidence on structural vulnerability and health inequality (WHO, 2010).

The findings contribute to a better understanding of microinsurance demand and provide actionable insights to guide the strategic expansion and targeted marketing of BVFE's insurance services, particularly in underserved regions and among populations typically excluded from traditional financial systems (Bowser et al., 2025; Coka Barriga & BVFE, 2025). The study also explores a channel through which BVFE insurance can improve family well-being by providing access to health services and strengthening resilience to adverse health shocks (Lorenzetti et al., 2017; Leatherman et al., 2012).

Studying the determinants and effects of microinsurance is crucial. Despite the significant global growth in microinsurance coverage, an estimated 90% of the world's population remains unprotected against escalating risks such as health crises, natural disasters, and conflicts. According to the Landscape of Microinsurance 2024 report, insurers, policymakers, and development partners must prioritize expanding access, improving affordability and gender inclusivity, fostering long-term market sustainability, and narrowing the protection gap (Microinsurance Network, 2024).

This study contributes to the microinsurance literature in at least three ways. First, it explores the demand for microinsurance in a middle-income Latin American country, whereas previous literature has focused mainly on low-income African and Asian contexts (Dhungana, 2023; ILO, 2010). Second, it examines a channel through which microinsurance can increase population resilience to aggregate health shocks (Pud-pong et al., 2019). Third, it contrasts the benefits of different health insurance services, including monetary compensation, telemedicine, access to medicines, and e-doctor services, in line with recent findings on the integration of health and microfinance (Leatherman et al., 2012; Lorenzetti et al., 2017).

The remainder of this paper is structured as follows. Section 2 describes the administrative datasets used in this study, the outcome and control variables, and a new dataset on pneumonia cases by province, as well as descriptive statistics. Section 3 presents the results of the analysis on the determinants of health insurance enrollment. Section 4 reports the results of the analysis on the health attention of FP holders and their

children. Section 5 examines resilience to pneumonia cases in Ecuador through the use of insurance services. Finally, Section 6 concludes.

2. DATA

2.1 CREDIT AND INSURANCE DATA

This study utilizes the complete credit portfolio of BVFE covering the period from January 2021 to June 2025, which includes a total of 210,806 loans granted to 108,694 clients. Table1 presents descriptive statistics for the variables used in the analysis, providing an overview of the socioeconomic and demographic profile of BVFE credit clients. This type of analysis is essential to understand how access to credit and microinsurance can contribute to household economic stability, particularly in contexts of vulnerability and limited formal employment (ILO, 2010; Leatherman et al., 2012).

From BVFE's administrative records, we obtain a comprehensive set of demographic and geographic variables that characterize the insurance beneficiaries. These variables include borrower demographics (age, gender, marital status, nationality, and rural residence), socioeconomic indicators (formal employment status, reported labor income, proxy measures of wealth, and access to financial services), educational attainment (categorized as primary, secondary, or tertiary education), and credit-related characteristics (duration of the client's relationship with BVFE, loan term, and number of dependents). All monetary values are expressed in nominal U.S. dollars. Observations with missing data—less than 0.5 % for any given variable—were excluded from the analysis to maintain data integrity. This methodological approach follows previous studies on financial inclusion and risk management in microfinance, which highlight the importance of data quality to accurately measure the effects on economic stability (Lorenzetti et al., 2017).

The average applicant is approximately 38 years old, with women representing 62 % of the sample and single individuals accounting for 61 %. Only 0.6 % report formal salaried employment, indicating a predominance of informal or self-employment, a phenomenon widely described in the microfinance literature in Latin America (Dhungana, 2023). Regarding nationality, 0.7 % of applicants are Venezuelan and 2.2 % are Colombian, reflecting the growing participation of migrant populations in financial inclusion programs and their relevance to income stability and access to basic services (Bowser et al., 2025).

Educational attainment is concentrated at the primary (46 %) and secondary (46 %) levels, while only 5 % hold a university or postgraduate degree. The average reported monthly income is USD 1,498, and average wealth is USD 14,974. Finally, BVFE clients' tenure with the institution averages 3 years. These indicators of human capital and economic stability are positively associated with greater financial resilience, which is one of the pillars for microinsurance to have sustainable effects on household well-being (Leatherman et al., 2012).

Table 2 compares the means of individual, household, and economic characteristics between clients who purchased the microinsurance and those who did not. Gender composition is similar across both groups (around 60 %), although insured clients have fewer single individuals (60 % vs. 70 %). There are some educational differences between groups, but tertiary education rates remain low in both (approximately 5 %). Economically, insured clients report higher average monthly income (USD 1,543 vs. USD 1,237) and greater wealth, suggesting a positive association between economic capacity and insurance uptake, consistent with prior findings on microinsurance and financial stability (Lorenzetti et al., 2017; König et al., 2024). Additionally, insured clients exhibit a longer average tenure with BVFE (3.1 vs. 2.9 years), which can be interpreted as a sign of institutional trust and lower economic vulnerability (Pudpong et al., 2019).

We also employ the complete database of *FP* compensations, covering the period from January 2022 to June 2025, with a total of 13,039 compensations corresponding to 6,584 clients. The compensation data includes monetary payments and the number of attentions in the different insurance services by type of beneficiary. Table 3 presents descriptive statistics for the variables used in the insurance compensation analysis, considering

all clients who used the service. The data show that telemedicine consultations range from 0 to 8, medicine consultations from 0 to 8, and e-doctor consultations from 0 to 16. The number of attentions by insurance holders ranges from 0 to 8, while consultations for their children range from 0 to 10. On average, insurance holders have 1.4 children, are primarily women, and are 37 years old.

2.2 RESPIRATORY ILLNESSES DATA

To analyze the impact of adverse aggregated health shocks on insurance usage, we construct a monthly province-level dataset that includes the number of pneumonia cases. We built the database by using official records from the Ministry of Public Health of Ecuador. Specifically, we use the hospital discharge databases for the years 2022, 2023, and 2024, which provide detailed information on diagnoses, age, province of residence, and other health indicators. We filter only pneumonia cases, selecting the variables province and age group to distinguish between total cases into children and adults. This database allows us to identify monthly peaks of infection and higher concentrations of cases in specific provinces, highlighting both the temporal and geographic heterogeneity of the phenomenon.

The number of pneumonia cases is used as an external health shock in the analysis aimed at capturing changes in public health conditions. This approach makes it possible to measure how fluctuations in the health environment promote the use of medical services offered by FP. Table 4 presents the cases by province for the year 2022. We observe considerable heterogeneity across provinces. For example, Galapagos presented 8 cases, while Pichincha presented 6,194 cases. Figure 1 shows the evolution of pneumonia cases over time. The table also shows a significant heterogeneity in terms of population and population density, with the province with more cases being the one with a larger population and population density.

2.3 SURVEY DATA

To assess the effects and satisfaction associated with the FP insurance program, we designed a purpose-specific survey targeting clients of BVFE [12]. A structured sample of clients—both with and without FP insurance—was selected to enable comparative analysis. The survey was conducted over five weeks between September and October 2025 and included retrospective questions comparing 2024 to 2025. These comparisons were self-reported by respondents within the same instrument. The survey was structured around six core dimensions designed to capture the multifaceted experience of households: (1) socio-demographic and household characteristics; (2) effective use of BVFE services; (3) perceived quality of life and well-being; (4) children's well-being; (5) financial resilience and economic stability; and (6) user experience, awareness, and suggestions for improvement.

The survey was administered via an online platform. Dashboards and survey indicators were regularly reviewed by the quality assurance team in coordination meetings throughout the survey period, ensuring that sampling quotas and representativeness goals were being met. The sample was drawn from BVFE's administrative database using stratified random sampling to ensure proportional representation across insurance status, gender, and migrant status. Several eligibility criteria were applied to define the survey population: clients had to be active between January 2024 and December 2025; only one client per household was inter-viewed; respondents were required to be between 18 and 65 years old; and only current loan holders—whether up-to-date, overdue, or fully overdue—were included, while clients with cancelled, written-off, or foreclosed loans were excluded. To maintain clear categorization, clients were required to have all their loans either with or without FP coverage. Finally, the sample included individuals from the most representative nationalities in the portfolio: Ecuadorian, Venezuelan, and Colombian.

[12] A detailed methodology survey report see Appendix 4 of this report.

A total of 1,215 surveys were successfully completed, representing 81 percent of the target for a 95 percent confidence level with a 7 percent margin of error, 104 percent of the target for a 90 percent confidence level with a 7 percent margin of error, and 184 percent of the target for a 90 percent confidence level with a 10 percent margin of error. These figures confirm that the sample achieved is statistically robust at a 90 percent confidence level with a 7 percent margin of error, and more than exceeds the minimum threshold required for a 10 percent margin of error. Survey completions were distributed as follows: 675 clients without insurance, 540 clients with insurance, 697 women (57 percent), and 518 men (43 percent)[13].

Although certain smaller segments—such as Venezuelan and Colombian clients—were underrepresented relative to their sampling targets, the key demographic strata, particularly Ecuadorian women and men with and without insurance, reached or surpassed 90 percent of their intended sample sizes. As a result, the final sample provides strong analytical power for the overall population and the major subgroups, enabling meaningful comparisons between FP-insured and non-insured clients

3. ADMINISTRATIVE DATA ANALYSIS

3.1 DETERMINANTS OF *FP* ENROLLMENT

Table 5 reports the results from a set of linear probability models where the dependent variable equals one for credit clients enrolled in FP and zero otherwise. Columns (1) to (5) present specifications examining the association between insurance enrollment and different sets of explanatory variables, while column (6) shows the specification including all covariates simultaneously. All models include canton fixed effects to control for time-invariant characteristics at the canton level, and month–year fixed effects to control for macroeconomic factors that affect enrollment of all clients.

Overall, gender, age, and education emerge as significant predictors of insurance uptake. Being female is associated with a lower probability of insurance enrollment, while older age and university-level education are also negatively correlated with participation. These results mirror patterns observed in other contexts, where gender differences in financial decision-making and healthcare access influence microinsurance adoption (Blanchard-Horan, 2007). For instance, evidence from Uganda shows that women, despite being primary caregivers, face greater barriers to joining microinsurance schemes due to income constraints and limited financial autonomy.

Conversely, formal employment, single marital status, and ownership of a savings account are positively associated with enrollment. The effect of having a savings account is particularly pronounced, increasing the likelihood of insurance enrollment by 25 percentage points. Similarly, financial inclusion and stable employment conditions have been shown to facilitate retention in insurance systems by improving payment consistency and strengthening trust in service providers (Pudpong et al., 2019). Venezuelan nationality is also a strong predictor, with Venezuelan migrants showing a 6.5 percentage point higher likelihood of enrollment compared to Ecuadorian nationals. Higher income and wealth are negatively and significantly associated with uptake, suggesting that the insurance plays an inclusive role by attracting individuals with limited access to traditional protection mechanisms.

The joint model explains 32 % of the variation in insurance enrollment, which is substantial for cross- sectional observational data. In summary, the results indicate that FP insurance tends to attract migrants and clients with lower education and income levels, while enrollment is lower among women and older clients.

The findings presented in Table 1 indicate that the influence of individual characteristics on the likelihood of possessing FP insurance is heterogeneous. The effects differ significantly depending on specific combinations of demographic and socioeconomic attributes. Generally, being female has a statistically significant and negative association with insurance coverage; however, this effect is moderated when interaction terms are incorporated

[13] See Appendix 3 for more information.

into the model. This section also examines how enrollment varies across different demographic groups. For example, single women and single employees are more likely to enroll, while employed women and those with university education are less likely to do so. These patterns reinforce the idea that interest in FP strongly depends on family status, gender, and education level, and that these factors interact in complex ways rather than exerting uniform effects.

3.2 DETERMINANTS OF CHILDREN AND INSURANCE HOLDER ATTENTION

Table 6 relates the number of attentions by the insurance holder and the beneficiary children of FP with some characteristics of the insurance holder (gender, nationality, and age) and the family composition (number of children). The results suggest that the number of children's attentions is higher when the insurance holder is a woman, younger, and has more children. This pattern is consistent with previous evidence showing that women tend to prioritize healthcare access for their children, which directly contributes to child well-being and improved household health outcomes (Lorenzetti, Leatherman, & Flax, 2017). Likewise, the attentions made by the holder are more frequent when the holder is female, older, Venezuelan, and has fewer children. These findings emphasize that the use of insurance by different types of beneficiaries depends on both individual characteristics and family composition.

Table 10 examines how the use of FP services varies between insurance holders and their dependents. The results show a positive relationship between the number of medical visits and the use of key services such as compensation payments, telemedicine, and medication. This means that as families access healthcare more frequently, they also make greater use of their insurance benefits, confirming that FP effectively facilitates access to essential health services for both adults and children. Table 11 presents the results of how the use of insurance services varies between holders and dependents using panel data.

3.3 PERIODS OF PNEUMONIA AND HEALTH ATTENTIONS

Table 7 explores the impact of province-level cases of children's pneumonia by estimating a difference-in-difference econometric model with insurance holder fixed effects and time fixed effects. Insurance holder fixed effects control for all the time-invariant characteristics associated with the holder and their family, and time fixed effects control for all the macro factors in Ecuador that influence the use of the insurance compensations and services. The results show that increases in pneumonia cases across provinces are strongly associated with a higher use of FP services. When respiratory illnesses rise, insurance holders significantly more often use compensation payments, telemedicine, and medication benefits. E-doctor consultations remain

mostly unaffected. These results suggest that during public health shocks, households rely more on insurance for both financial and medical support. The effect is more pronounced in remote or low-income areas, where formal healthcare access is limited, indicating that FP plays a key role in providing quick assistance during illness peaks.

Table 8 expands the previous analysis by incorporating control variables such as gender, age, number of children, and nationality. To explore the effect of the time-invariant characteristics of the holder and their families, we exclude holder fixed effects. In this version, individual fixed effects are replaced with provincial fixed effects, allowing the model to control for structural differences across provinces—such as healthcare infrastructure, population density, or local economic conditions—that may influence insurance usage. The results confirm that increases in pneumonia incidence remain strongly associated with higher use of compensation payments, telemedicine, and medication, while e-doctor consultations continue to show no significant effect. Families with more children also appear to rely on insurance more, suggesting that FP acts as a substantial safety net for households with dependents. Venezuelan holders are more likely to use telemedicine and medicine compensations than Ecuadorians. Women tend to use telemedicine services more frequently than

men, likely due to their role in managing household health. Older holders use insurance services less often than younger holders. Overall, the table demonstrates that health shocks lead to higher demand for medical attention and that this response varies across different demographic groups.

The findings remain consistent: higher pneumonia incidence continues to be associated with a greater use of compensation payments, telemedicine, and medication among policyholders. This confirms that the response to health shocks is not dependent on individual-level variation but is also observable at the regional level. Overall, the results reinforce the conclusion that FP effectively serves as a protective mechanism during unexpected health events, providing both financial support and timely access to medical services when public health conditions deteriorate.

3.4 DISCUSSION

The results highlight the central role of microinsurance in improving both participation in risk-pooling arrangements and access to essential healthcare. First, by identifying the key factors associated with insurance participation, the study sheds light on the mechanisms through which microinsurance can extend coverage among low-income or otherwise vulnerable populations. These participation patterns are not merely descriptive; they reveal how product design, affordability, household characteristics, and information frictions shape decisions to enroll. Understanding these drivers is critical, as insurance participation is a precondition for any downstream welfare effects. The evidence suggests that when microinsurance is made accessible and responsive to household needs, it can substantially reduce financial and logistical barriers that typically hinder timely care.

Furthermore, the finding that insured individuals experience greater improvements in access to health services—especially during periods characterized by higher pneumonia incidence—underscores the dynamic, countercyclical value of microinsurance in public health. This pattern suggests that insurance does not simply facilitate routine healthcare use; it becomes particularly salient when health risks intensify. In contexts where seasonal or epidemic spikes can overwhelm both household finances and local health systems, microinsurance provides a stabilizing mechanism that enables prompt and sustained medical attention. Such responsiveness enhances not only individual health outcomes but also the broader effectiveness of public-health systems by encouraging earlier treatment, reducing delays in seeking care, and mitigating the burden on emergency services during high-incidence periods.

Taken together, these findings indicate that microinsurance operates at the intersection of financial protection and health-system strengthening. By promoting participation in insurance schemes and improving access during both normal and high-risk periods, microinsurance can serve as a policy lever that enhances resilience, facilitates preventive care, and supports more equitable health outcomes. These results therefore reinforce the potential of microinsurance to complement public provision, particularly in settings where health shocks are frequent and disproportionately affect vulnerable households.

4. SURVEY DATA ANALYSIS

4.1 INSURANCE AND HOUSEHOLD SAVINGS

Table 12 explores the relationship between FP's coverage and use and household savings. The dependent variable in all specifications in the table is a dummy variable equal to 1 if the insurance holder saved money in the last 12 months. All specifications include an explanatory variable equal to 1 if the household faced an economic emergency in the last 12 months. All specifications include dummies for FP coverage, FP use, and both variables simultaneously. These variables examine potential differences between credit customers with and without insurance coverage and explore the benefits of FP's insurance services. Additionally, the model specifications in columns 4 to 6 include a comprehensive set of client and family characteristics and agency

fixed effects. The agency-level fixed effects control for potential economic, geographic, and demographic time-invariant factors that may influence household savings.

The table shows that both insurance coverage and insurance use are positively and significantly associated with the likelihood that households save. Across specifications, insurance users exhibit a notably larger effect than those with coverage alone, suggesting that the active use of FP's insurance services, rather than mere enrollment, plays a more substantial role in promoting household savings behavior. Importantly, these findings remain robust after controlling for a comprehensive set of client and family characteristics as well as agency-level fixed effects, which absorb economic, geographic, and demographic factors that are constant within agencies. The economic magnitude of the results is also meaningful: using the insurance increases the probability of having saved in the past 12 months by approximately 8 to 16 percentage points, underscoring the substantive influence of insurance utilization on household financial resilience.

4.2 INSURANCE AND MEDICAL ATTENTION

Table 13 examines the relationship between FP's insurance coverage and use and the intensity of medical attention, measured on a scale from 0 (no medical attention) to 5 (eight or more medical attentions). All specifications include an indicator for whether the household experienced an economic emergency in the past 12 months, alongside dummy variables for FP coverage, FP use, and the simultaneous inclusion of both variables. These variables allow us to identify differences in medical service utilization between credit customers with and without insurance, thereby capturing the potential benefits of FP's insurance products for access to health care. As before, columns 4-6 include a comprehensive set of client and family characteristics, along with agency-level fixed effects. The inclusion of agency fixed effects helps account for time-invariant economic, geographic, and demographic factors that could influence the intensity of medical attention.

The table shows that both insurance coverage and insurance use are positively and significantly associated with higher intensity of medical attention. However, once both variables are controlled for, the coefficient for insurance use is the only one that remains highly significant. This suggests that effectively using FP's insurance services plays a more critical role in increasing the frequency of medical consultations than mere enrollment alone. These results are robust to the inclusion of an extensive set of household- and client-level controls, as well as agency-level fixed effects, which absorb unobserved, time-invariant agency-level characteristics. The economic magnitude of the findings is sizable.

4.3 HOUSEHOLD PROBLEMS AND USE O FP

Table 14 examines the relationship between FP use and different household well-being problems. Column 1 includes an indicator for whether the children in the household experienced severe cold issues during the academic period 2024-2025. Column 2 includes an indicator for whether the children's school absenteeism during the academic period 2024-2025. Column 3 includes our index of mental health problems (GHQ-5). Columns 4 to 6 augment the previous specifications with a comprehensive set of control variables and with agency fixed effects. The inclusion of agency fixed effects helps account for time-invariant economic, geographic, and demographic factors that could influence the intensity of medical attention.

The table shows a positive association between health, educational, and mental health problems and the use of FP services. All coefficients are positive, though they are statistically significant in the baseline regressions. The positive association between mental health issues and FP use remains highly statistically significant even after controlling for all set of controls. Overall, the results suggest that FP is a tool that families employ to face well-being problems.

4.4 DISCUSSION

The results collectively point to the multifaceted role that microinsurance can play in shaping household behavior and welfare (see Figure 2). First, the positive and significant associations between both insurance coverage and insurance use with the likelihood of saving suggest that microinsurance may enhance financial resilience not only by reducing exposure to shocks but also by promoting forward-looking financial behaviors. Insurance can reduce uncertainty and free up liquidity that would otherwise be held in precautionary reserves, allowing households to accumulate savings more systematically. This dynamic is consistent with theories of precautionary savings, where the availability of risk-pooling instruments substitutes for costly self-insurance. Moreover, the fact that insurance use—not just coverage—is correlated with saving indicates that active engagement with insurance products may reinforce financial planning and risk-awareness, rather than simply reflecting the effect of selection into insurance.

Second, the evidence that both insurance coverage and insurance use are positively associated with greater intensity of medical attention underscores the potential of microinsurance to reduce barriers to healthcare access. This is important in low- and middle-income settings, where medical utilization is often suppressed by affordability constraints. By lowering the effective price of care or by providing streamlined access through predefined networks, microinsurance may encourage earlier and more frequent health-seeking behavior. Such patterns are aligned with preventive-care models: insured households may substitute away from delayed or catastrophic care toward more continuous engagement with the health system. This shift has the potential to improve long-term health outcomes and reduce system-wide inefficiencies.

Finally, the finding that households with health, educational, and mental health problems are more likely to use Family Protection (FP) services—such as telemedicine, access to medicines, and e-doctor plat-forms—suggests that microinsurance products offering digital or ancillary health services fill meaningful gaps in existing public provision. These services appear to function as responsive mechanisms for vulnerable groups who face frictions in traditional healthcare access, whether due to mobility constraints, stigma, or limited local supply of specialized services. Their uptake among households with multiple vulnerabilities indicates that microinsurance may operate as a complementary node in the broader public-health ecosystem, expanding the reach of care and enabling continuity of treatment. Taken together, the results imply that microinsurance does more than protect against shocks: it shapes financial behaviors, promotes early and sustained healthcare utilization, and supports vulnerable households through integrated service bundles. These pathways highlight the potential for microinsurance to be leveraged as a policy instrument that bridges financial inclusion and public health objectives.

CONCLUSIONS

Despite recent progress, significant protection gaps persist, with roughly 90 % of the global population lacking insurance coverage against growing risks such as climate change, health crises, and disasters. Bridging this gap requires coordinated action among insurers, governments, and development partners to expand access, improve affordability, and design gender-responsive, locally relevant products. Strengthening regulatory frameworks and market infrastructure is essential to build sustainable systems that enhance financial protection and health security, particularly in low- and middle-income contexts.

This study provides a comprehensive analysis of the determinants influencing enrollment in BVFE's FP microinsurance program linked to microcredit. The findings highlight that demo- graphic, geographic, and socioeconomic factors play a pivotal role in shaping insurance uptake. Specifically, clients with salaried employment, savings accounts, and lower income levels are more inclined to enroll. At the same time,

enrollment rates are comparatively lower among women, older individuals, and those with higher educational attainment. The elevated likelihood of enrollment among Venezuelan migrants underscores the program's reach within vulnerable populations, whereas the lower participation among individuals already financially included by traditional financial institutions highlights the program's effectiveness. The findings also indicate that insured individuals experience greater improvements in access to health services, particularly during periods with a higher incidence of pneumonia.

Furthermore, the observed patterns align with evidence suggesting that microinsurance and microfinance initiatives can improve well-being and reduce vulnerability by enabling low-income households to better manage health and financial shocks (Dhungana, 2023). This highlights the importance of inclusive financial instruments that combine protection with empowerment, fostering resilience in communities often excluded from formal systems.

Overall, the results emphasize the need for tailored interventions that consider the diverse characteristics of potential clients. By addressing the specific barriers and facilitators identified, BVFE can enhance the inclusiveness and effectiveness of its microinsurance offerings, thereby promoting greater financial resilience among its clientele. This research contributes valuable knowledge to the field of microinsurance adoption, underscoring the complex interplay of demographic and socioeconomic factors that influence insurance decisions in emerging markets. It also emphasizes microinsurance as an effective tool for resilience to negative health shocks.

Table 1: Descriptive Statistics - Credit Data

	Mean	Std. Dev.	Min	Max	N
Applicant characteristics					
Age	38.828	13.880	18	75	**108,694**
Woman	0.620	0.485	0	1	**108,694**
Single	0.611	0.487	0	1	**108,694**
Employee	0.006	0.081	0	1	**108,694**
Primary	0.457	0.498	0	1	**108,694**
Secundary	0.461	0.498	0	1	**108,694**
University	0.049	0.217	0	1	**108,694**
Nationality					
Venezuelan	0.007	0.083	0	1	**108,694**
Colombian	0.022	0.147	0	1	**108,694**
Ecuatorian	0.970	0.168	0	1	**108,694**
Other	0.022	0.147	0	1	**108,694**
Loan characteristics					
Maturity	18.140	8.900	1	76	**108,694**
Delinquent	0.119	0.324	0	1	**108,694**
Matured	0.773	0.418	0	1	**108,694**
Income and wealth					
Income	1,498	1,375	50	25,000	**108,694**
Equity	14,974	24,588	0	1,306,457	**108,692**
Financial inclusion					
Seniority	3.063	4.085	0	14	**108,694**
Savings account	0.960	0.193	0	1	**108,694**
Other financial instruments	**0.617**	**0.486**	**0**	**1**	**108,694**

Table 2: Mean comparisons: Without vs. With FP

	Mean Without FP	Mean With FP	N
Applicant characteristics			
Age	36.877	39.164	**108.694**
Women	0.592	0.625	**108.694**
Single	0.708	0.595	**108.694**
Employee	0.012	0.006	**108.694**
Primary	0.403	0.467	**108.694**
Secundary	0.505	0.454	**108.694**
University	0.057	0.048	**108.694**
Nationality			
Venezuelan	0.008	0.007	**108.694**
Colombian	0.029	0.021	**108.694**
Ecuatorian	0.963	0.972	**108.694**
Other	0.029	0.021	**108.694**
Loan characteristics			
Maturity	15.091	18.666	**108.694**
Delinquent	0.110	0.121	**108.694**
Matured	0.489	0.823	**108.694**
Income and wealth			
Income	1,237.359	1,543.075	**108.694**
Equity	12,256.761	15,442.421	**108.692**
Financial inclusion			
Seniority	2.855	3.099	**108.694**
Savings account	0.852	0.980	**108.694**
Other financial instruments	**0.710**	**0.601**	**108.694**

Table 3: Descriptive Statistics - Insurance Data

Variable	Obs	Mean	Std. dev.	Min	Max
Compensation	6584	2.2	0.7	1.6	**8.1**
Telemedicine	6584	1.1	0.8	0.0	**8.0**
Drugs	6584	0.6	0.8	0.0	**8.0**
E-doctor	6584	0.2	0.6	0.0	**16.0**
Holder attentions	6584	0.9	1.0	0.0	**8.0**
Children attentions	6584	0.7	1.1	0.0	**10.0**
Children	6584	1.4	1.1	0.0	**7.0**
Venezuela	6584	0.0	0.1	0.0	**1.0**
Women	6584	0.7	0.4	0.0	**1.0**
Age	6584	37.3	11.3	19.0	**77.0**
Pneumonia	**6106**	**0.1**	**0.2**	**0.0**	**1.1**

Table 4: Pneumonia Cases by Province, 2022

Province	Cases	Population	Density (Pop/km²)
Azuay	1052	712,127	**86**
Bol´ıvar	222	183,641	**47**
Ca ñ a r	396	225,184	**72**
Carchi	339	164,524	**44**
Chimborazo	736	458,581	**71**
Cotopaxi	648	409,205	**67**
El Oro	688	600,659	**104**
Esmeraldas	572	534,092	**33**
Gala´pagos	8	25,124	**3**
Guayas	2,422	3,645,483	**236**
Imbabura	741	398,244	**87**
Loja	747	448,966	**41**
Los R´ıos	531	778,115	**108**
Manab´ı	573	1,369,780	**72**
Morona Santiago	713	147,940	**6**
Napo	194	103,697	**8**
Orellana	134	136,396	**6**
Pastaza	145	83,933	**3**
Pichincha	6,194	2,576,287	**270**
Santa Elena	165	308,693	**84**
Santo Domingo de los Tsa´chilas	504	368,013	**107**
Sucumb´ıos	142	176,472	**10**
Tungurahua	1,049	504,583	**149**
Zamora Chinchipe	**351**	**91,376**	**9**

Table 5: Determinants of FP enrollment

	(1)	(2)	(3)	(4)	(5)	(6)
Age	-0.000609***					**-0.000381***
	(7.14e-05)					**(7.92e-05)**
Women	-0.00356**					**-0.00254**
	(0.00175)					**(0.00176)**
Single	0.00249					**0.00347***
	(0.00199)					**(0.00207)**
Employee	0.0590***					**0.0529***
	(0.0157)					**(0.0157)**
Secundary	-0.00164					**-0.00386****
	(0.00189)					**(0.00190)**
University	-0.0219***					**-0.0269***
	(0.00411)					**(0.00411)**
Venezuelan		0.0639***				**0.0650***
		(0.00952)				**(0.00951)**
Colombian		0.000841				**-0.00780**
		(0.00634)				**(0.00636)**
Children			-0.00134			**-0.00267***
			(0.000929)			**(0.000964)**
Maturity				0.00238***		**0.00230***
				(0.000111)		**(0.000127)**
Delinquent				-0.0108***		**0.000565**
				(0.00399)		**(0.00396)**
Income					-2.39e-05***	**-2.44e-05***
					(1.49e-06)	**(1.50e-06)**
Lnequity					-0.00906***	**-0.00832***
					(0.00134)	**(0.00139)**
Seniority					-0.00217***	**-0.00280***
					(0.000227)	**(0.000252)**
Savings account					0.245***	**0.253***
					(0.00709)	**(0.00718)**
Other financial instruments					-0.0206***	**-0.0219***
					(0.00183)	**(0.00195)**
Observations	108.694	108.694	108.694	108.694	108.694	**108.694**
R-squared	**0.303**	**0.302**	**0.305**	**0.305**	**0.309**	**0.315**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Table 6: Determinants of Children and Insurance Holder Attention

	(1)	(2)
	Children attentions	**Holder attentions**
Women	0.0606**	**0.0689*** **
	(0.0289)	**(0.0247)**
Age	-0.0115***	**0.00631*** **
	(0.000877)	**(0.000950)**
Children	0.286***	**-0.180*** **
	(0.0127)	**(0.0102)**
Venezuelan	-0.00692	**0.270*** **
	(0.103)	**(0.0993)**
Observations	6,584	**6,584**
R-squared	**0.183**	**0.154**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Table 7: Periods of Pneumonia and Health Attentions

	(1) Compensation	(2) Telemedicine	(3) Drugs	(4) E-doctor
Pneumonia	0.0603***	0.0298***	0.0159**	**-0.00428**
	(0.0182)	(0.0102)	(0.00797)	**(0.00410)**
Observations	139,578	139,578	139,578	**139,648**
R-squared	**0.076**	**0.100**	**0.110**	**0.090**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Table 8: Periods of Pneumonia and Health Attentions

	(1)	(2)	(3)	(4)
	Compensation	Telemedicine	Drugs	**E-doctor**
Pneumonia	0.0620***	0.0309***	0.0167**	**-0.00433**
	(0.0188)	(0.0108)	(0.00843)	**(0.00420)**
Children	0.00613***	0.00523***	0.00367***	**0.000400**
	(0.00115)	(0.000645)	(0.000506)	**(0.000293)**
Venezuela	0.0173	0.0112*	0.0104**	**-0.00236***
	(0.0120)	(0.00675)	(0.00502)	**(0.00127)**
Women	-0.000105	0.00304*	0.00170	**-0.00280*****
	(0.00300)	(0.00165)	(0.00131)	**(0.000979)**
Age	-0.000397***	-5.78e-05	-0.000131***	**-0.000237*****
	(0.000104)	(5.18e-05)	(4.00e-05)	**(2.75e-05)**
Observations	139,578	139,578	139,578	**139,578**
R-squared	**0.003**	**0.003**	**0.005**	**0.002**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Table 9: Heterogeneities Models for FP enrollment

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Age	-0.000343***	-0.000361***	-0.000345***	-0.000340***	-0.000345***	-0.000343***	-0.000343***	-0.000342***	-0.000343***	**-0.000345*** **
	(6.99e-05)	(7.03e-05)	(6.99e-05)	(6.99e-05)	(6.99e-05)	(6.99e-05)	(6.99e-05)	(6.99e-05)	(6.99e-05)	**(6.99e-05)**
Women	-0.00221	-0.00760***	-0.00257	-0.00247	-0.00251	-0.00253	-0.00256	-0.00248	-0.00253	**-0.00254**
	(0.00157)	(0.00251)	(0.00157)	(0.00157)	(0.00157)	(0.00157)	(0.00157)	(0.00157)	(0.00157)	**(0.00157)**
Single	0.00345*	-0.00205	0.00301	0.0113***	0.00346*	0.00345*	0.00343*	0.00334*	0.00343*	**0.00347***
	(0.00184)	(0.00283)	(0.00184)	(0.00247)	(0.00184)	(0.00184)	(0.00184)	(0.00184)	(0.00184)	**(0.00184)**
Employee	0.0786***	0.0501***	0.00137	0.0506***	0.00557	0.0694***	0.248***	-0.0619***	0.0503***	**0.0500*** **
	(0.0187)	(0.0140)	(0.0245)	(0.0140)	(0.0195)	(0.0152)	(0.0571)	(0.0208)	(0.0140)	**(0.0140)**
Secundary	-0.00349**	-0.00356**	-0.00343**	-0.00343**	-0.00385**	-0.00352**	-0.00349**	-0.00352**	-0.00346**	**-0.00348** **
	(0.00169)	(0.00169)	(0.00169)	(0.00169)	(0.00169)	(0.00169)	(0.00169)	(0.00169)	(0.00169)	**(0.00169)**
University	-0.0248***	-0.0250***	-0.0248***	-0.0249***	-0.0241***	-0.0232***	-0.0248***	-0.0254***	-0.0249***	**-0.0249*** **
	(0.00362)	(0.00362)	(0.00362)	(0.00362)	(0.00361)	(0.00362)	(0.00362)	(0.00362)	(0.00362)	**(0.00362)**
Venezuelan	0.0645***	0.0646***	0.0646***	0.0646***	0.0645***	0.0644***	0.0646***	0.0647***	0.106***	**0.0646*** **
	(0.00928)	(0.00929)	(0.00928)	(0.00928)	(0.00928)	(0.00928)	(0.00929)	(0.00928)	(0.0128)	**(0.00929)**
Colombian	-0.0476	-0.0476	-0.0476	-0.0474	-0.0476	-0.0475	-0.0476	-0.0477	-0.0476	**-0.0185**
	(0.0292)	(0.0292)	(0.0292)	(0.0292)	(0.0292)	(0.0292)	(0.0292)	(0.0292)	(0.0292)	**(0.0304)**
Savings account	0.163***	0.163***	0.163***	0.165***	0.164***	0.163***	0.164***	0.164***	0.163***	**0.164*** **
	(0.00630)	(0.00630)	(0.00630)	(0.00632)	(0.00630)	(0.00630)	(0.00631)	(0.00630)	(0.00630)	**(0.00630)**
Other financial instruments	-0.0132***	-0.0132***	-0.0132***	-0.00647***	-0.0132***	-0.0131***	-0.0132***	-0.0139***	-0.0129***	**-0.0124*** **
	(0.00166)	(0.00166)	(0.00166)	(0.00236)	(0.00166)	(0.00166)	(0.00166)	(0.00166)	(0.00166)	**(0.00167)**
Women × Employee	-0.0617**									
	(0.0281)									
Women × Single		0.00814**								
		(0.00319)								
Single × Employee			0.0793***							
			(0.0297)							
Single ×										
Other financial instruments				-0.0113***						
				(0.00295)						
Secundary × Employee					0.0878***					
					(0.0278)					
University × Employee						-0.0981***				
						(0.0376)				
Employee × Savings account							-0.199***			
							(0.0588)			
Employee ×										
Other financial instruments								0.165***		
								(0.0274)		
Venezuelan ×										
Other financial instruments									-0.0559***	
									(0.0170)	
Colombian ×										
Other financial instruments										**-0.0372*** **
										(0.0118)
Control Variables	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Yes**
Observations	108.694	108.694	108.694	108.694	108.694	108.694	108.694	108.694	108.694	**108.694**
R-squared	**0.481**	**0.481**	**0.481**	**0.481**	**0.481**	**0.481**	**0.481**	**0.481**	**0.482**	**0.481**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Table 10: Access to Health Services through Insurance

	(1)	(2)	(3)	(4)
	Compensation	Telemedicine	Drugs	**E-doctor**
Holder attentions	0.363***	0.341***	0.555***	**0.0143**
	(0.00763)	(0.0117)	(0.0130)	**(0.0109)**
Children attention	0.350***	0.493***	0.492***	**0.00526**
	(0.00686)	(0.00873)	(0.00813)	**(0.00349)**
Women	-0.0986***	-0.0378***	-0.0635***	**-0.0317****
	(0.0175)	(0.0137)	(0.0136)	**(0.0153)**
Age	0.00153**	0.00293***	-0.00119**	**-1.22e-05**
	(0.000733)	(0.000497)	(0.000501)	**(0.000373)**
Venezuela	0.0260	0.00259	-0.0489	**-0.0270***
	(0.0585)	(0.0412)	(0.0375)	**(0.0151)**
Observations	6,584	6,584	6,584	**6,584**
R-squared	**0.474**	**0.672**	**0.683**	**0.560**

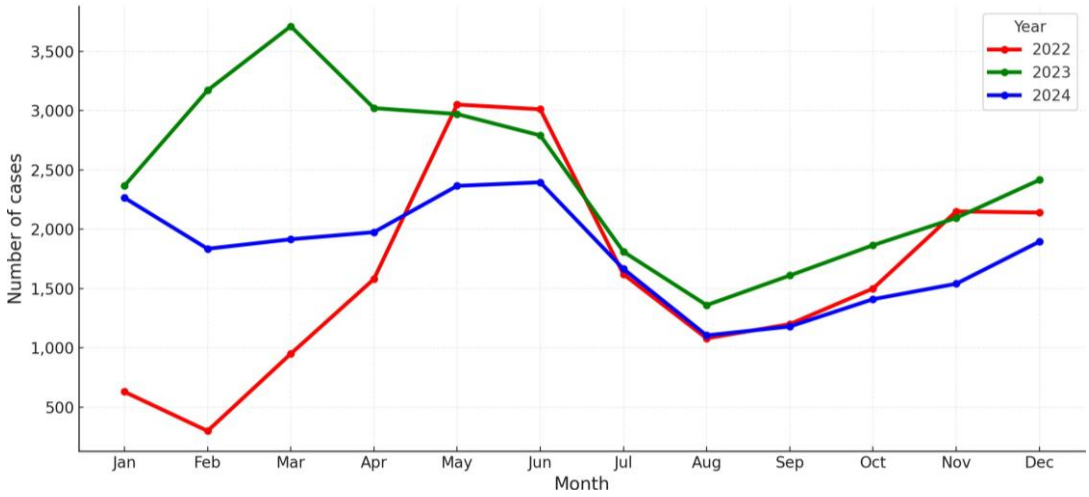
Notes: Robust standard errors in parentheses. *** $p < 0{,}01$, ** $p < 0{,}05$, * $p < 0{,}1$.

Table 11: Health Insurance Beneficiaries

	(1)	(2)	(3)	(4)
	Compensation	Telemedicine	Drugs	**E-doctor**
Holder attentions	0.0339***	0.0307***	0.0309***	**-0.00811*** **
	(0.00207)	(0.00148)	(0.00128)	**(0.000495)**
Children attentions	0.0345***	0.0389***	0.0306***	**-0.00851*** **
	(0.00222)	(0.00186)	(0.00152)	**(0.000507)**
Children	0.00326***	0.000666	0.00127**	**0.00115*** **
	(0.00120)	(0.000633)	(0.000505)	**(0.000357)**
Venezuelan	0.00870	0.00201	0.00272	**-0.000259**
	(0.0120)	(0.00676)	(0.00501)	**(0.00127)**
Women	-0.00355	-0.000680	-0.00138	**-0.00196** **
	(0.00299)	(0.00164)	(0.00130)	**(0.000966)**
Age	-0.000396***	1.72e-05	-0.000138***	**-0.000240*** **
	(0.000106)	(5.26e-05)	(4.09e-05)	**(2.90e-05)**
Observations	139,578	139,578	139,578	**139,578**
R-squared	**0.007**	**0.017**	**0.022**	**0.005**

Notes: Robust standard errors in parentheses. *** $p < 0,01$, ** $p < 0,05$, * $p < 0,1$.

Figure 1: Monthly Pneumonia Cases by Year



Note: This figure displays the monthly number of pneumonia cases in Ecuador for the years 2022 (red), 2023 (green), and 2024 (blue). The data illustrate strong temporal variation, with infection peaks typically observed between March and June, and a steady increase again toward the end of each year.

Table 12: FP and Household Savings

Houshold savings	(1)	(2)	(3)	(4)	(5)	(6)
Emergency	-0.1470***	-0.1539***	-0.1472***	-0.1383***	-0.1409***	**-0.1388*** **
	[0.0310]	[0.0308]	[0.0310]	[0.0332]	[0.0332]	**[0.0332]**
FP	0.0883***		0.0688**	0.0684**		**0.0546**
	[0.0284]		[0.0301]	[0.0320]		**[0.0337]**
FP use		0.1596***	0.1189**		0.1185**	**0.0883**
		[0.0452]	[0.0482]		[0.0516]	**[0.0544]**
Age				-0.0020	-0.0019	**-0.0021**
				[0.0014]	[0.0014]	**[0.0014]**
Women				-0.0123	-0.0128	**-0.0114**
				[0.0295]	[0.0295]	**[0.0295]**
Single				0.0169	0.0190	**0.0158**
				[0.0335]	[0.0335]	**[0.0334]**
Employee				-0.1030***	-0.1047***	**-0.1007*** **
				[0.0368]	[0.0366]	**[0.0368]**
Secondary				0.0498	0.0530	**0.0521**
				[0.0355]	[0.0356]	**[0.0356]**
University				0.1034**	0.0982**	**0.1027** **
				[0.0468]	[0.0464]	**[0.0467]**
Venezuelan				-0.0449	-0.0346	**-0.0521**
				[0.0630]	[0.0618]	**[0.0629]**
Colombian				-0.0253	-0.0206	**-0.0287**
				[0.0482]	[0.0479]	**[0.0483]**
Children (0–5)				-0.0045	-0.0058	**-0.0058**
				[0.0124]	[0.0121]	**[0.0123]**
Children (6–14)				0.0068	0.0066	**0.0068**
				[0.0084]	[0.0082]	**[0.0083]**
Children (15–17)				0.0035	0.0033	**0.0036**
				[0.0084]	[0.0084]	**[0.0084]**
Income				0.0564***	0.0582***	**0.0559*** **
				[0.0191]	[0.0188]	**[0.0189]**
Observations	1,079	1,079	1,079	1,058	1,058	**1,058**
R-squared	**0.0333**	**0.0325**	**0.0372**	**0.0910**	**0.0903**	**0.0928**

Table 13: FP and Health Access

Medical attention	(1)	(2)	(3)	(4)	(5)	(6)
Emergency	0.2443***	0.2397***	0.2438***	0.2513***	0.2487***	**0.2491*** **
	[0.0695]	[0.0689]	[0.0696]	[0.0735]	[0.0733]	**[0.0735]**
FP	0.1151*		0.0416	0.0792		**0.0124**
	[0.0623]		[0.0661]	[0.0685]		**[0.0720]**
FP use		0.4770***	0.4525***		0.4348***	**0.4278*** **
		[0.1009]	[0.1084]		[0.1177]	**[0.1246]**
Age				0.0008	0.0007	**0.0007**
				[0.0034]	[0.0034]	**[0.0034]**
Women				0.1870***	0.1937***	**0.1939*** **
				[0.0624]	[0.0619]	**[0.0619]**
Single				0.0415	0.0362	**0.0354**
				[0.0749]	[0.0749]	**[0.0748]**
Employee				0.0442	0.0552	**0.0561**
				[0.0796]	[0.0796]	**[0.0795]**
Secondary				-0.0351	-0.0243	**-0.0244**
				[0.0749]	[0.0746]	**[0.0747]**
University				0.0131	0.0056	**0.0067**
				[0.1093]	[0.1075]	**[0.1080]**
Venezuelan				0.2096	0.1783	**0.1745**
				[0.1609]	[0.1584]	**[0.1601]**
Colombian				-0.0124	-0.0271	**-0.0289**
				[0.0972]	[0.0959]	**[0.0971]**
Children (0–5)				0.0159	0.0096	**0.0096**
				[0.0257]	[0.0254]	**[0.0254]**
Children (6–14)				-0.0292	-0.0296	**-0.0296**
				[0.0187]	[0.0184]	**[0.0184]**
Children (15–17)				0.0041	0.0044	**0.0045**
				[0.0167]	[0.0165]	**[0.0165]**
Income				0.0140	0.0124	**0.0118**
				[0.0345]	[0.0341]	**[0.0343]**
Observations	1,044	1,044	1,044	1,025	1,025	**1,025**
R-squared	**0.0153**	**0.0274**	**0.0278**	**0.0867**	**0.0962**	**0.0962**

Table 14: Household Problems and FP Use

FP Use	(1)	(2)	(3)	(4)	(5)	(6)
Children severe cold	0.0828*			0.0311		
	[0.0468]			[0.0434]		
School absenteeism		0.2577***			0.0446	
		[0.0790]			[0.0772]	
GHQ-5			0.0241*** [0.0075]			**0.0147** [0.0065]**
Age				0.0030	0.0018	**0.0003**
				[0.0027]	[0.0027]	**[0.0016]**
Women				-0.0244	-0.0322	**-0.0152**
				[0.0403]	[0.0410]	**[0.0306]**
Single				-0.0124	-0.0034	**0.0125**
				[0.0438]	[0.0443]	**[0.0358]**
Employee				-0.0712* [0.0402]	-0.0730* [0.0441]	**-0.1020*** [0.0353]**
Secondary				-0.0348	-0.0356	**-0.0405**
				[0.0543]	[0.0547]	**[0.0393]**
University				0.0346	0.0281	**0.0378**
				[0.0739]	[0.0729]	**[0.0572]**
Venezuelan				-0.0025	0.0118	**0.0360**
				[0.0811]	[0.0814]	**[0.0689]**
Colombian				0.0049	-0.0050	**0.0291**
				[0.0522]	[0.0527]	**[0.0420]**
Children (0–5 years)				0.0338** [0.0150]	0.0314** [0.0152]	**0.0319* [0.0167]**
Children (6–14 years)				-0.0018	-0.0028	**0.0026**
				[0.0109]	[0.0109]	**[0.0105]**
Children (15–17 years)				-0.0065	-0.0055	**-0.0064**
				[0.0082]	[0.0081]	**[0.0068]**
Income				0.0346	0.0346	**0.0304**
				[0.0291]	[0.0288]	**[0.0233]**
Observations	316	314	302	311	308	**528**
R-squared	**0.0108**	**0.0518**	**0.0254**	**0.3229**	**0.3346**	**0.2336**

Figure 2: Well-Being to Savings Pathway

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APPENDIX 3

SURVEY SAMPLE TARGETS

				95% confidence level with a 5% margin of error.	95% confidence level with a 7% margin of error.	90% confidence level with a 7% margin of error.	90% confidence level with a 10% margin of error.
Familia Protegida	**Gender**	**Nationality**	**Population**	**Sample**	**Sample**	**Sample**	**Sample**
FP=0	Women=1	Ecuatorian=1	11619	372	193	138	68
FP=0	Women=1	Venezuelan=1	120	92	75	65	44
FP=0	Women=1	Other=1	377	191	130	102	58
FP=0	Women=0	Ecuatorian=1	6844	364	191	137	68
FP=0	Women=0	Venezuelan=1	62	54	48	44	33
FP=0	Women=0	Other=1	215	139	103	85	52
FP=1	Women=1	Ecuatorian=1	18563	377	194	138	68
FP=1	Women=1	Venezuelan=1	129	97	79	68	45
FP=1	Women=1	Other=1	402	197	132	104	59
FP=1	Women=0	Ecuatorian=1	10901	372	193	138	68
FP=1	Women=0	Venezuelan=1	98	79	66	58	41
FP=1	Women=0	Other=1	283	164	117	94	56
			49613	**2498**	**1521**	**1171**	**660**
Simple Random Sampling				**382**	**196**	**139**	**68**

RESPONSE ANALYSIS

The survey followed a stratified sampling framework showed in Appendix 3 to ensure representativeness across client gender, nationality, and FP insurance status. Sampling goals were calculated based on four statistical thresholds:

- 95% confidence level with a 5% margin of error: Target = 2,498
- 95% confidence level with a 7% margin of error: Target = 1,521
- 90% confidence level with a 7% margin of error: Target = 1,171
- 90% confidence level with a 10% margin of error: Target = 660

A total of 1,215 surveys were successfully completed, representing:

- 81% of the target for a 95% confidence level / 7% margin of error
- 104% of the target for a 90% confidence level / 7% margin of error

- 184% of the target for a 90% confidence level / 10% margin of error

This confirms that the achieved sample is statistically robust at a 90% confidence level with a 7% margin of error, and fully exceeds the minimum threshold for a 10% margin.

Survey completions were distributed as follows:

- Clients without insurance: 675 surveys
- Clients with insurance: 540 surveys
- Women: 697 surveys (57%)
- Men: 518 surveys (43%)

While certain segments, such as Venezuelan and Colombian clients, were underrepresented in relation to their targets, key demographic strata such as Ecuadorian women and men—both with and without insurance—achieved or exceeded 90% of their sampling goals. This enables reliable subgroup analysis for the largest client segments, however, the analysis of Venezuelan and Colombia clients only apply to observation sample.

The final achieved sample supports strong analytical power for the overall population and core subgroups, ensuring meaningful comparisons between FP-insured and non-insured clients.

APPENDIX 4

REPRESENTATIVE SURVEY OF BVFE CLIENTS

KEY FINDINGS

I. SAMPLE CHARACTERIZATION (N = 1,215)

- **Familia Protegida (FP) Coverage**: 44.4% have FP); 55.6% do not.
- **Gender**: 57.3% women; 42.7% men.
- **Age**: 37% aged 25–35; 23.1% aged 36–45; 19% aged 46–59; 16% aged 18–24; 4.8% aged 60+.
- **Children aged 0–23**: 61.3% have children (54.3% with 1–3 children; 7.0% with 4 or more).
- **Marital status**: 62.5% single; 19.9% married; 11.1% in a common-law union.
- **Nationality**: 74.9% Ecuadorian; 17.6% Colombian; 7.0% Venezuelan.
- **Education**: 47.8% secondary education; 31.5% primary; 11.5% university; 6.7% technical training.
- **Occupation**: 72.2% self-employed or business owners; 23.8% salaried workers. Economic sectors: 35.8% agriculture; 26.4% commerce; 10.5% services.
- **Income variation**: 44.3% reported an increase; 39.4% no change; 16.3% reported a decrease.
- **Key insights**: High prevalence of self-employment, agro-commercial sectors, and households with children; FP coverage reaches 4 out of 10 clients.

II. USE OF FP SERVICES (INSURED CLIENTS ONLY)

- **Awareness**: Highest for Telemedicine and pharmacy (66%) and accidental death benefit (61%); lower awareness for family income support (23%), scholarship (21%), and *Brigadas Médicas (Medical Brigades)* (24%).
- **Service use in past 12 months**: Mostly used were *Ambulancia Naranja (Orange Ambulance)* (44%) and Telemedicine/pharmacy (38%); remaining services ≤21%. A total of 70.6% did not use any services during the period.
- **Valid reasons for non-use**: 55.9% "did not need it"; 12.6% unaware of eligibility; 9.7% received care elsewhere; 7.6% attempted but could not access.
- **Key insights**: High recall of telemedicine and ambulance services, but overall low activation rates and persistent gaps in information and service management.

III. PERCEIVED QUALITY OF LIFE AND WELL-BEING *(GHQ-5, 2025 vs. 2024)*

- **Stable balance**: Between 87%–92% reported no change in sleep, stress, daily activity, mood, and happiness.
- **Net changes (Better – Worse)**: Sleep ±1 p.p. (6.0% vs. 7.2%), Stress ~0 (5.5% vs. 5.7%), Activity +0.2, Depression −1.4, Happiness +2.5.
- **By subgroup**: Modest improvements are concentrated among those with increased income, and marginally among insured individuals, 4.8% of the insured reported lower distress compared to 2024; among FP users, 3.4% showed improvement.
- **Key insights**: Overall stability in well-being, with slight emotional gains. Recent income increases are the strongest positive correlation (54.8% of insured clients saw income growth, versus 35.9% of the uninsured). Among FP users, 65.4% reported increased income, compared to 50.4% of non-users.

IV. CHILDREN'S WELL-BEING AT HOME *(INSURED CLIENTS ONLY)*

- **Insurance activation and effective access to services**: Use of FP services by children is highly concentrated in households where the insurance is activated. Among FP users, 47.3% reported use of *Ambulancia Naranja* by children (vs. 13.5% of non-users), and 35.1% reported use of Telemedicine (vs. 8.1%).
- **Significant differences** between users and non-users were observed in access to *Brigadas Médicas* (14.9% vs. 5.4%) and medications (6.8% vs. 2.7%). Although less frequent, psychological assistance was also activated more among users (2.7% vs. 0%). Services like E-doctor and accident-related medical expense coverage showed low usage in both groups, suggesting limited awareness or suitability for pediatric needs.
- **Limited awareness among non-users**: Among those who did not activate FP, the most common responses were "none" (84%) and "don't remember" (21.6%), indicating both low actual use and limited recognition of benefits available for children.

V. FINANCIAL RESILIENCE AND STABILITY

- **Savings**: 64.4% managed to save; 33% did not; insured clients were less likely to report "no savings at all."
- **Emergencies**: 30.2% experienced a financial emergency, with higher incidence in households with children and without FP. Among those facing emergencies, only 12% used FP services; 25.6% were insured but did not use them.
- **Coping strategies (multiple responses)**: Loans (37.6%), savings (33.2%), family support (27.0%), sale of assets (7.9%, exclusively among non-users of FP services), and inability to fully address the emergency (9.0%, with higher rates among FP users: 24.2% vs. 15.2%). Use of FP for non-health emergencies was marginal (1.1%, of whom 25% were FP users and 75% were uninsured).

- **Health emergencies**: Mainly resolved through public healthcare (49.6%), followed by private providers (21.8%), and BVFE services (2.7%). Among those who resolved a health emergency using BVFE medical services (*Brigadas Médicas*, *Ambulancia Naranja*, or Telemedicine), 80% were active FP users; non-users relied primarily on public or private systems.
- **Perception of FP during economic emergencies**: 22.4% said it helped (a lot/somewhat); 34.1% said it had no effect; 26.8% did not use it or found it unhelpful; 16.7% were unaware it could help. Among those who said FP was helpful, about 6 out of 10 were users; among those who said it didn't help or didn't know, about 3 out of 4 were non-users.
- **Key insights**: Main safety nets during shocks are credit, savings, and family. For FP to be an effective financial and health protection tool, activation and timely access to its services must become an active source of household resilience.

VI. CROSS-CUTTING RECOMMENDATIONS

- **Activation and education**: Simple campaigns on "what is covered and how to use it" (telemedicine, ambulance, referral pathways, and real-life examples), with a focus on households with children.
- **Access management**: Fast-track protocols for channeling clients into BVFE services and follow-up after critical events.
- **Monitoring**: Track effective use of FP and resolution of health needs; segment data by income and family size to target support strategies.

INTRODUCTION

This report presents the findings from the field data collection conducted as part of the study on the use and effects of the *Familia Protegida (FP)* insurance offered by BVFE in the daily lives of its clients and their households. The focus is twofold: on one hand, the quality of life and healthcare access for insured individuals; on the other, the well-being of children and adolescents (ages 0 to 23) and the financial resilience of households in response to recent emergencies.

BVFE implements FP as a tool for financial protection and timely access to healthcare services (e.g., Telemedicine, *Ambulancia Naranja*, *Brigadas Médicas*, and access to medications). The study seeks to measure outcomes in access, usage, satisfaction, and perceived effects, and to provide evidence to inform operational and product improvements.

Data was collected through a structured survey administered via BVFE agencies and remote channels, with national coverage. A total of 1,215 individuals participated (44.4% with FP and 55.6% without). The goal is to compare profiles and outcomes by sex, age, country of origin, number of children, employment type, occupation sector, recent income variation, and perceived well-being. The questionnaire included modules on sociodemographic and employment characteristics, use and knowledge of FP benefits, quality of life and well-being perception (GHQ-5), child well-being, and financial resilience/stability. Fieldwork was carried out by BVFE's agency teams and central office with methodological support from EGES, following safeguards regarding informed consent, anonymity, and use of data solely for service improvement.

The analysis combines descriptive statistics (percentages and distributions) with cross-tabulations by key variables (FP, income variation, country of origin, number of children) and basic statistical contrasts (chi² tests) when applicable. The report emphasizes operational interpretation, highlighting benefit activation gaps and opportunities for improving referral pathways and user experience. All tables and graphs were developed specifically for this report.

The report is structured as follows:

1. Methodology of field data collection
2. Module 1: Sample characterization: sociodemographic and employment profiles; FP coverage distribution
3. Module 2: Use of FP services: awareness, 12-month usage, reasons for non-use, satisfaction, and perceived access
4. Module 3: Quality of life and well-being (GHQ-5): comparison of 2024–2025 across dimensions (sleep, stress, activity, mood, happiness) and subgroups
5. Module 4: Child well-being in the household: benefit utilization, perceived improvements (health, education, nutrition, housing), school attendance, and illness episodes
6. Module 5: Financial resilience and stability: recent savings, emergencies experienced, coping strategies, resolution of health-related emergencies, and FP’s contribution
7. Module 6: Analysis of the survey’s final comment

8. Conclusions and responses to evaluation questions: cross-cutting synthesis and operational recommendations

METHODOLOGY

STUDY DESIGN

This is a descriptive–analytical quantitative study supported by qualitative inputs drawn from open-ended comments at the end of the questionnaire. The objective is to characterize BVFE clients, assess usage and perception of services (including the FP insurance), and explore quality of life, child well-being, and economic resilience. A single cross-sectional measurement was conducted during September and October 2025, with comparative items referring to 2024 (e.g., income change 2024–2025, self-reported GHQ-5 variation).

POPULATION, SAMPLING FRAME, AND SAMPLE

The target population was defined according to the following criteria:

1. Clients active between January 2024 and December 2025.
2. Unique client per sample entry.
3. Clients aged 18 to 65 years.
4. Only active loans were considered, including current, past due, and fully overdue. Cancelled, written-off, and legal-status loans were excluded.
5. In cases where a client had multiple loans, only clients with FP coverage in all or none of their loans were included.
6. The three most representative nationalities were considered: Ecuadorian, Venezuelan, and Colombian.

This yielded a target population of 49,613 clients.

Exclusion criteria included individuals under 18 and non-clients. A probability-based quota sampling method was applied based on operational variables (sex, origin, agency) to ensure heterogeneity.

The final valid sample consisted of 1,215 cases with national coverage across Ecuador and identification of country of origin (Ecuador, Venezuela, Colombia) to allow for comparative analysis. With this sample size (N = 1,215), the estimated sampling error is ±2.8 percentage points (at 90% confidence and 7% margin of error). The results are not statistically representative at the national level but are valid for the sample studied.

RECRUITMENT STRATEGY

Recruitment was conducted via BVFE agencies, using advisors, customer service desks, and remote outreach. Primary contact methods included phone calls, SMS, and BVFE's official social media channels. An external call center was also used, although it achieved only 26% of its target.

INSTRUMENT

A structured questionnaire was jointly designed with the client for this specific study. The median administration time was 8 minutes. It was organized into six modules:

1. Sociodemographic and employment characteristics
2. Use and knowledge of BVFE and FP services
3. Quality of life and well-being perception
4. Child well-being
5. Financial resilience
6. An open-ended comment field at the end

ONLINE SURVEY PLATFORM

The secure LimeSurvey platform was used to deploy the questionnaire. It allowed for logic-based question flows and visibility conditions, ensuring that each respondent answered only those sections relevant to their experience with BVFE services.

The software was installed on the proprietary server of Gerencia Salud Consultores, ensuring that no third-party intermediaries handled the data. It was deployed with high standards of cybersecurity and data protection. Anonymity was safeguarded through technical configurations and data handling protocols embedded in the survey logic.

This methodology ensures transparency in data collection and analysis, supports replicability, and provides a solid foundation for the comparisons and cross-tabulations presented in the report, while upholding ethical standards and data quality.

MODULE 1: SAMPLE CHARACTERIZATION

The BVFE questionnaire was administered between September 18 and October 24, 2025, using the bank's operational channels: Service Desk, Advisors, and Call Center (plus a residual group without channel identification). At the close of fieldwork, a total of 1,215 valid surveys were completed.

SOCIODEMOGRAPHIC CHARACTERISTICS

The following presents the composition of the sample based on key sociodemographic variables of respondents.

Table 1. Sample Distribution by Sociodemographic Variables
Do you have FP insurance?

		Has FP insurance?		
		Yes	**No**	**Total**
Sex	Male	19.6%	23.1%	42.7%
	Female	24.9%	32.4%	57.3%
Age Group	18–24 years	5.3%	10.7%	16.0%
	25–35 years	15.8%	21.2%	37.0%
	36–45 years	10.8%	12.3%	23.1%
	46–59 years	10.2%	8.8%	19.0%
	60+ years	2.3%	2.5%	4.8%
Number of Children (0–23)	None	15.6%	23.0%	38.7%
	1–3 children	26.3%	28.1%	54.3%
	4 or more children	2.6%	4.4%	7.0%
Marital Status	Married	9.0%	10.9%	19.9%
	Divorced	2.2%	3.3%	5.5%
	Single	27.8%	34.7%	62.5%
	Common-law union	5.1%	6.0%	11.1%
	Widowed	0.3%	0.7%	1.0%
Total (n)		540 (44,4%)	675 (55,6%)	1,215

SEX

Among the total sample (n=1,215), women represent a majority (57.3%) compared to men (42.7%). When disaggregated by FP insurance status, 24.9% of all respondents are women with FP and 32.4% are women without FP; 19.6% are men with FP and 23.1% men without. In both genders, non-FP coverage is more prevalent, with a slightly larger gap among women.

AGE GROUP

The sample is concentrated in early and mid-working ages: 37.0% are between 25–35, and 23.1% between 36–45. The 18–24 and 46–59 age ranges represent 16.0% and 19.0%, respectively, while those 60 and over make up 4.8%. Younger age groups (18–35) are more prevalent among those without FP. Conversely, among those aged 46–59, FP coverage is slightly more common (10.2% vs. 8.8%). Among the 60+, proportions are low and evenly distributed.

NUMBER OF CHILDREN (AGES 0–23) IN THE HOUSEHOLD

38.7% of respondents have no children in the 0–23 age range; 25.5% have one child, 20.6% have two, and 15.2% have three or more (including 8.2% with 3, 2.0% with 4, and 5.0% with 5 or more).

Among those with FP, only 15.6% have no children (vs. 23.0% without FP), suggesting higher insurance uptake in caregiving households. Among large families (5+ children), those without FP predominate (3.3% vs. 1.7%).

MARITAL STATUS

Single status is most common (62.5%: 27.8% with FP and 34.7% without), followed by married (19.9%), common-law union (11.1%), divorced (5.5%), and widowed (1.0%). The distribution by FP is similar among married and common-law respondents, with a slight skew toward the uninsured.

Among all respondents, 38.7% have no children under 23, while 61.3% do: 25.5% have 1 child, 20.6% have 2, 8.2% have 3, 2.0% have 4, and 5.0% have 5 or more.

- **Single**: most are without children (46.5%). Larger families are rare (5.7% have 3 children; 1.4% have 4; 2.6% have 5+), suggesting lower childcare burdens.
- **Married**: more "family-oriented" profile, 28.5% have no children; 22.3% have 1; 22.3% have 2; 12.8% have 3; and 9.9% have 5+, showing highest concentration of large families, representing key targets for health and education-related benefits.
- **Common-law union**: concentrated in households with 2 (37.0%) or 1 child (28.1%); only 14.1% are childless, suggesting likely demand for pediatric and educational services.
- **Divorced**: 35.8% have no children in the household, but 19.4% have 3 children, a relatively high share, indicating overlapping parental obligations and economic challenges.
- **Widowed**: 41.7% childless (ages 0–23), as expected by age; moderate representation in households with 1–2 children (25.0% each), possibly indicating a focus on personal health or care for older dependents.

In short, household structures are diverse, but core segments where FP can deliver high social value are married or common-law unions with 1–2 children, along with a notable group of large families requiring tailored offers and communication.

SPOUSE'S AGE (STATISTICAL SUMMARY)

Valid data for this variable were available for only 242 cases, meaning the subgroup of respondents with a spouse who reported their age. Measures of central tendency are: mean = 44.7 years; median = 45; mode = 45. These aligned values suggest a roughly symmetrical distribution centered in the mid-40s. The standard deviation is 11.7 years, indicating high heterogeneity. The age range spans from 19 to 75 years.

Table 2. Sample Distribution by Sociodemographic Variables (continued)
Do you have FP insurance?

		Has FP insurance?		
		Yes	**No**	**Total**
Country of Origin	Ecuador	30.6%	44.3%	74.9%
	Venezuela	4.8%	2.2%	7.0%
	Colombia	9.0%	8.6%	17.6%
	Other	0.1%	0.4%	0.5%

Highest Education Level Completed	None	0.7%	1.1%	1.7%
	Primary	15.7%	15.8%	31.5%
	Secondary	21.0%	26.8%	47.8%
	Technical/Technological	2.3%	4.4%	6.7%
	University	4.6%	6.9%	11.5%
	Postgraduate	0.2%	0.5%	0.7%
Type of Employment	Self-employed / Business owner	34.6%	37.6%	72.2%
	Employee	8.6%	15.1%	23.8%
	None	1.2%	2.8%	4.0%
Sector of Activity	Agriculture / Livestock / Agroindustry	19.1%	16.7%	35.8%
	Commerce / Trade	10.7%	15.7%	26.4%
	Manufacturing / Production	3.3%	3.5%	6.8%
	Services	5.1%	5.3%	10.5%
	Other	6.3%	14.2%	20.5%
Income Variation	Decreased	6.4%	9.9%	16.3%
	Stayed the same	13.7%	25.7%	39.4%
	Increased	24.4%	19.9%	44.3%

COUNTRY OF ORIGIN

Most respondents are Ecuadorian (74.9%), followed by Colombian (17.6%) and Venezuelan (7.0%). Among those with FP, 30.6% are Ecuadorian, 9.0% Colombian, and 4.8% Venezuelan; among those without FP, 44.3% are Ecuadorian, 8.6% Colombian, and 2.2% Venezuelan. This shows that FP coverage is relatively more present among Ecuadorian and Venezuelan populations, while the Colombian proportion is consistent across both groups.

EDUCATIONAL ATTAINMENT

Secondary education is most common (47.8%), followed by primary (31.5%). Technical training accounts for 6.7%, university education 11.5%, and postgraduate studies 0.7%. The group without FP has a higher share of secondary (26.8% vs. 21.0% with FP), as well as more technical and university education. This suggests that FP is more prevalent among individuals with diverse education levels, but slightly less so among those with middle to higher educational attainment.

TYPE OF EMPLOYMENT

Self-employment/business ownership dominates (72.2%), with 23.8% being employees and 4.0% currently unemployed. The structure is similar across groups, though salaried employment is more prevalent among those without FP (15.1% vs. 8.6%). Self-employment is overwhelmingly common in the sample.

OCCUPATIONAL SECTOR

The most common employment sectors are agriculture/agroindustry (35.8%) and commerce (26.4%). Services (10.5%) and industry (6.8%) are less common. “Other” represents 20.5%, with a higher share among the uninsured (14.2% vs. 6.3%). Agriculture is slightly more represented among FP clients (19.1% vs. 16.7%), while commerce is more prominent among non-FP respondents (15.7% vs. 10.7%).

It is important to disaggregate findings by sector, as healthcare and protection needs (e.g., accident risk, travel time, income seasonality) vary across agriculture and trade/services sectors.

When analyzing employment type by education level, self-employment dominates across all groups (72.2% overall), but its prevalence decreases as education rises: 81% (no formal education), 79% (primary), 71.6% (secondary), 64.6% (technical), 58.6% (university), and 62.5% (postgraduate).

The trend is reversed for salaried employment, which increases with education level: 15.4% (primary), 25.1% (secondary), 29.3% (technical), and 38% among those with university/postgraduate degrees. This indicates greater formal job insertion with higher education. The unemployed account for only 4.0% of the sample, with slight increases among those with technical (6.1%) or only primary education (5.2%).

INCOME AND VARIATION BETWEEN 2024 AND 2025

When asked "What is your household's average monthly income? (sum of income from all household members, in June 2025)" (and June 2024), the valid data coverage was 1,192 (2025) and 1,185 (2024). Missing values were low (~2%), making year-to-year comparisons stable.

Average income rose from $710.52 (2024) to $756.40 (2025), a ~6.5% nominal increase (+$45.9). Median and mode remained at $500 for both years, suggesting a stable "typical income" for a large portion of households.

Standard deviation dropped from $824.55 to $775.72 (–5.9%), indicating slightly reduced income dispersion. Minimum income remained at $1 in both years (likely from respondents unwilling to disclose income), while maximum dropped from $10,000 to $9,600 (–$400), lowering the upper outlier range.

This reflects a positively skewed distribution, with the mean exceeding median and mode in both years, driven by a few high-income households.

While average income rose (~6.5%), the median and mode remained unchanged, indicating gains were concentrated at the upper end of the income distribution. The slight compression of income spread does not significantly shift the central value.

In the last 12 months, 44.3% reported income increases, 39.4% remained stable, and 16.3% saw decreases. The increase was higher among FP clients (24.4% vs. 19.9% without FP), while income stagnation was more common among those without FP (25.7% vs. 13.7%). Income decline was also slightly more frequent among the uninsured (9.9% vs. 6.4%).

These patterns suggest a more favorable income trajectory among FP clients; however, no causality is implied.

FP OWNERSHIP BY BRANCH

The branch-level analysis helps identify the geographic distribution of respondents in the sample, as well as target BVFE's efforts to better reach its clients with the products offered, including the FP.

Table 3. Sample distribution by Branch and FP enrollment

	Do you have BVFE's FP Insurance?			
	Yes		No	
Branch	Count	%	Count	%

	Do you have BVFE's FP Insurance?			
Ambato	16	47.1%	18	52.9%
Cayambe	17	53.1%	15	46.9%
Chillanes	17	44.7%	21	55.3%
Chone	18	51.4%	17	48.6%
Esmeraldas*	1	33.3%	2	66.7%
El Ángel	26	40.6%	38	59.4%
Guamote	30	60.0%	20	40.0%
Guaranda	17	53.1%	15	46.9%
Ibarra	9	23.7%	29	76.3%
La Mana	16	34.0%	31	66.0%
Latacunga	38	57.6%	28	42.4%
Lita	47	85.5%	8	14.5%
Machachi	9	33.3%	18	66.7%
Otavalo	18	40.9%	26	59.1%
Pimampiro	38	48.7%	40	51.3%
Portoviejo	31	36.9%	53	63.1%
Quevedo	16	51.6%	15	48.4%
Riobamba	12	29.3%	29	70.7%
Salcedo	33	50.0%	33	50.0%
San Gabriel	51	26.8%	139	73.2%
San Lorenzo	11	33.3%	22	66.7%
Tulcán	69	54.3%	58	45.7%
Total	**540**		**675**	

In the full sample (n=1,215), 44.4% reported having FP insurance, while 55.6% do not. Distribution by branch is heterogeneous, with some branches reporting over 60% FP ownership and others below 35%. The association between branch and FP enrollment is statistically significant ($\chi^2 = 98.83$; $p < 0.001$).

However, effect sizes are small (Pearson's R = 0.069; Spearman = 0.066), indicating that while there are differences across branches, the strength of this relationship is weak, and the statistical significance is largely driven by the large sample size.

It is important to emphasize that this sample is not representative at the branch level; therefore, results should not be generalized to each branch but rather interpreted as indicative.

SUMMARY OF SAMPLE SOCIODEMOGRAPHIC CHARACTERISTICS

- **FP Coverage**: 44.4% reported having FP insurance, 55.6% did not. This allows comparison of insured and uninsured profiles without major imbalance.
- **Sex**: Women outnumber men (57.3% vs. 42.7%). Among the uninsured, the female share is higher, warranting review of barriers and/or outreach strategies focused on women.
- **Age**: Predominantly working-age adults: 25–35 (37%) and 36–45 (23.1%). Young adults (18–24) make up 16%, and seniors (60+) 4.8%. This aligns with an economically active client base.
- **Children (0–23)**: 38.7% have no children in this age range; 25.5% have 1, and 20.6% have 2. The majority are not in caregiving households; it is relevant to interpreting child well-being indicators.

- **Marital Status**: Majority are single (62.5%), followed by married (19.9%) and common-law unions (11.1%). Divorced and widowed are minority groups.
- **Country of Origin**: Mostly Ecuadorian (74.9%), with Colombian (17.6%) and Venezuelan (7.0%) minorities, providing sufficient basis for cross-national analysis.
- **Education**: Low to middle formal education profile: 47.8% secondary, 31.5% primary. University (11.5%) and technical (6.7%) are less common. This is key for understanding insurance comprehension and communication strategies.
- **Employment**: Self-employment/business dominates (72.2%), followed by employees (23.8%) and the unemployed (4.0%). Agriculture (35.8%) and commerce (26.4%) are the leading sectors. This suggests variable income and high exposure to economic shocks.
- **Income Trends**: In the last year, 44.3% saw income increase, 39.4% remained the same, and 16.3% declined.

In conclusion, the sample is broad, diverse, and representative of BVFE's target clientele: working-age, self-employed, engaged in agro-commercial sectors, predominantly female, and mostly without children aged 0–23. The balanced presence of FP-insured vs. uninsured clients and multiple nationalities enables robust comparison of access, use, and impact of FP. Education and income variability must be considered when interpreting benefit use and in designing communication and improvement strategies.

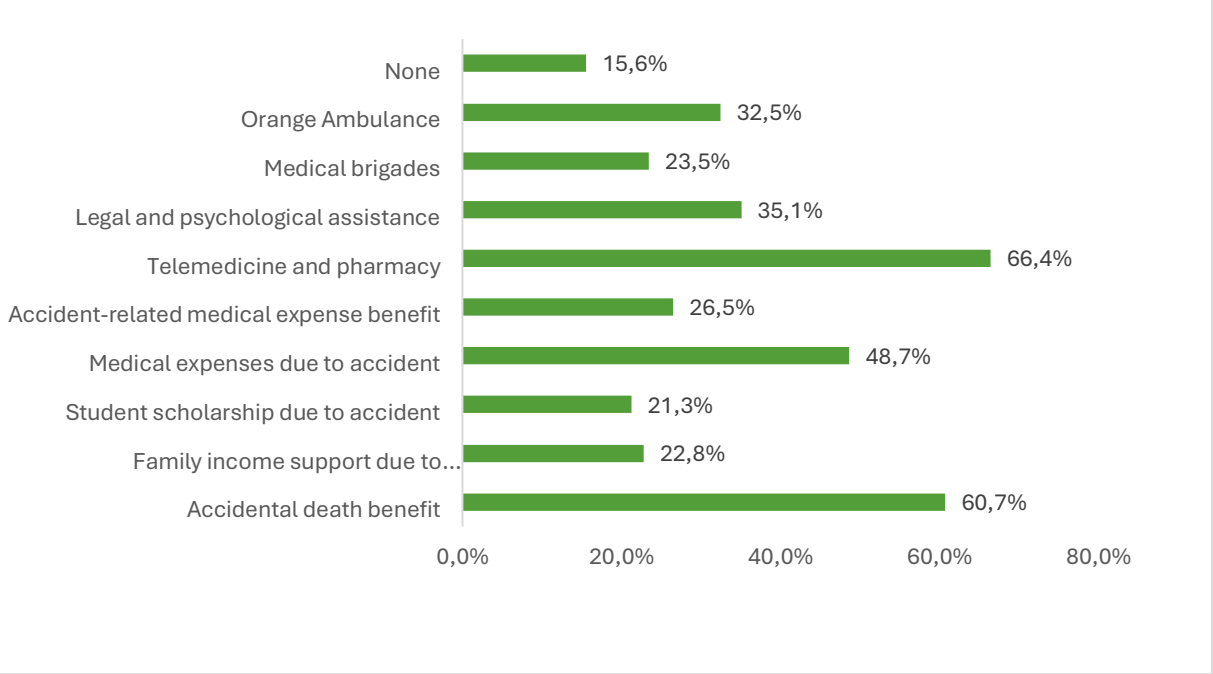
MODULE 2: USE OF BVFE SERVICES: FP INSURANCE

This section describes how FP insurance is effectively used by surveyed individuals and how well it responds to everyday needs and emergencies. In the final sample (n=1,215), 44.4% report having FP insurance, while 55.6% do not. The modules on knowledge and use are analyzed **only** among those who report having FP.

KNOWLEDGE OF FP BENEFITS (INSURED ONLY, N=540)

Among those who do have FP, awareness of the benefits is mixed and concentrated in two main areas: services for everyday/quick access and those for catastrophic events. Still, 15.6% state they are not aware of any benefits, a critical finding for management and support.

Chart 1. Awareness of FP benefits
Please indicate which of the following benefits of your Familia Protegida insurance you are aware of. You may select all that apply. (% selected)



BENEFITS WITH HIGHEST AWARENESS:

- Telemedicine and pharmacy (66.4%): the most recognized benefit; confirms that "low-barrier" and immediate care offerings are more easily absorbed.
- Accidental death benefit (60.7%): strong recall of the main catastrophic coverage.
- Medical expenses due to accident (48.7%): mid-to-high awareness, consistent with the logic of protection for acute events.

BENEFITS WITH INTERMEDIATE AWARENESS:

- Legal and psychological assistance (35.1%) and Orange Ambulance (32.5%): awareness is lower than expected for services perceived as highly valuable during crises; their use may be limited due to lack of knowledge about when and how to activate them.
- "Medical expense benefit due to accident" (26.5%): the overlap with “Medical expenses due to accident” (48.7%) suggests semantic confusion; name duplication likely hinders recall.

***BENEFITS WITH LOWER RECOGNITION*:**

- Family income due to accidental death (22.8%), Educational scholarship due to accident (21.3%), and Brigadas Médicas (Medical Brigades) (23.5%): low visibility despite their relevance for households with children and local interventions. These are “less tangible” or less frequently used benefits, requiring proactive communication and real-life examples.

Summary: 1 in 6 insured individuals does not recognize any benefit. FP has high recall for telemedicine and accidental death coverage, but benefits with high social value (income support, scholarships, Brigadas Médicas, ambulance) need to be simplified, better publicized, and supported by standardized terminology to improve understanding and timely use.

USE OF FP SERVICES IN THE PAST 12 MONTHS (INSURED ONLY, N=540; N=159 WHO USED SERVICES)

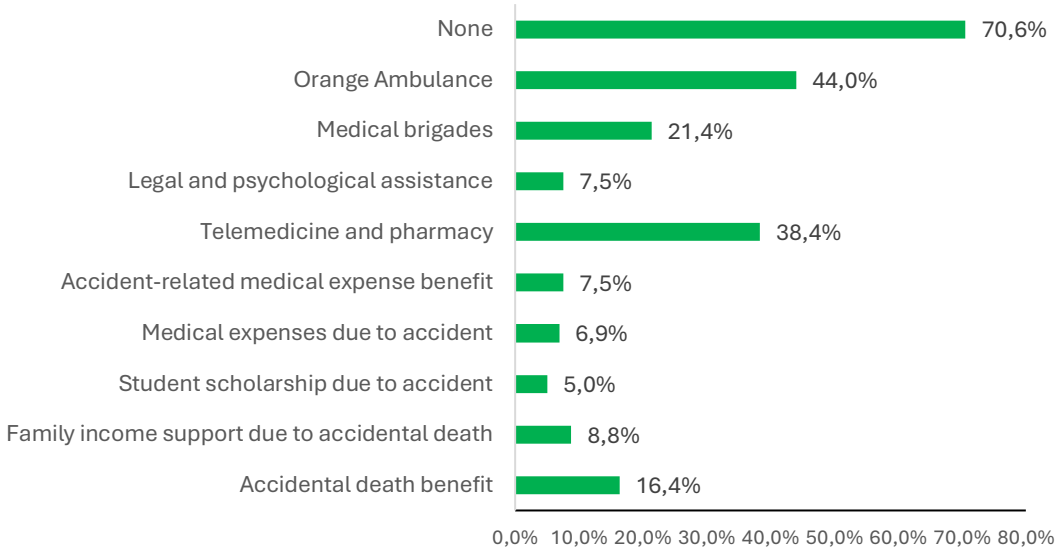
70.6% report not having used any FP service in the past year. Among those who did, the most used are immediate-response services:

- Orange Ambulance: 44.0% (mostly used),
- Telemedicine and pharmacy: 38.4% (second main access point),
- Brigadas Médicas: 21.4%.

Indemnity and support services show low usage, consistent with benefits triggered by less frequent events or requiring additional procedures:

- Accidental death benefit: 16.4%,
- Family income due to accidental death: 8.8%,
- Medical expenses/benefit due to accident: 6.9%–7.5% (with possible confusion in terminology),
- Legal and psychological assistance: 7.5%,
- Educational scholarship due to accident: 5.0%**.**

Chart 2. Use of FP services (insured only)
Now, please tell us which of these services you have used in the past 12 months. You may select all that apply (% selected)



This shows high non-usage (7 out of 10), which is expected for low-claim insurance. However, compared to "awareness," there remains an activation gap: More people remember telemedicine (66%) than those who used it (38%), and a similar pattern appears with ambulance services (33% aware; 44% report using it, likely influenced by field experiences in recent emergencies).

Fast-access services (ambulance/telemedicine) dominate actual use, suggesting that simple and visible channels lead to more effective activation.

Lastly, low usage of financial coverage (income, accident expenses, scholarships) could be due to:

- Lower occurrence of triggering events,
- Documentation requirements,
- Lack of clarity on eligibility, or
- Terminological overlap ("medical expenses due to accident" vs. "medical expense benefit").

REASONS FOR NOT USING FP BENEFITS (BASE: INSURED WHO DID NOT USE ANY SERVICE IN THE PAST 12 MONTHS, N=381)

Among those who did not use FP benefits and answered the question (n=381; 31.4% of total), the main reasons are concentrated in four areas:

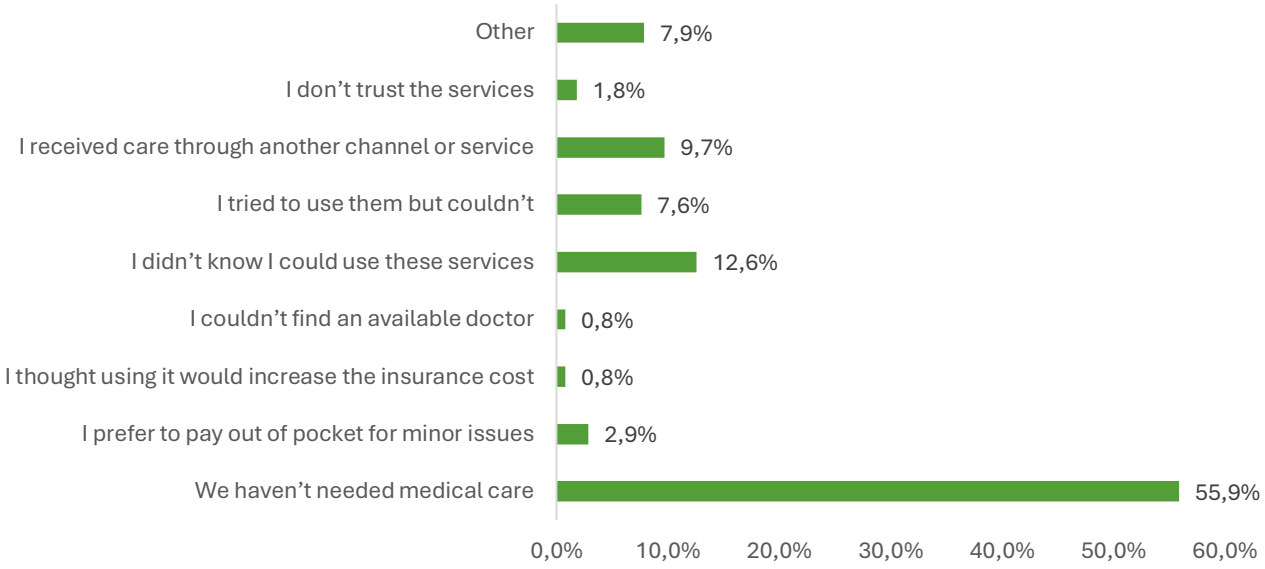
- No medical attention was needed: 55.9%. The primary and expected reason for low-claim insurance.

- Lack of knowledge about eligibility/use: 12.6% stated they didn't know they could use the services.
- Use of other alternatives outside of FP: 9.7% sought care through other means (public/private).
- Access barriers when trying to activate the insurance: 7.6% tried but couldn't use it; 0.8% reported no doctor was available.

Less frequent reasons:

- Prefers to pay out-of-pocket for minor services: 2.9%
- Lack of trust in services: 1.8%
- Fear of increased cost usage: 0.8%
- Other (unspecified): 7.9%

Chart 3. Reasons for not using FP benefits
If you haven't used the insurance benefits, what is the main reason?



While the lack of need dominates, there is an avoidable gap (≈22–30% of valid responses) linked to information and friction in usage: lack of knowledge, activation issues, and availability.

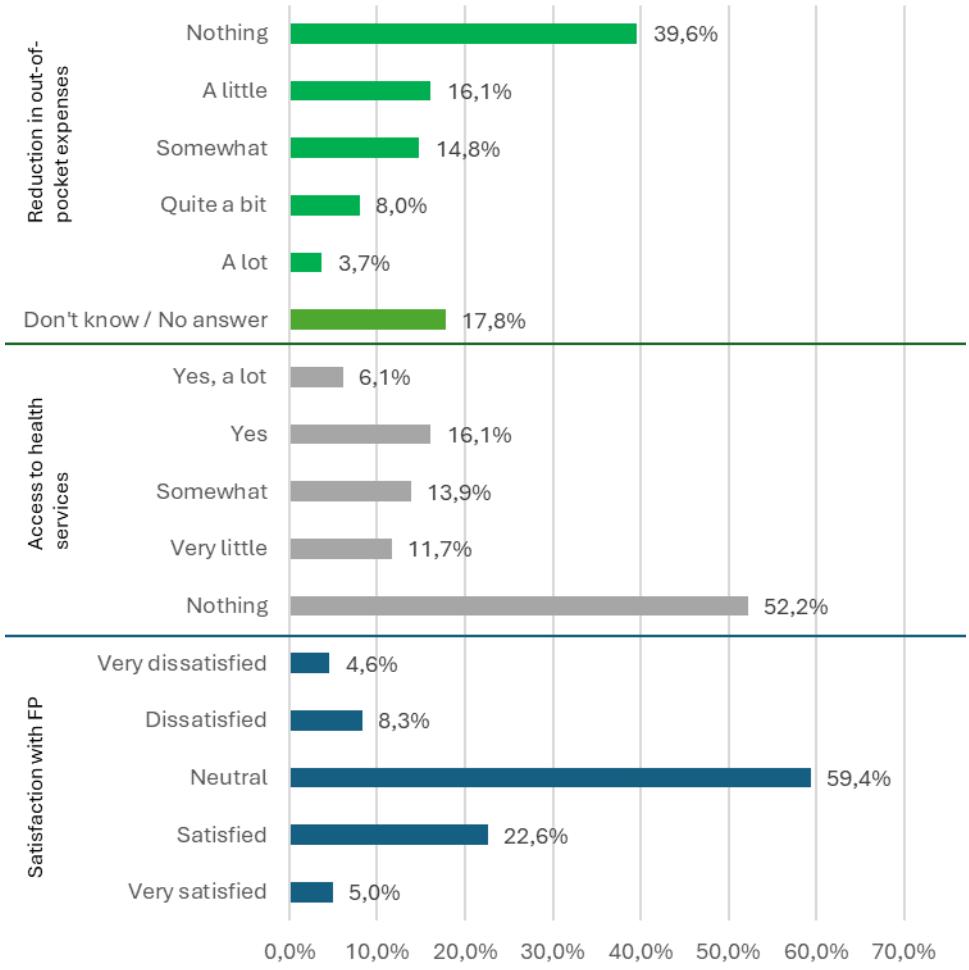
In summary, beyond low claim rates, there is room to improve FP benefit activation and recall through simple education actions, streamlined processes, and ensuring service availability.

PERCEPTION OF FP INSURANCE

Below, we analyze three perception items, applied only to respondents who have the FP insurance from BVFE (n=540, 44.4% of the total sample):

1. Savings on household expenses (health, transportation, medication),
2. Improved access to health services due to FP coverage, and
3. Satisfaction with the FP services received.

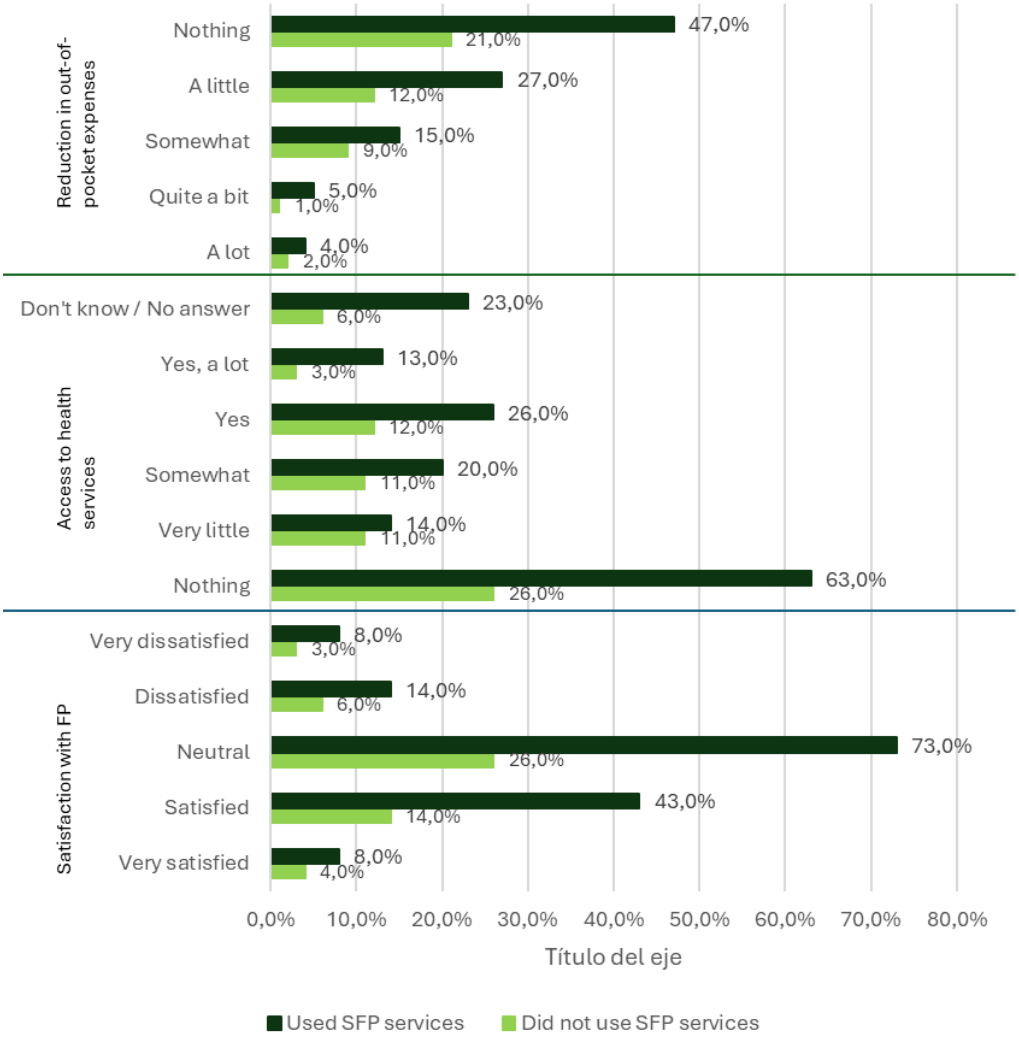
Chart 4. General Perception of FP (in %, n=540)



These questions capture perceived value and user experience, and do not represent a causal effect. Responses were measured using ordinal scales (from “None/Very little/…” to “A lot/Very satisfied”) and are reported as valid percentages. The results provide a snapshot of recent user experience.

The analysis is broken down by whether the insured respondent used FP services or not (as shown in the next chart) and is complemented with sociodemographic cross-analysis (income, age, country of origin, and household size) to explore differences in perception and insurance activation. These variables are analyzed based on income variation, perceived wellbeing, age group, country of origin, and number of children.

Chart 5. Perception of FP, by usage of FP services (in %)



"THE FP SERVICES HELPED REDUCE HOUSEHOLD EXPENSES"

The overall results show that perceived savings are limited: "None" (39.6%) and "Little" (16.1%) are the most frequent responses. Positive evaluations ("Somewhat" 8.0%, "A lot" 3.7%) are a minority; "Moderate" reaches 14.8%. A significant share selected "Don't know/No response" (17.8%), suggesting gaps in awareness or effective use. Key findings by variable:

- FP service usage (Chart 5): Among those who used FP, nearly 3 out of 4 say the insurance helped "somewhat," "moderately," or "a lot" (27% + 29% + 15%), while only 21% say "none." Among non-users, almost half (47%) report no help at all, and "don't know" responses are common (23%). This reveals a clear gap in perceived economic impact based on actual use.
- Income variation: Respondents whose income increased show more responses of "None" (20.9%) and some in mid-levels ("Moderate" 8.3%, "Somewhat" 5.1%). In the stable-income group, "None" (14.2%) and "Don't know" (6.3%) dominate. Among those with decreased

income, perceived savings are low (only 4–5% in each positive category), which aligns with financial pressures that may obscure perceived benefits.

- Change in perceived wellbeing (GHQ): Among those reporting "less distress," small but present proportions appear in "Somewhat/A lot" (0.9%–1.0%). In the "no change" group, most responses fall under "None" (36.9%). Among those with "greater distress," responses are marginal. In sum, perceived savings are slightly more likely when wellbeing does not worsen, but the effect is moderate.
- Age: The 25–35 age group concentrates more responses in "None" (15.6%) and "Moderate" (5.4%). The 36–45 and 46–59 groups show a similar pattern: high "None" and few in "Somewhat/A lot." For both the 18–24 and 60+ groups, positive responses are very low.
- Country of origin: Ecuador accounts for the majority of responses, with "None" being most frequent (24.3%). Colombia contributes 10.9% to the "None" category and has limited positive responses. Venezuela appears in low proportions across all categories. Perceived savings among migrants exist but are less pronounced.
- Number of children: Households with 1–3 children report the most "None" (24.1%) and a portion of "Moderate/Somewhat." Childless households also report high "None" (13.5%). Households with 4+ children are marginal across all categories, suggesting that where care burdens are high, savings are not clearly recognized.

"HAVING FP HAS IMPROVED ACCESS TO HEALTH SERVICES"

Overall, responses are again dominated by "None" (52.2%) and "Very little/Moderate" (11.7% and 13.9%). Strong improvement responses ("Yes, a lot" 6.1%, "Yes" 16.1%) are a minority. Perceived improvement is partial, with a large segment not noticing any change. Analysis by subgroup:

- FP service usage (Chart 5): Among FP users, 59% say the insurance has improved their access to health services ("a lot," "yes," or "moderate") versus only 26% of non-users. In contrast, 63% of non-users say access has not improved at all. This confirms a clear link between effective use and more favorable perceptions of access.
- Income variation: Most responses are from the stable/increased income groups, including some positive responses ("Yes" 8.2% for increased; 5.7% for stable). Where income declined, strong improvement is low (only 1.3% say "Yes, a lot"), and "None" dominates (6.3%). Economic stress seems to reduce the perception of improved access.
- Change in perceived wellbeing (GHQ): With "less distress," more say "Yes" (14.6%) and "Yes, a lot" (5.2%); in "no change" and "more distress" groups, "None" is more frequent. Perceived improved access is associated with better subjective wellbeing.
- Age: In the 25–35 age group, more respondents report "Yes" (6.3%) and "Yes, a lot" (1.7%). The 36–45 group also shows some improvement. For 18–24 and 60+, "None" dominates, with very low strong-improvement responses. Positive perception appears more common in middle age groups.

- Country of origin: Ecuadorians are more likely to respond “Yes” and “Yes, a lot” (12.8% and 4.5%). Colombians and Venezuelans show lower satisfaction and more “None” responses. This may reflect access barriers or weaker connections to the healthcare network among migrants.

- Number of children: Households with 1–3 children report more improvement (“Yes” 9.1%, “Yes, a lot” 4.3%). Among childless households, “None” dominates (18.3%). Improvement is more noticeable where health service demand is higher.

SATISFACTION WITH FP SERVICES RECEIVED (INSURED, N=540; N=159 WHO USED SERVICES)

As shown on the chart (Chart 5), the modal response is “Neutral” (59.4%), followed by “Satisfied” (22.6%) and “Very satisfied” (5.0%). Dissatisfaction is present but low (8.3% + 4.6%). Overall, the experience is average, with a quarter of respondents in positive categories.

- FP service usage (Chart 5): Users are more satisfied, 51% report being satisfied or very satisfied, and only 22% are dissatisfied. Among non-users, “Neutral” dominates (73%), and satisfaction is lower (18%). This reflects more positive evaluations when actual experience exists.

- Income variation: Among those with increased income, many responses fall under “Neutral” (32.8%) and “Satisfied” (11.8%). The same is true for those with stable income (“Neutral” 18.6%, “Satisfied” 7.6%). Among those with decreased income, “Neutral” is still dominant (8.0%), with some dissatisfaction, suggesting that financial constraints can moderate satisfaction levels.

- Change in perceived wellbeing (GHQ): Among those with “less distress,” satisfaction grows (“Satisfied” 3.1%, “Very satisfied” 0.6%). The “no change” group contains most “Neutral” responses (54.3%). Where distress increased, dissatisfaction rose again pointing to a correlation between subjective wellbeing and satisfaction.

- Age: Most “Neutral” and “Satisfied” responses come from the 25–35 and 36–45 age groups. The youngest and oldest groups show very low percentages at the extremes (“Very satisfied” or “Dissatisfied”). The pattern suggests correct, though not exceptional, experiences during active age ranges.

- Country of origin: Ecuador contributes most to “Neutral” (38.4%) and “Satisfied” (18.2%). Colombia and Venezuela have fewer respondents in the “Satisfied” categories and more “Neutral” responses, likely reflecting differences in expectations or access experiences.

- Number of children: Households with 1–3 children show the highest “Satisfied” (13.5%) and “Very satisfied” (3.3%). Among childless households, “Neutral” is dominant. Where children are present, satisfaction tends to rise when services are used.

SUMMARY:

Across the three items (savings, access, satisfaction), the same pattern is observed: **high levels of lack of knowledge or neutrality**, **partial improvements**. In contrast, **positive association between effective use, lower distress, and better evaluation**.

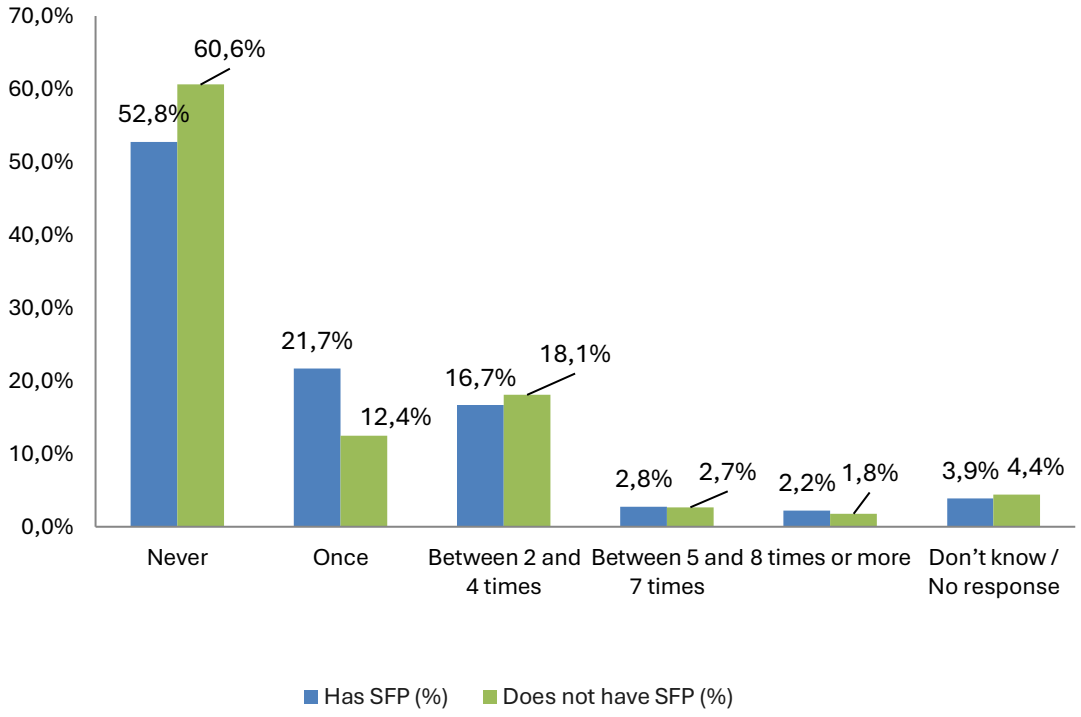
This suggests that the main area for improvement lies in **activating informed usage**, through onboarding, clear service routes, referrals, and follow-up, with a focus on **migrants, households with children, and clients facing declining income**. These actions align with evaluation goals and increase the likelihood of observing real change in access, savings, and wellbeing during results analysis.

FREQUENCY OF HEALTHCARE VISITS IN THE LAST 12 MONTHS (INCLUDING REMOTE CARE, TOTAL SAMPLE, N=1,215)

Across the total sample, 57.1% reported no healthcare visits in the past 12 months; 16.5% had one visit, 17.4% had 2–4 visits, and approximately 4.7% reported 5 or more visits (2.7% had 5–7, and 2.0% had 8+). An additional 4.2% responded "Don't know/No response."

The distribution differs significantly by FP insurance status ($chi^2 = 19.5$; $p = 0.002$). However, the linear-by-linear association test is not significant ($p = 0.445$), indicating that there is no consistent increasing or decreasing trend across all categories; instead, the differences are concentrated in specific categories.

Chart 6. Frequency of healthcare visits in the last year, by FP insurance status
How many times have you received health care (including remote care) in the past 12 months? (% based on whether the respondent has SFP or not)

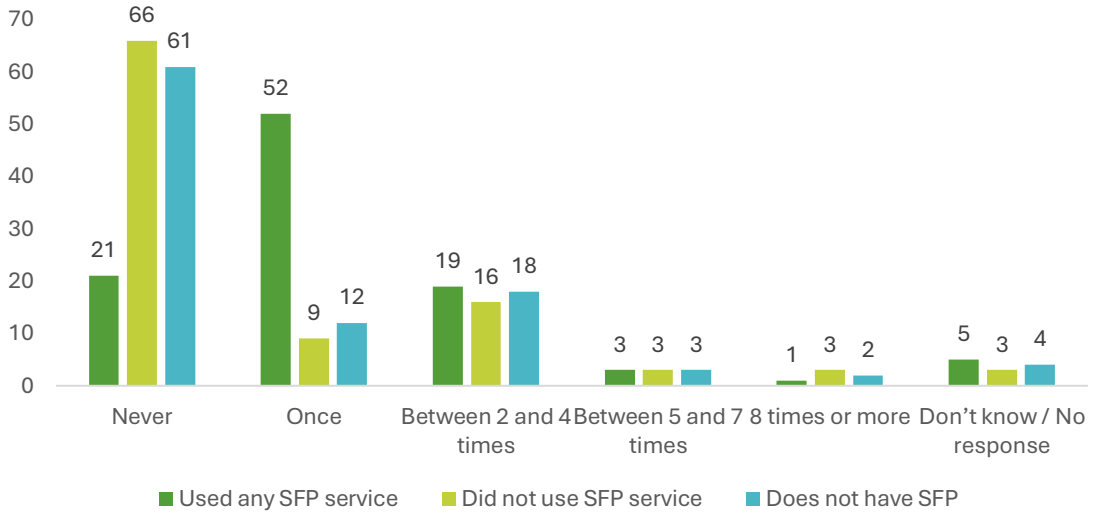


When comparing FP vs. No FP groups:

- No visits: FP 52.8% vs. No FP 60.6%. Those with FP are less likely to have had no healthcare at all.

- One visit: FP 21.7% vs. No FP 12.4%. FP is associated with a higher likelihood of at least one healthcare (possibly through telemedicine/pharmacy or a one-off consultation).
- 2–4 visits: Small difference (FP 16.7% vs. No FP 18.1%).
- High-frequency visits (5–7 and 8+): Slightly more common among those with FP (2.8% and 2.2%) compared to No FP (2.7% and 1.8%), though the difference is minimal.
- Don't know/No response (DK/NR): Similar between groups (FP 3.9% vs. No FP 4.4%).

Chart 7. How many times did you receive health care (including remote care) in the past 12 months?
(% based on whether the respondent has FP, used services or not, or does not have FP)



When analyzing healthcare use based on whether FP services were used or not, the data reveals:

- The previous chart shows that FP insurance, when used, is associated with a shift from no care to at least one healthcare contact. Among those who used FP services, just over half (51.6%) had one healthcare visit in the past 12 months, and nearly 19% had 2–4 visits. Only 20.8% had no visits. In contrast, among those who have FP but did not use it, two-thirds (66.1%) had no healthcare visits, and only 9.2% had one visit, a pattern nearly identical to those without FP (60.6% no visits; 12.4% one visit).
- High-frequency healthcare use (5+ visits) remains low and similar across all three groups. This indicates that FP does not lead to overuse or excessive utilization. Instead, it appears to enable at least one annual point of contact for some covered clients who otherwise might have remained entirely outside the healthcare system.

SUMMARY:

The evidence confirms that **FP insurance only makes a clear difference when services are used**. Among those who activated their FP coverage, the majority had **at least one interaction with the**

health system in the past year, **over half had one visit**, and **about one-fifth had 2–4 visits**. Only a minority (about 20%) had no health contact.

In contrast, the pattern for those **who did not use their FP coverage is nearly identical to the uninsured group**: roughly two-thirds had no visits, and only 10–12% had a single visit.

Frequent healthcare use (5 or more visits) is low and comparable across all groups. This suggests that **FP does not encourage overutilization** but rather acts as a **trigger mechanism** helping a subset of insured individuals move from **"no healthcare use" to "at least one annual visit"**, thus reducing the number of people who remain entirely disconnected from the healthcare system.

MODULE 3: QUALITY OF LIFE AND PERCEIVED WELL-BEING

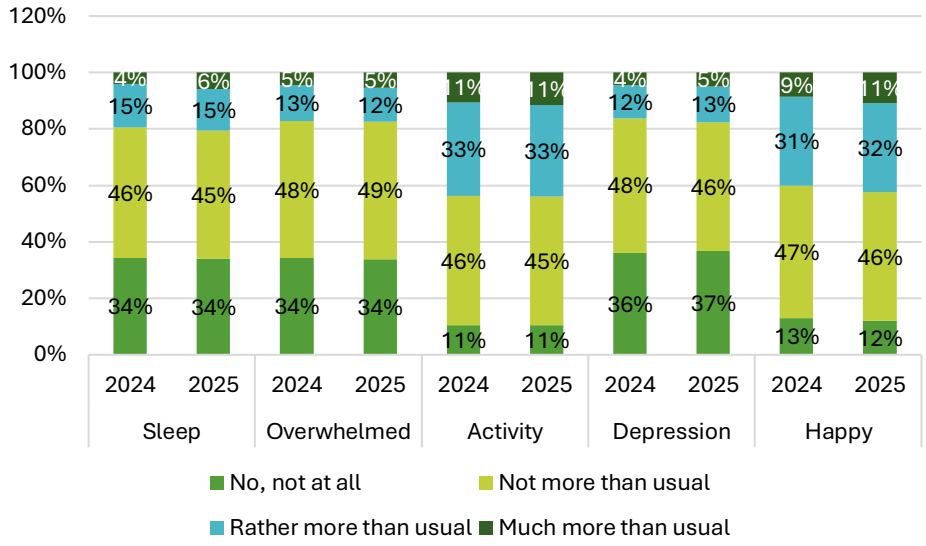
This section uses the GHQ-5 (General Health Questionnaire, 5-item short version), a screening tool for psychological distress in the general population. The GHQ-5 briefly assesses symptoms and perceptions related to stress and mood. Higher scores indicate greater distress. It was included because it provides a standardized and clear measure of emotional state, which is useful for exploratory connections between perceived well-being, use of FP, and changes between last year and this year. It is important to note that this instrument does not constitute a clinical diagnosis.

The GHQ combines negative and positively framed items and is interpreted as a variation in recent distress/well-being compared to one's usual state. In our analysis, "better/worse" refers to perceived changes year-over-year in each domain. The five items included are:

- Sleep: "Have your worries caused you to lose much sleep?" Evaluates sleep disturbances due to worry or rumination (difficulty falling asleep, awakenings, non-restorative sleep). More agreement = more distress; improvement = better sleep/less interference from worries.
- Overwhelm: "Have you felt constantly under strain and pressure?" Captures perceived sustained stress (feeling pressured, nervous, tense). More agreement = more stress; improvement = reduced perceived strain.
- Activities: "Have you been able to enjoy your normal daily activities?" Measures functioning and pleasure in daily routines (enjoyment of work, home tasks, leisure). Less enjoyment = possible anhedonia; improvement = resumption of enjoyment and regular functioning.
- Depression: "Have you felt unhappy and depressed?" Explores perception of depressive mood (sadness, discouragement, loss of interest). More agreement = higher perceived distress; improvement = reduced depressive feeling.
- Happiness: "Have you felt reasonably happy, considering all circumstances?" A general assessment of well-being. More agreement = greater perceived subjective well-being; worsening = drop in mood/global satisfaction.

GENERAL GHQ-5 ANALYSIS BY DOMAIN: JUNE 2024 VS. JUNE 2025

Chart 8. Year-over-year difference by GHQ-5 aspect: 2024 vs. 2025 (%)



Below is a concise reading of GHQ-5 results comparing 2024 vs. 2025. First, we review the response profiles for each item, followed by the recoding into "low distress / distress of concern" as per GHQ-5 methodology.

SLEEP

The pattern is very similar between years, but with a slight deterioration: "Much more than usual" rises from 4% to 6%, and "No more than usual" drops by 1 percentage point (46% → 45%). A small shift toward greater sleep disruption.

- Low distress: 81% → 79%
- Distress of concern: 20% → 21% (Slight worsening in insomnia/hyperarousal.)

OVERWHELM

Virtually unchanged: "Not at all" remains at 34%, and the sum of higher distress categories stays around 17%–18%. No relevant changes.

- No change (Low distress: 83%, distress: 17%)

ACTIVITIES

No variation: 11% "Not at all," 33% "Much more than usual," and 11% "Far more than usual" in both years. Persistent high levels of functional limitation.

- Distress remains high (56%); only 44% report low distress. This is the primary functional red flag among the items.

DEPRESSION

Slight worsening: "No more than usual" drops from 48% to 46%, while higher distress categories increase (12% → 13%, and 4% → 5%).

- Low distress: 84% → 82%

- Distress of concern: 16% → 18% (Marginal decline in mood.)

HAPPINESS

Slight improvement: higher categories increase ("Much more than usual" 31% → 32%; "Far more" 9% →11%). The only item with a consistent positive signal.

- Mild improvement:
    - Low distress: 40% → 43%
    - Distress: 60% → 58% Suggests slightly greater "subjective well-being" despite stability in other domains.

THE EMOTIONAL PROFILE AND PERCEPTION OF WELL-BEING/DISTRESS ARE GENERALLY STABLE, WITH SMALL SHIFTS IN OPPOSING DIRECTIONS:

- Slight deterioration in sleep and depressive mood.
- Improvement in happiness.
- No change in perceived tension.
- Functional limitation on daily activities remains the most critical issue (56% in distress of concern).

GHQ-5 ANALYSIS BY VARIABLES OF INTEREST

In the analysis by sociodemographic variables and others of interest (such as FP coverage), the following patterns are observed:

- Sleep. Year-over-year stability predominates, and variations (better/worse) are minor. The only consistent gradient is economic: when household income increases, there is a slight rise in those reporting better sleep. No relevant differences are observed based on FP coverage or country of origin.
- Overwhelm. Also remains mostly "the same." Small improvements are concentrated among those reporting increased income; the rest is distributed between slight improvement and slight worsening, with no clear trends by FP status or nationality. This suggests that economic pressure has a greater impact than other characteristics.
- Activities. This is the most "inert" domain: "no change" dominates, and improvements or declines are minimal. When improvements do occur, they are slightly more frequent among those with increased income and households with 1–3 children.
- Depression. Small and symmetric changes; improvement is slightly more frequent when income rises, but with no substantive differences by FP status or country. This dimension requires continued monitoring rather than causal inferences.
- Happiness. This is the most "responsive" indicator to economic context: among those with increased income, a higher proportion reports feeling better, while the proportion reporting worsening remains low. The pattern is flat again across FP status and country.

Across all domains, stability ("no change") predominates, with proportions close to or exceeding 40% in each sub-table. When aggregated by country, Ecuador accounts for most of the responses due to its sample weight. The proportions of improvement and worsening are low and similar within each item, with nuances described below:

FP Coverage.

No substantive gaps are observed between people with and without FP. For example:

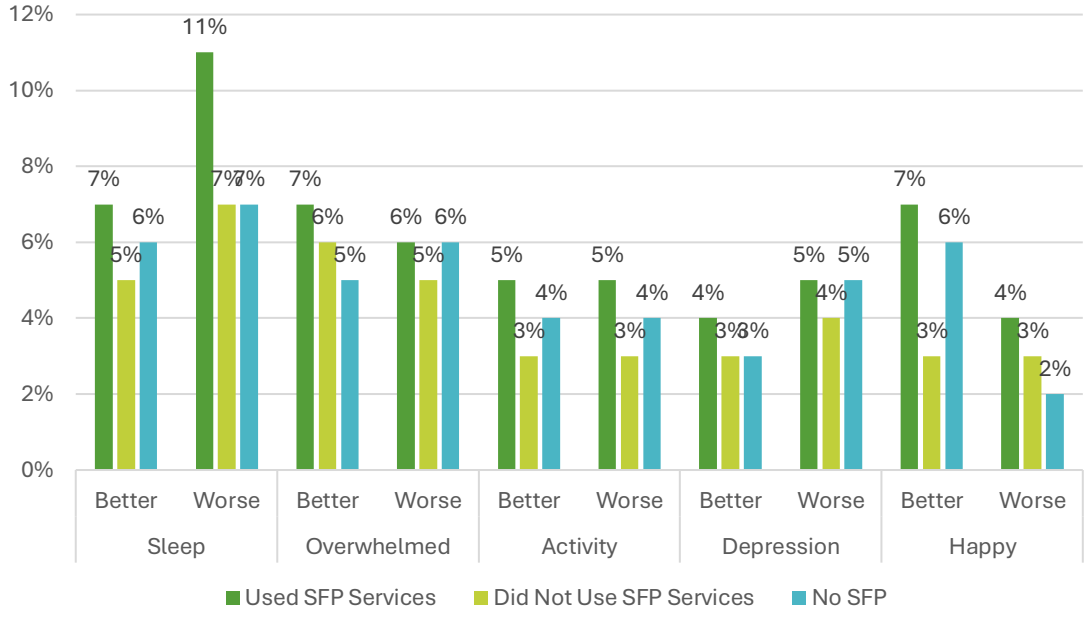
- "Better" in sleep: 2.6% (FP) vs. 3.5% (no FP),
- Overwhelm: 2.7% vs. 2.8%,
- Depression: 1.6% vs. 1.9%."Same" responses are slightly more common among those without FP (e.g., activities: 51.4% vs. 40.8%), but absolute differences remain small.

FP Users vs. Non-Users (among those with FP):

For sleep and happiness, those who have used FP services show slightly higher improvement than non-users (e.g., "better in happiness": 6.9% vs. 3.4%), but also a slightly higher proportion reporting worsening:

- Sleep worse: 10.7% vs. 7.3%
- Happiness worse: 4.4% vs. 2.6%. For overwhelm, activity, and depression, differences between users, non-users, and those without FP are minimal and inconsistent; the percentages of "better" and "worse" vary only by 1–2 points between groups.

Chart 9. Year-over-Year Difference in GHQ-5 Dimensions
Difference between 2024 and 2025 in GHQ-5 Dimensions, only "better" and "worse". (% based on use or non-use of SFP services and no SFP)



The data suggest that between 2024 and 2025, mental health measured by the GHQ-5 remains largely stable, and differences between users, non-users, and those without FP are small and unsystematic.

The use of the FP insurance does not appear to be associated with marked or sustained changes in sleep, overwhelm, activity, depression, or happiness. Rather, a pattern of minor variations in both directions (better/worse) is observed, without a clear and consistent effect attributable to FP on clients' psychological well-being.

Country of Origin.

The structure by country reflects the weight of Ecuador (e.g., "same" in happiness: 69.2% Ecuador, 6.5% Venezuela, 16.4% Colombia). The proportions of "better" and "worse" in each item are low and similar across countries. Colombia shows slightly more "same" responses in several rows, while Venezuela contributes smaller proportions (due to the small subsample). No clear gradient**s** by nationality are observed; a more refined analysis would require a larger sample of Venezuelan/Colombian respondents.

Sex

Across all GHQ-5 items, stability predominates (≈80–88% "same" among both men and women). Women show slightly more variability:

- Higher percentages of "somewhat worse" in sleep (10.5% vs. 6.7%) and overwhelm (8.8% vs. 5.6%),
- But also, more improvements than men in most dimensions (e.g., depression and activities). In happiness, stability is nearly identical (≈86%), with slightly greater deterioration among men.

Sex differences are small (2–4 pp) but suggest that women experience more changes, both negative and positive, especially in sleep and tension. Operationally, it is advisable to reinforce stress management and rest support targeted at women while maintaining universal interventions, given the overall high level of stability.

Number of children (aged 0–23).

In general, households with 1–3 children:

- Concentrate more "same" responses (e.g., sleep 46.8%; overwhelm 47.8%; happiness 50.1%),
- And most of the minor improvements (sleep 3.0%; overwhelm 3.6%; happiness 2.7%), consistent with their sample weight.

Households with more than 4 children show very little variation (better or worse <1% in almost all items) and high stability, which may be due to low sample size or adaptation of routines with few changes year to year.

In this sense, if the goal is to improve well-being:

- The typical family with 1–3 children is the largest-volume target for brief interventions (e.g., education on sleep, stress management).
- For households with >4 children, strategies should focus on logistical support (time, caregiving assistance) rather than generic psychoeducation.

Income variation.

This is the variable with the most consistent signal:

- When income increased, the share of "better" responses grew in all items:
    - Sleep: 4.0% (vs. 1.4% stable; 0.6% decreased),
    - Overwhelm: 3.6% (vs. 1.1%; 0.8%),
    - Activities: 2.6% (vs. 0.8%; 0.7%),
    - Depression: 1.8% (vs. 0.8%; 0.8%),
    - Happiness: 2.9% (vs. 1.2%; 1.0%). Worsening is not concentrated in a single group but tends to be slightly higher when income increases (sleep: 3.2%; depression: 2.3%), suggesting heterogeneity, some improvement, others worsen (possibly due to increased work hours/stress from new jobs).

The income gradient supports the idea that economic improvement is associated with better self-reported well-being.

Operationally, it is recommended to:

- Prioritize psychosocial support/stress management education for those whose income did not grow (or declined),
- For those who gained income but show greater distress, explore work-related psychosocial risks (workload/shifts, work-life balance, transport) and offer targeted tele-support.

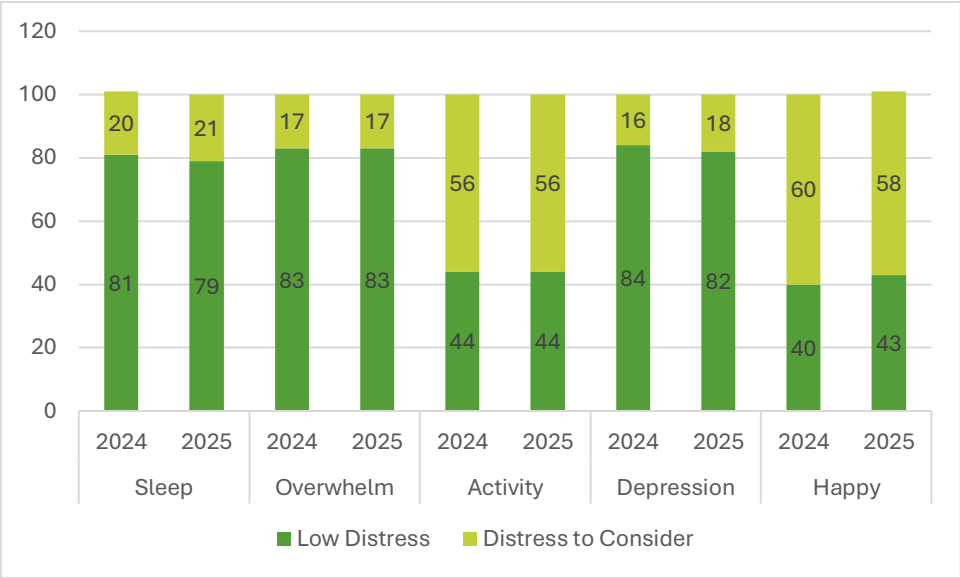
GHQ-5 VARIATION ANALYSIS: 2024–2025

The temporal pattern aligns with a state of equilibrium with small fluctuations. Two signals coexist:

- A more positive emotional tone: slight improvement in happiness and some shift from moderate distress to low distress levels.
- Stress-sleep as bottlenecks: sustained stress appears coupled with slight deterioration in sleep, suggesting a stress → light sleep → less daily recovery cycle.

Functionally, difficulty enjoying/resuming activities remains the most persistent gap: even though it has not worsened, it continues to limit subjective recovery and daily functioning.

Chart 10. Evolution of Perceived Distress Between 2024 and 2025
Difference in GHQ-5 between 2024 and 2025 (in %)



From a programmatic perspective, this points to the need for low-intensity, high-reach interventions, such as:

- Sleep hygiene reminders,
- Brief stress regulation techniques (e.g., breathing, psychoeducation),
- "Activity prescriptions" (micro-goals, pleasure/dominance agendas), to be integrated into FP channels (telemedicine/support services).

SUMARY: QUALITY OF LIFE AND PERCEIVED WELL-BEING

These items were included to estimate the proximal effect of BVFE services, particularly FP, on effective access to care and its translation into psychosocial well-being (the core objective of the study). The results show largely stable well-being, with slight improvements in happiness and residual tensions in stress and sleep. This supports **the hypothesis that FP helps contain psychological distress in a demanding economic context but also points to areas for improvement: strengthening services and communication focused on stress management, rest, and reactivation of gratifying activities.**

In this sense, the findings are aligned with the study's purpose: to identify where services are already mitigating distress and where support should be focused to increase their impact on quality of life. It is important to emphasize that **causality cannot be established**, and that this instrument does not constitute a clinical diagnosis but rather an approximation of individuals' self-perceived well-being.

When comparing FP users and non-users, perceived changes in quality of life and psychosocial well-being are moderate and, overall, very similar between both groups. Those who use FP show slight signals of improvement in areas such as sleep and happiness, but also a slightly higher proportion reporting isolated deteriorations, suggesting individual variation rather than a systematic pattern of impact.

Among non-users, perceived stability is more prevalent, with no significant differences compared to those who do use the insurance. Taken together, the data show that effective use of FP is **not associated with marked or sustained changes in GHQ-5 scores between 2024 and 2025**, but rather with **discrete fluctuations in both directions**.

This reinforces the interpretation that **FP plays a role of containment rather than transformation** in psychosocial well-being, and that its greatest added value may lie in its **capacity to prevent deterioration**, rather than to generate noticeable short-term improvements.

MODULE 4: CHILD WELL-BEING

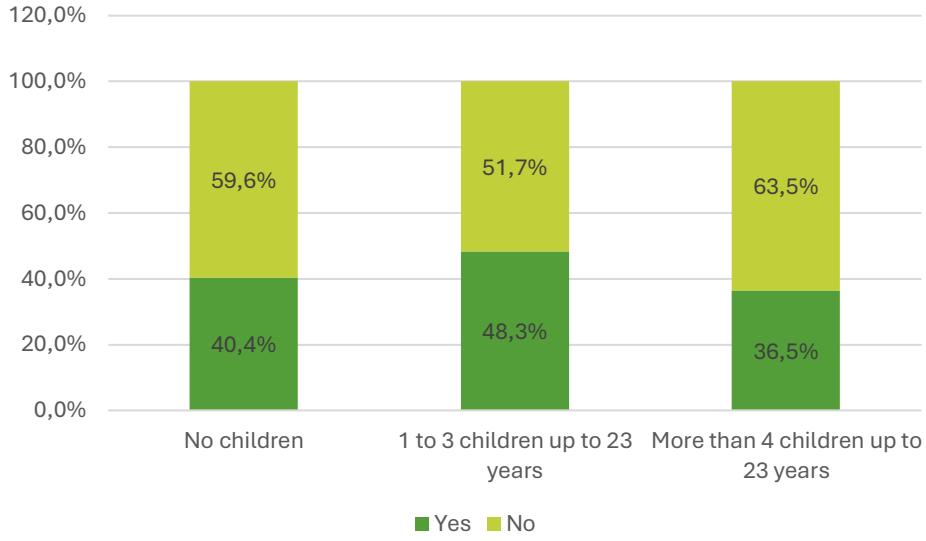
The study includes a dedicated module on the well-being of children and adolescents (ages 0–23, the upper age limit to qualify as a beneficiary of FP) because this is a key channel to observe indirect effects of BVFE's FP insurance, and more broadly, the impact of access to healthcare and financial protection at the household level. This section is guided by two main areas of focus:

- Use of services and potential impacts on health and educational trajectories (such as regular school attendance, illness episodes, access to medical care and medicines); and
- Perceptions of well-being in daily-life dimensions (such as time for play/study, household workload, school supplies, etc.).

HOUSEHOLDS WITH CHILDREN AND FP ENROLLMENT

Out of the total sample (n=1,215), 745 individuals report having children aged 0 to 23, which represents 61.3% of the total. Within this subgroup of caregivers/parents, 350 are enrolled in FP, meaning 47% of those with children (equivalent to 28.8% of the total sample).

Chart 11. FP Enrollment by Number of Children in the Household
Do you have VFE's Family Protection Insurance? by whether or not you have children (percentage by group)

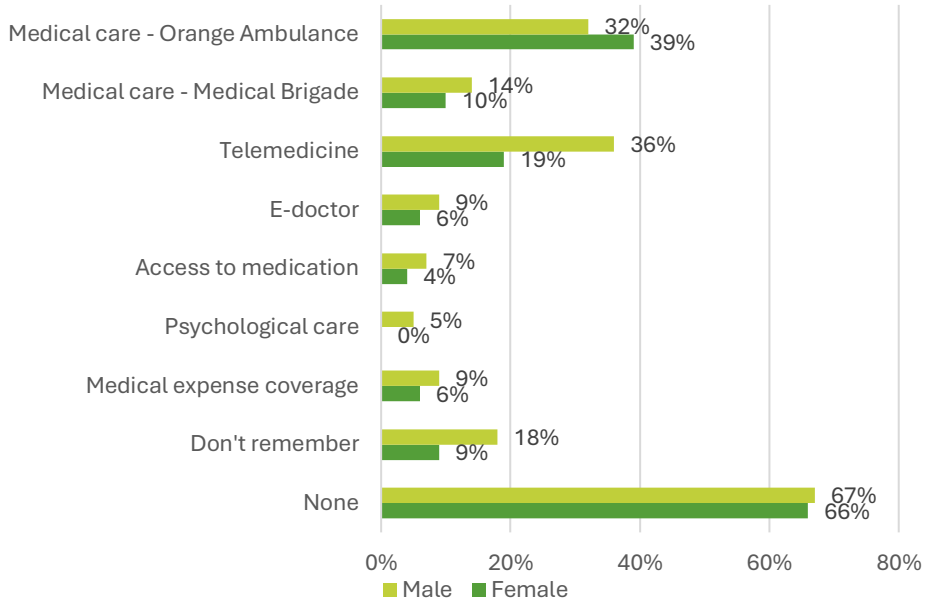


SFP coverage varies by household composition. Among households without children, 40.4% have SFP coverage. Coverage is highest among households with 1–3 children (48.3%), while it is lowest among households with four or more children (36.5%). Overall, SFP coverage among households with children reaches 44.4%, compared to 40.4% among households without children. This indicates that SFP adoption is more common in households with 1–3 children, whereas larger families show comparatively lower uptake.

USE OF FP SERVICES FOR CHILDREN (SUBSAMPLE: HOUSEHOLDS WITH FP AND WITH CHILDREN, N=350)

Below is a breakdown of each item related to the use of FP services for children and adolescents, with analysis segmented by country of origin, household composition (0, 1–3, or ≥4 children), GHQ-5 variation between 2024 and 2025, and income variation.

Figure 12. FP Benefits Used by Children
What type of benefit or service from the Family Protection Insurance has the child used? (You may select all options that apply) (percentage selected by sex)

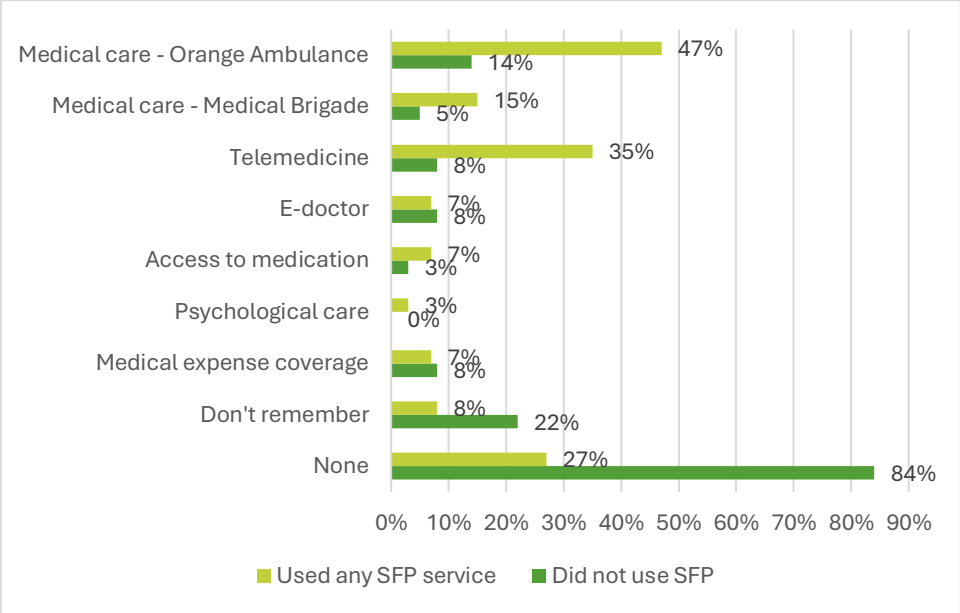


ANALYSIS OF USAGE BY POLICYHOLDER'S GENDER (N = 350)

In both groups, around two-thirds report that their children did not use any FP benefits during the period (Men: 67%, Women: 66%). Among those who did report usage, certain differences emerge female policyholders more frequently report use of the Orange Ambulance (39% vs. 32% among men). In contrast, male policyholders report higher usage of Telemedicine (36% vs. 19%), and slightly more use of Medical Brigades (14% vs. 10%), E-doctor (9% vs. 6%), access to medication (7% vs. 4%), medical expense coverage (9% vs. 6%), and psychological support (5% vs. 0%). The “don’t remember” response is also higher among men (18% vs. 9%).

- The high rate of “none” reported in both groups indicates underutilization or low activation of child-related benefits, rather than access gaps based strictly on the policyholder's gender.
- The patterns suggest different preferred channels: women tend to use in-person urgent care (ambulance), while men use remote services (telemedicine/E-doctor) more often and report slightly more financial benefits (medications/coverage). These trends may reflect differences in caregiving roles (who accompanies the child in emergencies), schedule availability, digital familiarity, or even recall bias (as seen in the higher “don’t remember” rate among men).

Chart 13. Types of FP Benefits Used for Children (%)
"What type of benefit or service from the Family Protection Insurance has the child used? (You may select all options that apply) (percentage selected based on whether SFP services were used or not)"



ANALYSIS OF USAGE BASED ON WHETHER THE POLICYHOLDER USES FP SERVICES (N = 350)

Use of FP services for children is highly concentrated in households where the policyholder has personally used the insurance. Among those who have used FP services themselves:

- Nearly half report that a child used the Orange Ambulance (47.3% vs. 13.5% among non-users).
- Over one-third report use of Telemedicine (35.1% vs. 8.1%).
- There are also higher reports of Medical Brigades (14.9% vs. 5.4%), access to medications (6.8% vs. 2.7%), and to a lesser extent psychological support (2.7% vs. 0%).

In contrast, E-doctor and medical expense coverage show low and similar levels of usage in both groups, suggesting these benefits are less known or less used for children specifically.

Among policyholders who have not used FP themselves, most responses indicate either "none" (84.0%) or "don't remember" (21.6%), pointing to a combination of low actual usage and limited awareness of available child benefits.

In summary, activation of FP by the policyholder is clearly associated with greater usage of child-specific benefits, particularly urgent care and telemedicine. In contrast, in households where the insurance is not used, children are largely excluded from these advantages.

The following section analyzes each service according to selected variables of interest.

MEDICAL CARE THROUGH AMBULANCIA NARANJA (ORANGE AMBULANCE)

- Use (Yes): 29.1% Ecuador; 6.4% Venezuela; 0.9% Colombia. Concentrated in households with 1–3 children (34.2%) and nearly absent in families with ≥4 children (1.8%).
- Well-being / Income: Most cases come from adults reporting no change in GHQ-5 distress (29.7%); use is also observed when income increased (22.0%).
- Interpretation: Activated mainly in acute events, particularly among Ecuadorian households with 1–3 children. Its association with increased income suggests greater capacity to activate benefits when households have higher financial and logistical stability.

CARE THROUGH BRIGADAS MÉDICAS (MEDICAL BRIGADES)

- Use (Yes): 9.1% Ecuador; 2.7% Venezuela; 0% Colombia. Concentrated among households with 1–3 children (11.7%).
- Well-being / Income: Mainly among respondents with no change in GHQ-5 (11.7%); participation is low across all income levels.
- Interpretation: Underutilized coverage; brigades appear not to be reaching, or aligning with reported needs, except among households with 1–3 children.

TELEMEDICINE

- Use (Yes): 10.9% Ecuador; 5.5% Venezuela; 10.0% Colombia. Concentrated among households with 1–3 children (25.2%) and nearly absent in households with ≥4 children.
- Well-being / Income: More frequent among those with no change in GHQ-5 (23.4%) and when income increased (21.1%).
- Interpretation: An accessible and accepted modality for children and adolescents. Similar usage levels among Ecuadorians and Colombians suggest fewer barriers by country of origin. Dissemination and scheduling should be strengthened.

E-DOCTOR

- Use (Yes): 6.4% Ecuador; none in Venezuela; 0.9% Colombia. Concentrated among households with 1–3 children (7.2%).
- Well-being / Income: Observed mainly among those with no change in GHQ-5 (7.2%) and slightly more when income increased (1.8%).
- Interpretation: Early-stage adoption; possible lack of functional understanding (what it solves, how to schedule) or technological friction.

ACCESS TO MEDICINES

- Use (Yes): 5.5% Ecuador; 0% Venezuela and Colombia. Highly concentrated among households with 1–3 children (5.4%).
- Well-being / Income: Concentrated in the “no change” GHQ-5 group (5.4%); marginal presence when income decreased.

- Interpretation: Underutilized despite its potential to reduce out-of-pocket spending; likely due to lack of information or redemption barriers.

PSYCHOLOGICAL CARE

- Use (Yes): 1.8% Ecuador; 0% Venezuela and Colombia. Concentrated among households with 1–3 children (1.8%).
- Well-being / Income: Appears among those with no change in GHQ-5 (1.8%) and stable income (1.8%).
- Interpretation: Very low utilization despite reported mental health needs among children and adolescents, suggesting referral gaps and/or stigma.

MEDICAL EXPENSE COVERAGE

- Use (Yes): 5.5% Ecuador; 0% Venezuela; 1.8% Colombia. Concentrated among households with 1–3 children (6.3%).
- Well-being / Income: Higher among those with no change in GHQ-5 (7.2%); marginal presence when income increased (2.8%).
- Interpretation: Low use of this insurance benefit for children; potential confusion between "coverage" and point-of-care services (consultations or brigades), or administrative barriers to reimbursement/validation.

DOES NOT RECALL WHICH BENEFIT WAS USED

- "Yes" (Does not recall): 10.9% Ecuador; 1.8% Colombia. Associated with households with 1–3 children (10.8%).
- Well-being / Income: More frequent among those with no change in GHQ-5 (11.7%) and when income increased (6.4%).
- Interpretation: Indicates deficits in traceability and communication: families use services but cannot identify the specific benefit. This underscores the need to simplify messaging and provide clear confirmations of service use.

NONE (NO FP SERVICES USED FOR CHILDREN)

- "Yes": 45.0% Ecuador; 8.8% Venezuela; 13.0% Colombia. Concentrated among households with 1–3 children (59.6%) and among respondents with no change in GHQ-5 (59.9%); also high when income increased (34.7%).
- Interpretation: The majority did not use FP services for children during the period. While this may reflect absence of health events, it may also indicate underreporting or lack of awareness of pediatric benefits.

CROSS-CUTTING FINDINGS

1. Sex of the insured adult. Pediatric coverage is activated at very similar levels among men and women (≈ two-thirds report "none"), but the entry channel differs: women more frequently use Ambulancia Naranja (in-person/urgent care), while men concentrate

telemedicine and E-doctor use and, to a lesser extent, medicines/coverage; "does not recall" is also more frequent among men. This suggests channel preference rather than access differences: in-person emergencies associated with caregiving roles versus remote resolution among men.

2. Use concentrated in households with 1–3 children. In nearly all benefits, participation among households with ≥4 children is very low, suggesting additional logistical/time barriers or specific lack of information for large families.

3. Predominance of "no change" in GHQ-5 among adults. Pediatric service use is more closely associated with stability in adult distress rather than higher distress, reinforcing the idea that benefit activation depends primarily on child health events rather than the adult's emotional state.

4. Income increase is associated with greater activation of services such as Ambulancia Naranja, Telemedicine, and Coverage. This may reflect that households with better organization, time availability, and lower financial stress can activate insurance more easily (calls, transport, documentation).

5. Low utilization of key benefits (medicines, expense coverage, psychological care). Despite their potential to reduce out-of-pocket costs and address mental health, use remains marginal. The presence of "does not recall" responses support the hypothesis of information and usability gaps.

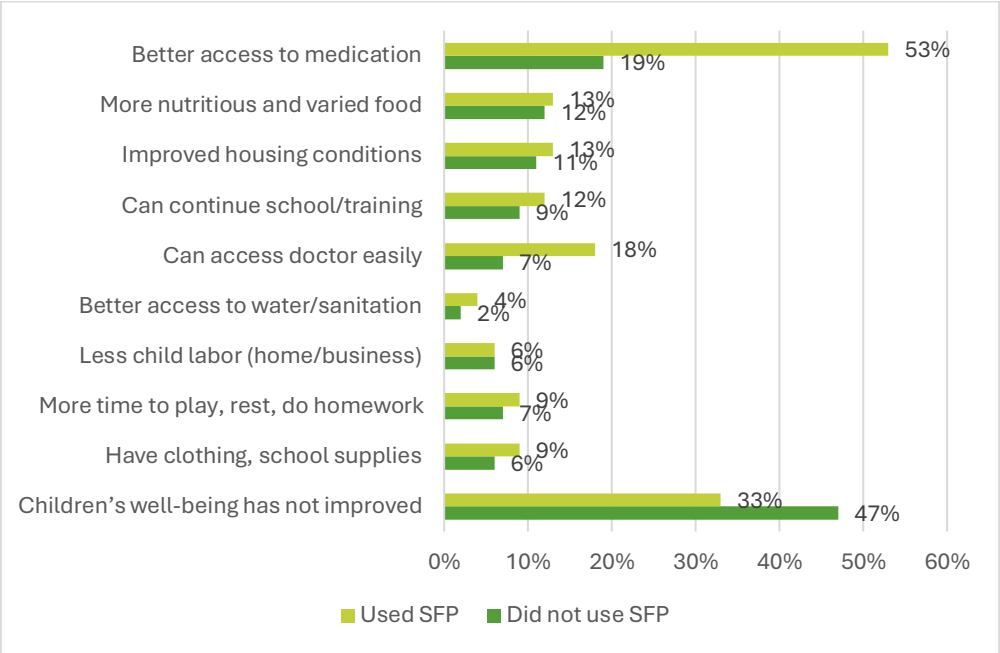
6. Country of origin. Ecuadorians account for most usage (consistent with sample weight). Colombian respondents stand out in telemedicine use, while Venezuelan usage is low across almost all items, indicating the need for tailored messaging and a review of potential documentation barriers.

This module indicates low activation of FP pediatric benefits, with telemedicine and Ambulancia Naranja as the most visible entry points. There is substantial room for improvement through clear communication, integrated pediatric service pathways, and targeted efforts with large families and migrant populations.

PERCEIVED IMPROVEMENT IN CHILD WELL-BEING (HOUSEHOLDS WITH FP AND CHILDREN, N = 350)

Item coverage and exclusion rule: Respondents who selected "Child well-being has not improved" were not allowed to mark any other option. Of the total households, 142 (42.8%) chose this response. The remaining respondents selected one or more perceived improvements.

Chart 14. Perceived Improvement in Child Well-being
Since your family has had the VFE Bank insurance, the well-being of children in your household has improved (Please select all options that apply)



The following percentages reflect the internal distribution within each category (by country, household composition, GHQ variation, and income change). The focus is on identifying **relative patterns**, i.e., which groups concentrate the most "Yes" responses.

GREATER ACCESS TO MEDICINES

- Users vs. non-users of FP services: 53% of those who used FP services report better access to medicines for children, compared to only 19% among non-users. This is the most significant gap: FP use is clearly associated with better perceived access to medicines for children and adolescents (C&A).
- Where "Yes" is concentrated: Households in Ecuador (25.4%) and, especially, those with 1–3 children (28.4%); marginal among households with ≥4 children (2.6%).
- Well-being and income: The "Yes" response is mainly linked to increased income (20.3%) and stable GHQ (28.4%).
- Interpretation: Perception of improved access to medicines is stronger where household budgets are less constrained and among medium-sized families. Opportunity to reinforce access pathways and communication in larger households.

MORE NUTRITIOUS AND VARIED FOOD

- Users vs. non-users of FP services: Figures are very similar: 13% among users, 12% among non-users. This suggests that FP is not having a differentiated impact on perceived food quality.
- Where "Yes" is concentrated: Mostly in Ecuador (8.5%) and among those with 1–3 children (11.6%); low in households with ≥4 children (1.1%).

- Well-being and income: Increases with rising income (5.3%) and stable GHQ (11.6%).
- Interpretation: The nutritional improvement appears indirect (via household budget) rather than attributable to a specific FP service. Prioritize nutritional education and linkages to local food programs, especially for large families.

IMPROVED HOUSING CONDITIONS

- Users vs. non-users of FP services: 13% of FP users report improvement vs. 11% of non-users. The difference is minimal, as housing is a structural determinant unlikely to be directly influenced by FP.
- Where "Yes" is concentrated: Ecuador (9.5%) and households with 1–3 children (10.0%).
- Well-being and income: More common with income increase (6.4%) and stable GHQ (10.0%).
- Interpretation: Likely an indirect economic effect (e.g., reduced spending on health/transport). Suggests potential for articulation with local government/NGO housing support programs.

SCHOOL CONTINUITY / EDUCATION

- Users vs. non-users of FP services: 12% of users vs. 9% of non-users report improvement. A slight advantage among FP users, though perceived impact is limited.
- Where "Yes" is concentrated: Households with 1–3 children (8.9%) and in Ecuador (6.9%).
- Well-being and income: Linked to rising income (5.3%) and stable GHQ (9.5%).
- Interpretation: FP may help reduce interruptions due to illness or cost, though the effect is modest. Recommendation: strengthen telemedicine and medication access during the school year.

GREATER EASE IN SEEING A DOCTOR WHEN SICK

- Users vs. non-users of FP services: 18% of FP users vs. 7% of non-users. This is another clear gap: FP use is associated with improved perceived access to medical care.
- Where "Yes" is concentrated: Households with 1–3 children (8.9%) and in Ecuador (9.5%).
- Well-being and income: Tied to increased income (5.3%) and stable GHQ (9.5%).
- Interpretation: Perception aligns with core FP service channels (Ambulancia Naranja, telemedicine). Suggests value in reinforcing reminders and contact pathways, especially for larger families.

BETTER ACCESS TO WATER/SANITATION

- Users vs. non-users of FP services: 4% of users vs. 2% of non-users. These very low figures indicate that FP has little to no impact on basic infrastructure conditions.
- Where "Yes" is concentrated: Low across all groups; observed among households with 1–3 children (2.6%) and in Ecuador (2.1%).

- Well-being and income: No strong association (very low values).
- Interpretation: FP does not operate on this dimension. Maintain it as a context indicator, not as an expected outcome.

LESS CHILD LABOR AT HOME/BUSINESS

- Users vs. non-users of FP services: Both groups report 6%. No observable difference: FP use does not appear to affect household labor burden among children.
- Where "Yes" is concentrated: Slightly higher among households with 1–3 children (5.3%).
- Well-being and income: Improves with increased income (3.7%).
- Interpretation: Possible economic relief reduces support tasks. Future studies should include qualitative follow-up (e.g., hours/week).

MORE TIME TO PLAY, REST, OR DO HOMEWORK

- Users vs. non-users of FP services: 9% of users vs. 7% of non-users. Perceived improvement in free time is slightly higher among users, though still a minority.
- Where "Yes" is concentrated: Ecuador (7.4%) and households with 1–3 children (6.8%).
- Well-being and income: Increases with income growth (3.2%) and stable GHQ (7.4%).
- Interpretation: Consistent with fewer illness episodes and smoother access to care. Recommendation: reinforce telemedicine and E-doctor to sustain this effect.

SUFFICIENT CLOTHING, FOOTWEAR, AND SCHOOL SUPPLIES

- Users vs. non-users of FP services: 6% of users vs. 9% of non-users. No clear pattern favoring FP use; improvements appear to depend more on other household resources.
- Where "Yes" is concentrated: Ecuador (6.9%) and households with 1–3 children (6.8%).
- Well-being and income: Linked to increased income (4.3%).
- Interpretation: Another indirect economic impact; relevant for school supply distribution campaigns at the start of the academic year.

NO IMPROVEMENT IN CHILD WELL-BEING

- Users vs. non-users of FP services: 33% of FP users say child well-being has not improved, compared to 47% of non-users. While a significant share of both groups reports no change, perception of "no improvement" is notably higher among non-users.
- Where "Yes" (no improvement) is concentrated: Households with 1–3 children (39.2%), stable GHQ (38.6%), and those with increased income (24.5%).
- Interpretation: Despite economic and access improvements, nearly half report no perceived change. Possible reasons: benefits not recognized or underutilized (information gap); non-health-related needs (schooling, housing, safety) not covered by FP; or elevated expectations after enrolling in the insurance.

OPERATIONAL CONCLUSIONS

1. The most visible improvements (medicines, ease of seeing a doctor, more time for homework/play) are concentrated among households with 1–3 children, stable or rising income, and stable psychological well-being (GHQ).
2. Larger families (≥4 children) are almost absent from "Yes" responses: they require targeted actions (proactive outreach, short messages, benefit navigation support).
3. Several dimensions (housing, supplies, food) reflect indirect economic effects: FP messaging should frame it as a financial protection mechanism that frees up resources for childcare.
4. The large group reporting "no improvement" suggests information and expectation gaps: prioritize user onboarding (ambulance, telemedicine, reimbursements/coverage), post-event follow-up, and tailored messaging by household size.

SCHOOL ATTENDANCE AND COLD EPISODES (TOTAL HOUSEHOLDS WITH CHILDREN AGED 0–23; N = 745)

Table No. 4. School attendance and strong colds, 2023–2024 and 2024–2025 school years

	Did any of your children experience problems/difficulties attending school regularly during the following periods?		Did any of your children experience a strong cold during the following periods?	
	School year 2023–2024	**School year 2024–2025**	**School year 2023–2024**	**School year 2024–2025**
Yes	10.0%	12.9%	39,6%	37,8%
No	84.3%	81.6%	56,2%	58,1%
Don't know / No response	5.7%	5.5%	4,2%	4,1%

REGULAR SCHOOL ATTENDANCE

The vast majority reported regular attendance in both periods (84.3% in 2023–2024; 81.6% in 2024–2025). Difficulties increased slightly from 10.0% to 12.9% (~+2.9 pp), while "Don't know/No response" remained stable (~5.6%).

This represents a slight upward tension in attendance challenges. It may reflect short-term factors (e.g., seasonal illness, transportation or supply costs, relocations) rather than structural changes, but it should be monitored.

SOCIODEMOGRAPHIC PROFILE OF "YES" RESPONSES:

- Country of origin: Most come from Ecuadorian households (9.5% of total), followed by Colombians (2.3%) and Venezuelans (1.2%) consistent with sample proportions.
- Children in care: Most cases are in households with 1–3 children (10.7%); those with 4+ contribute 2.2%.
- Caregiver's well-being (GHQ-5): Most "yes" responses come from those reporting no variation in GHQ (11.4%); a small fraction from those with increased distress (0.9%).
- Household income: "Yes" responses are distributed among stable income (5.0%), decreased (2.8%), and increased (4.7%). No strong association is seen between attendance and income changes, though most "Yes" fall in the stable category.

The ~3-point increase in attendance difficulties is modest but consistent, concentrated in Ecuadorian households with 1–3 children. No clear gradient appears based on income or GHQ variation.

Analysis by FP ownership and use:

- In both school years, the majority report no attendance difficulties (between 72% and 87% across groups).
- Those who use FP services report more attendance problems: from 13.9% (2023–24) to 18.8% (2024–25). In contrast, non-users rose from 8.2% to 10.0%, and those without FP from 10.1% to 13.1%.
- This suggests that FP users tend to come from households with pre-existing school vulnerability, rather than the insurance causing or preventing attendance issues.

STRONG COLD EPISODES

The proportion of households reporting strong colds decreased slightly: from 39.6% to 37.8% (−1.8 pp). Meanwhile, "No" increased (56.2% to 58.1%), and "Don't know/No response" remained stable (~4%).

This indicates a modest reduction in respiratory infections during the most recent school year, possibly due to seasonal factors. Since school attendance difficulties did not decrease, and colds only declined slightly, it's important to activate and better communicate FP benefits that support school continuity:

- Telemedicine and e-Doctor for managing mild cases without missing school
- Ambulancia Naranja and medicine access for acute cases to reduce extended absences
- Reminders and fast-track contact options (WhatsApp/SMS) during peak viral seasons

Recommendation: Prioritize follow-up on repeated cases (households reporting problems in both years), and cross-analyze by household size and income level to focus advisor outreach on high-risk groups.

SOCIODEMOGRAPHIC PROFILE OF "YES" RESPONSES:

- Country of origin: Mostly Ecuadorian households (31.5% → 30.0%), followed by Colombian (5.2% → 4.7%) and Venezuelan (2.8% → 3.1%) families.
- Children in care: Highest prevalence in households with 1–3 children (34.6% → 32.8%); households with 4+ contribute ~5%.
- GHQ-5 well-being: "No variation" remains the majority among "Yes" responses (34.3% → 34.2%); those with increased distress are a minority (3.3% → 1.7%).
- Income change: Among those reporting colds: stable income (15.5% → 16.8%), decreased (6.3% → 6.5%), increased (17.4% → 14.0%). The drop in the "increased" group may reflect seasonal trends or better access to care/medication.

Respiratory morbidity is slightly down and continues to affect mostly households with 1–3 children. No strong influence is seen from income or psychological distress.

Analysis by FP ownership and use:

- Strong colds are common across all groups (~33–41% in both years), with no major differences by FP status.
- From 2023–24 to 2024–25, slight decreases are observed in FP users (40.6%→38.6%) and non-users (39.8%→33.3%), while a small increase is seen in households without FP (39.1%→40.5%). These changes are minor and do not form a clear pattern.

School attendance has slightly worsened; actions should focus on reducing avoidable absences through school–family coordination, telemedicine/e-Doctor for minor illness, and timely medication access via FP.

Colds have decreased only slightly; seasonal messaging (prevention, FP service use, rapid attention pathways) and follow-up with repeat-case households are recommended.

Most of the variation is concentrated in Ecuadorian households with 1–3 children, reflecting the sample structure. These groups should be targeted for benefit activation and communication.

Overall, neither school attendance nor colds show consistent improvement linked to FP use. Differences between users, non-users, and uninsured households are limited. It appears that FP users tend to have greater pre-existing challenges, while cold incidence remains similar across groups.

CONCLUSION – CHILD WELL-BEING

The child module reveals modest but consistent indirect effects of FP, with clear signals of improved health access and support for school continuity, although awareness and use of several benefits remain limited.

KEY FINDINGS

- **Child benefit usage:** Most reported services are Ambulancia Naranja and Telemedicine/Pharmacy. E-doctor, medical expense coverage, medicine access, and psychological care show low usage, suggesting activation or awareness gaps more than coverage issues.
- **Perceived improvements:** A significant proportion report better access to medical care and medicine, and easier doctor visits. Some also report improved school continuity and more time for study/play. In contrast, improvements in nutrition, housing, and water conditions are rare, these are structural determinants beyond the FP's direct scope.
- **Education and common illness outcomes:** School attendance difficulties increased slightly between 2023–2024 and 2024–2025, though most children continued attending

regularly. Strong colds slightly decreased. No major gradients were observed based on country of origin, income, or caregiver distress.

- **Who experiences effects:** Due to the sample design, Ecuadorian households with 1–3 children show the most changes. Patterns are similar among Colombians and Venezuelans, with no significant differences.
- **Internal coherence:** Where benefit knowledge/use is higher (e.g., telemedicine, ambulance), perceptions of access and reduced daily obstacles improve. Benefits with low uptake show no association with improvement.

Regarding FP Use:

- **Main differences appear in health**, not structural conditions. FP users are much more likely to report on improved medicine access and ease of seeing a doctor. In contrast, improvements in housing, water, food, clothing, or child labor are low and similar across all groups.
- **When the policyholder activates FP, children do access benefits.** Ambulancia Naranja, Telemedicine, Medical Brigades, and medicine access are concentrated among users. Non-users mostly report "no services" or "don't remember," meaning children are largely excluded from the benefit package.
- **School attendance and colds show no clear improvements linked to FP use.** Both outcomes are common across groups, and users tend to show greater prior vulnerability, rather than an impact of FP itself.
- **Perception of no improvement is lower among FP users**, but still significant. While both groups include many who report "no improvement in child well-being," this perception is more common among non-users. Still, one-third of users also report no perceived change.

Final Insight:

The FP acts as a micro-buffer: easing access (rapid medical consultations, transport, medications) and preventing contingent declines in well-being (common illnesses, administrative burdens, unexpected costs). This may help protect school attendance and study/play time.

However, its ability to transform structural determinants (nutrition, housing, water/sanitation) is limited, broader changes require complementary interventions.

In summary, the FP contributes meaningfully to daily protection of child well-being by improving access to care and reducing cost-related barriers. But its full potential depends on greater informed use and intersectoral support for structural issues.

MODULE 5: FINANCIAL RESILIENCE

This section assesses households' ability to face and recover from economic shocks, and the role that FP Insurance may play in that process. We combine indicators of stability (e.g., the ability to save over the last 12 months) with indicators of resilience (e.g., exposure to economic emergencies and strategies used to cope with them).

HAVE YOU BEEN ABLE TO SAVE MONEY IN THE LAST 12 MONTHS?

Three out of five households were able to save at least some money (64.4%); one-third were unable to save (33.0%), and only 2.6% reported saving "a lot." Subgroup analysis shows that:

- FP ownership: A lower proportion of insured households reported saving "nothing at all" compared to uninsured households (12.6% vs. 20.4%), suggesting slightly greater saving capacity among those with FP.
- FP usage: Saving capacity was higher among FP users: 85.5% of those who had used the insurance said they saved "a lot" or "some" money in the last 12 months (7.5% + 78.0%), compared to 65.8% of non-users and 63.3% of uninsured households. Only 14.5% of FP users reported saving nothing, nearly half the rate among non-users with FP (34.1%) and lower than among those without insurance (36.7%).
- Income change: "Some savings" was more common among households whose income increased (31.8%) and less so among those whose income decreased (9.8%).
- Children (0–23 years): Households with 1–3 children were more likely to report "no savings" than those without children (19.3% vs. 10.9%), indicating family size puts pressure on savings.

In summary, most households save small amounts. FP ownership and income growth are associated with greater financial capacity, while having children reduces the household's ability to save.

Chart No. 15. Ability to Save Money According to Whether the Family Protection Insurance (FP) Is Held or Not
Have you been able to save money in the last 12 months?

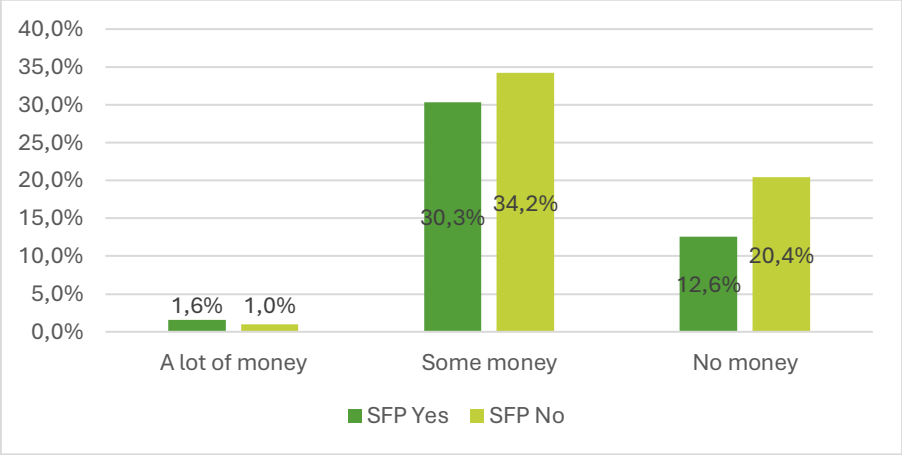
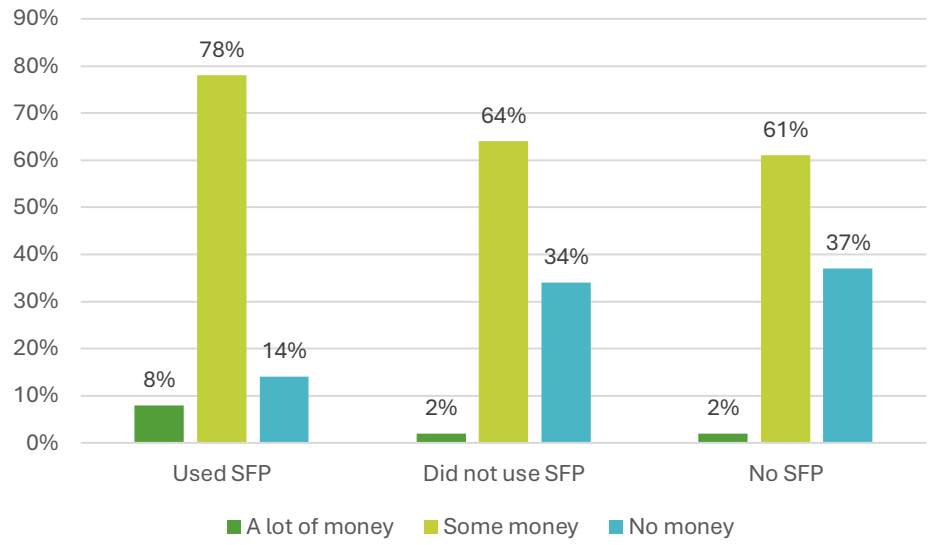


Chart No. 16. Ability to Save Money According to Family Protection Insurance (FP) Ownership
Have you been able to save money in the last 12 months?



ECONOMIC EMERGENCIES (LAST 12 MONTHS)

Three out of ten households reported experiencing a major economic emergency (30.2%); 58.6% did not, and 11.2% preferred not to respond. Subgroup analysis shows:

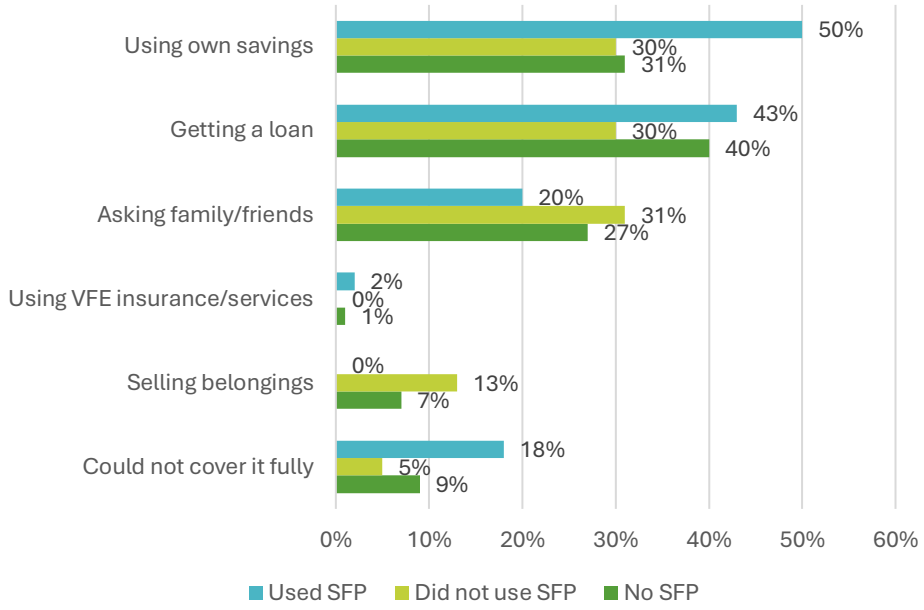
- FP ownership and usage: While all groups reported relatively high exposure, emergencies were slightly more concentrated among those without FP (33.9%), followed by FP users (27.7%), and were least frequent among FP non-users (24.7%). Reports of "no emergency" were more common among FP non-users (64.3%) and users (62.3%) than among those without insurance (54.5%). The proportion who preferred not to answer was similar across groups (≈10–12%), suggesting that discomfort or underreporting around economic hardship is not directly tied to FP status.
- Children: Households with 1–3 children accounted for more emergencies (17.9%) than childless households (9.5%).
- Income: Emergencies were more frequently reported among those whose income remained stable (12.6%) or increased (11.7%) than among those whose income fell (6.1%). This suggests that economic shocks do not always lead to an immediate or sustained drop in income, or that losses may have been temporary or offset.

In short, having children increases the likelihood of economic emergencies. Households without FP appear slightly more exposed.

HOW WAS THE EMERGENCY ADDRESSED?

(Base: n=367 who reported an emergency)

Chart No. 17 Strategies used to cope with economic emergencies (%)
How did you manage to deal with that financial emergency?



Most common strategies (multiple responses allowed):

- Loans: 37.6%
- Own savings: 33.2%
- Help from family/friends: 27.0%
- Selling assets: 7.9%
- Could not fully cover the emergency: 9.0%
- Used FP/BVFE services: 1.1% (very low)

Key differences observed:

- Use of own savings: Far more common among FP users (50%) than among non-users (29.8%) or the uninsured (31.4%). This suggests FP users have more financial cushion, combining insurance and personal savings.
- Loans: Frequent among FP users (43.2%) and the uninsured (39.7%), less so among FP non-users (29.8%). Emergencies in these groups more often require debt.
- Family/friend support: More frequent among non-users (30.9%) and uninsured (26.6%) than among users (20.5%), indicating informal networks play a larger role when insurance is not activated.
- Use of FP/BVFE services to address emergencies: Extremely low across all groups (2.3% for FP users, 0% for non-users, 1.3% for uninsured, likely from other BVFE products). FP is rarely used as a direct financial support mechanism for non-medical emergencies.

- Selling assets: Not reported among FP users (0%) but used by non-users (12.8%) and uninsured households (7.4%). This shows that more erosive coping mechanisms are concentrated where FP is not activated.
- Could not fully cover the emergency: Higher among FP users (18.2%) than non-users (5.3%) or uninsured (8.7%), suggesting that users may be facing more serious or expensive emergencies that exceed coverage or savings.

Takeaway: Credit, savings, and family remain the main buffers. FP is not being used as a direct tool to address general (non-medical) economic emergencies, possibly due to limited awareness or coverage. FP users tend to combine savings and debt while avoiding asset liquidation but still report gaps in coverage. In contrast, when FP is not used or held, support relies more on informal networks and the sale of household assets, with FP playing a minimal role in non-health emergencies.

HEALTH EMERGENCIES: HOW WERE THEY ADDRESSED?

(Among those reporting health-related emergencies)

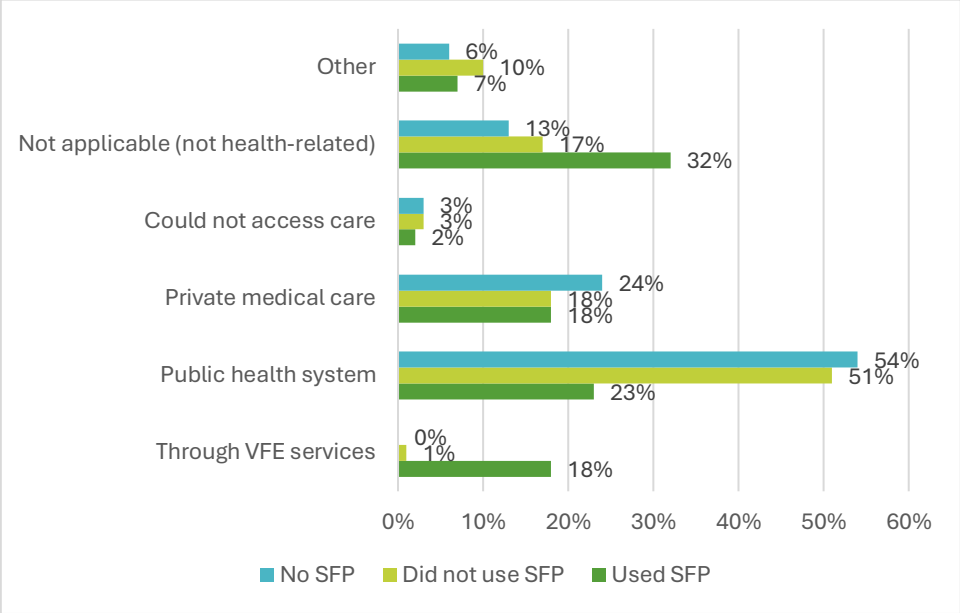
Resolution pathways for health emergencies:

- Public health system (MSP/public network): 49.6%
- Private care: 21.8%
- BVFE services (Medical Brigades, Orange Ambulance, Telemedicine): 2.7%
- Could not access care: 3.0%
- Emergency not related to health: 16.1%

Insights by subgroup:

- With FP: Slightly more use of BVFE services than among uninsured (2.5% vs. 0.3%), but the public system remains the primary provider (15.8% vs. 33.8% for uninsured).
- With 1–3 children: Public sector care is most concentrated in this group (30.8%).
- Income: Stable or increasing income is associated with higher use of both private (9.2%–8.3%) and public (21.4%–17.2%) care, suggesting better capacity to choose or combine sources.

Chart No. 18. Coping with health-related emergencies
If the emergency was health-related, how did you manage to get the necessary care or treatment?



The public health system remains the main provider, with limited use of BVFE services, and the private sector as a secondary option.

SUPPORT FROM FP IN ECONOMIC EMERGENCIES

(Only for those with FP who experienced an emergency; n=138)

Perceived support from FP:

- "Helped a lot": 7.2%
- "Helped somewhat": 15.2%→ Total positive: 22.4%
- "No influence": 34.1%
- "Didn't help or wasn't used": 26.8%
- "Didn't know FP could help in such cases": 16.7%

For health-related emergencies, the shift in care pathways is notable when FP is used. Among FP users, nearly 1 in 5 resolved their emergency via BVFE medical services (18.2%), much higher than among non-users (1.1%) and the uninsured (0.4%). In the latter groups, the public health system was the dominant response (51.1% and 54.1%, respectively), with similar or slightly higher use of private care.

The proportion unable to access care was low and similar across groups (≈2–3%). Additionally, FP users more often stated that the emergency was non-health-related (31.8% vs. 17.0% and 12.7%), suggesting that some health issues were indeed resolved through VFE services. In short, when activated, FP redirects health emergencies to the bank's service network, while non-users and the uninsured rely almost entirely on the public system.

Other patterns observed:

- Better perceived support among those whose income increased and among Ecuadorian households.
- Lack of awareness and non-use is widespread, highlighting a need to improve communication and activation, especially for non-health emergencies.

While FP reduces exposure and slightly improves saving capacity, its direct support during economic emergencies remains low and poorly recognized. There is a clear opportunity to strengthen areas such as: Financial education and benefit literacy (what's covered, how to use it); Activation of BVFE services during health events (brigades, telemedicine, ambulance); Liquidity-focused products and benefits (e.g., preferential microcredit, advance payments, flexible payment plans).

SUMMARY

- **Savings:** Most households saved "some" money. Better saving profiles among the insured and those with increased income. Households with children had tighter margins.
- **Emergencies:** 3 out of 10 households experienced at least one. More frequent among the uninsured and families with children.
- **Coping strategies:** Mainly loans, savings, and family support. Selling assets and unmet needs affected ~8–9% of households. FP was rarely used for non-medical emergencies.
- **Health emergencies:** Public system remained the main response, with private sector as a complement. Direct use of BVFE services was low.

Perception of FP support: Only 1 in 5 reported effective support. 1 in 6 were unaware FP could help indicating gaps in information and activation.

MODULE 6: ANALYSIS OF THE SURVEY'S FINAL COMMENT

At the end of the questionnaire, participants were invited to leave an open-ended comment. The response rate for comments was 40.4%, with 491 people writing something, while 59.6% left no comment.

To analyze the comments, the following steps were carried out:

1. All open-text responses were consolidated into a single spreadsheet.
2. A matrix of seven categories was defined to classify the content by intent and operational usefulness. Each comment was assigned exclusively to one category to simplify counting.
3. The following categories were established based on the content of the comments:
    - Congratulations / Praise: Explicit recognition of BVFE/team/services.
    - Suggestion: A concrete proposal for improvement (e.g., "extend telemedicine hours," "simplify requirements").
    - Complaint: Describes dissatisfaction or a grievance with a process or benefit.
    - Comment: General impression or narrative without a clear call to action.
    - Uninterpretable: Nonsense text, emojis, or random characters.
    - Blank: No text submitted.
4. Comments in each category were analyzed and summarized.

Table No. 5. Number and Percentage of Final Comments by Category

Category	Number of Comments	Percentage
Blank / No Comment	724	59.6%
Praise	239	19.7%
Suggestion	108	8.9%
Thanks	53	4.4%
Comment	50	4.1%
Complaint	31	2.6%
Uninterpretable	10	0.8%
Total	**1215**	**100.0%**

General Observations

- Overall tone: Positive messages dominate. Praise + Thanks make up 24.0% of all responses and 59.5% of non-blank comments.
- Operational value: Actionable feedback (Suggestion + Complaint + Comment) accounts for 15.6% of all responses, or 38.5% of non-blank comments.
- Low noise: Uninterpretable responses are minimal (0.8% of total; 2.0% of non-blank).

CATEGORY ANALYSIS

PRAISE

Spontaneous messages expressing approval and appreciation for BVFE and its staff (advisors, tellers, administrative personnel). Generally, respondents:

- Appreciate the quality of customer service (kind, respectful, "always attentive").
- Highlight the speed and ease of loan procedures.
- Describe BVFE as a "good" / "trustworthy" bank, offering help when it's most needed (e.g., emergencies, low-income situations, poor credit scores, Venezuelan migrants).
- Express loyalty and willingness to recommend the service to others.

MAIN THEMES (WITH REPRESENTATIVE EXAMPLES)

1. Quality of Service and Treatment *(dominant theme)*

- Keywords: "very good service," "kind," "respectful," "excellent advisor," "always helpful."
- Relevance: This theme recurs in most messages. Personalized support by the advisor is noted as a critical satisfaction factor ("they understood my issues and looked for solutions").

2. Speed and Ease of the Credit Process

- "Fast with procedures/disbursement," "easy," "they helped me get the loan."
- Often associated with trust and recommendation ("just because they give you the money quickly").

3. Financial Inclusion and Support During Difficult Times

- "They help low-income people / those with low credit scores," "opportunity to start a business," "one of the best institutions for those of us who had no access elsewhere."
- Migrants: Venezuelan client's express appreciation for access to services, reinforces BVFE's social role.

4. Appreciation for FP and Health Services (Testimonials)

- Ambulance and medications used "when I had no money"; debt coverage after a spouse's death.
- Some clients discovered the insurance during the survey and asked for more information.

5. Overall Brand Perception

- "The best bank," "serious and trustworthy," "recommended for our families."
- Loyalty is attributed to respectful treatment, fast service, emergency assistance, and business support.

6. Light Suggestions Within a Positive Tone

- Extend Saturday hours (e.g., 8 AM–12 PM); "keep supporting," "support women," "continue improving."

CORE MESSAGE

The compliments received confirm that the key value clients perceive in BVFE stems from the combination of **human-centered service, agile assistance, and a strong inclusion component**. Turning these praises into procedures, metrics, and testimonials will strengthen BVFE's reputation and help increase awareness and use of the FP Insurance, especially among those who value it but don't yet fully understand it.

SUGGESTIONS

The messages in this category are concrete proposals for improvement, covering user experience, FP Insurance information, credit offerings, and access to health services. The tone is largely constructive. Many suggestions appear across different branches, suggesting systemic gaps rather than isolated incidents.

KEY THEMES AND FINDINGS

1. Information and Use of FP Insurance *(most frequent theme)*

- "More information about the insurance," "clearly explain the benefits," "reminders," "informational talks," "where to call, where to go," "explain the benefits during the loan process."
- They request simple channels and tools: reminders, benefit flyers with phone numbers, a clearer mobile banking app, and well-trained advisors.
- Requests to expand and speed up coverage: larger or roll-over pharmacy quotas, more medications, pediatric dental care, in-person care, and more frequent medical brigades (including weekend attention in some areas).
- Blind spots: People who "didn't know the insurance existed" or "didn't know how to use it in an emergency."

2. Healthcare Access and Territorial Presence

- Requests for in-person doctors (not just telehealth), more medical brigades, ambulances with better-stocked medications, faster response for prescriptions/medication, and agreements with pharmacy chains.
- Rural outreach suggestions: "go out to the countryside," "offer more support for people in rural areas."

3. Digital Experience and Channels

- Improve mobile banking: "faster and more agile," a more stable app, and more ATMs owned by BVFE (e.g., Salcedo case fees from using other banks).
- Requests for direct communication with doctors (chat/call from the app) and geolocation of FP services.

4. Loans and Financial Conditions

- Larger loan amounts and faster renewals; freeze interest during crises (e.g., protests), allow payment extensions during emergencies, and offer flexibility for entrepreneurs (youth, women).
- Requests to lower interest rates, reduce requirements for long-time clients, and increase consistency in quick approvals/disbursements (already good but they want reliability).
- Ideas for incentives for good repayment and specific products: credit card, simplified microinsurance/health insurance.

5. Service Quality and Consistency

- While most praise the service, they ask for more consistent empathy and clearer explanations of products; some refer to excellent advisors, others mention "the insurance was not explained."
- Explicit recommendations for internal feedback and ongoing staff training.

6. Transparency and Usability of the FP Insurance

- Requests for clarity about limits/quotas, duration, coverage details, and how to activate each benefit.
- Ask for automatic reminders about benefits after loan disbursement and on key dates.

CORE MESSAGE

The suggestions express appreciation and trust in BVFE but highlight the need to **close information and access gaps** to the FP Insurance, **enhance digital channels and healthcare presence** (brigades, local doctors), and **maintain BVFE's strengths in speed and credit flexibility**.

If BVFE can **translate these suggestions into simple protocols and practical tech solutions**, usage of FP Insurance will grow, along with client satisfaction, **without significantly increasing operational costs**.

GRATITUDE

This category includes 53 comments (4.4% of cases) with primarily appreciative content. They do not request changes but recognize received benefits and the staff's treatment. These serve as a "positive thermometer" of the experience.

MAIN PATTERNS

1. Gratitude for Access to Credit and Speed
    - "Thanks for the opportunity to get a loan," "they helped me cover expenses," "I'm moving forward."
    - The speed of the process and ease for clients with urgent needs are highly valued.
2. Recognition of the Team's Care and Empathy

- Multiple mentions of good service, respect, understanding during difficult times, and praise for specific advisors (with requests to "not change them").
- Flexibility in cases of late payments or complex situations is especially appreciated.

3. Impact on Family Wellbeing and Business
   - Credit "helps support the children," "grow the business," "achieve dreams."
   - BVFE is seen as real support in daily life, especially during crises.
4. Value for Migrant Population and Geographic Reach
   - Migrants (e.g., Venezuelans) appreciate the openness and lack of discrimination: "other institutions don't support migrants."
   - They welcome new branches (e.g., El Ángel) for their proximity.
5. Loyalty and Desire for Continuity
   - Phrases like "keep going," "I hope to continue working with you" express an intention to stay.

OPERATIONAL SIGNALS THAT REINFORCE WHAT WORKS

- Speed and empathetic treatment are the most valued pillars: protecting them as the minimum service standard.
- Success stories (getting out of debt, growing a business, supporting migrants) are ideal inputs for client testimonials and financial education campaigns.
- Flexibility in repayment is seen as fair and generates gratitude, making the policies on extensions and payment support visible.
- Local presence (branches/hours) increases satisfaction, using new branch openings as community communication events.
- "What they say, without asking": subtle opportunities
  - Several gratitude messages reference difficult moments: a good entry point to offer the FP and post-credit financial education.
  - Gratitude for individual advisors: leverage for internal recognition programs and mentoring (to share best practices).
  - Migrant messages: position BVFE's inclusive approach clearly in campaigns and onboarding.

CORE MESSAGE

The "thank you" messages confirm that BVFE's value proposition, **timely credit and close support**, is creating tangible changes in households and microbusinesses and building trust among sensitive populations like migrants. Maintaining and scaling these attributes, and making them more visible, can strengthen loyalty and expand service reach.

COMMENTS

This category includes 50 messages (4.1%) with mixed content: general impressions about the bank, specific experiences with the insurance, and operational suggestions. Unlike “Congratulations” or “Gratitude,” these often highlight reasons for non-use, perceived barriers, and future intentions.

MAIN THEMES AND PATTERNS

1. Current Non-Use of FP Due to No Need or Forgetfulness
    - “I haven’t needed the services yet,” “I forgot about it.”
    - Implication: A “latent” group sees the FP as a good option but doesn’t activate it. They need contextual reminders (e.g., during flu season or back-to-school).
2. Information Gap / Incomplete Knowledge
    - “Lack of knowledge,” “asking for information to use the services,” “didn’t know about the insurance or which clinics had agreements.”
    - Implication: Strengthen onboarding and micro-reminders (SMS/WhatsApp) covering: what’s covered, how to use it, care network, and single helpline (some say they only got the number during the survey).
3. Future Intention to Use
    - “I’ll request/accept the FP with my next loan,” “I’ll use it when needed,” “after the explanation, I’ll use it next time.”
    - Implication: Opportunity for conversion by offering a welcome package + guided first use (e.g., telemedicine or outpatient visit), and an initial co-payment voucher.
4. Only Occasional Use
    - “It was only used once through the medical brigades.”
    - Implication: Brigades generate visibility; maintain them and link them to digital activation of the FP (on-site telemedicine registration and testing).
5. Interactions with Inclusive Loans
    - Multiple mentions: “has an inclusive loan, didn’t get offered the insurance,” “doesn’t have the insurance because the loan is inclusive,” “wasn’t aware of the insurance due to the inclusive loan.”
    - Implication: Review of the sales flow for the inclusive product, it currently disconnects the FP offer and causes misinformation. Define a clear rule: when to offer FP, associated costs, and compatibility with inclusive loans.
6. Resistance to Automatic Deductions / Perceived Cost
    - “Didn’t request the service because I don’t want it deducted from the loan,” “didn’t accept it because it didn’t seem beneficial,” “wants to receive the full loan amount,” “high loan percentage.”

- Implication: Communicate price–value clearly (real case savings vs. premiums), offer alternative payment methods and activation grace periods.

7. General Appreciation of the Bank and Loans
    - "Satisfied with the service," "quick loans," "help with minimal paperwork," "support for entrepreneurs," need for "larger loans" as credit scores improve.
    - Implication: Continue strengthening the loan scale-up pathway and communicate clearly the criteria for moving up.
8. Specific Suggestions
    - "Semiannual loan payments" (different frequency), FP is "especially useful for children."
    - Implication: Explore flexible frequencies (pilot bimonthly/semiannual repayment for seasonal activities) and child-focused FP messaging (pediatric benefits as a trigger for activation).

SUMMARY OF BARRIERS AND FACILITATORS

- **Barriers:** Lack of awareness, non-activation due to forgetfulness, exclusion from the FP offer in inclusive loans, aversion to premium deductions, cost perception, sporadic use.
- **Facilitators:** Satisfaction with the bank, fast credit process, usefulness of FP for children, brigades as entry points, willingness to use after a good explanation.

CORE MESSAGE

The "comments" reveal satisfaction with credit services and **untapped potential** of the FP due to **information gaps and commercial design issues** (e.g., inclusive loans, automatic deductions, activation barriers). With **clear onboarding**, **contextual reminders**, and **less invasive payment options**, **it is plausible to significantly increase FP adoption and effective use**.

COMPLAINTS

The Complaints category includes 31 messages (2.6%). Though relatively few, they are concentrated around operational bottlenecks in the insurance system and in-branch service, offering clear improvement signals.

CRITICAL ISSUES AND EVIDENCE

1. Telemedicine and Access to Medication (High Frequency)
    - Reported problems: "medicine/code message doesn't arrive," "calls go unanswered," "service is complicated," "they send you to distant pharmacies," "they ask for too many symptoms," and "they barely help with prescriptions."
    - Effect: Users give up ("it's a waste of time") and perceive the benefit as having low utility.

- Associated risk: Perception of the FP as “expensive insurance” or “useless” if no serious event occurs.

2. Interface with Insurer/Provider
    - “Called the insurer and no one answered,” “advisor in charge doesn’t respond to messages.”
    - Reveals gaps in coordination between BVFE, the insurer, and the pharmacy/medical brigade network.
3. Logistics for Pick-Up and Coverage Medication
    - Ongoing complaints about long distances to pharmacies/brigades and requests for “more medicines in the ambulance.”
    - Demand for in-person care in certain areas.
4. Service at BVFE Branches
    - “Long waits at the cashier,” “extremely slow agent,” “open earlier,” “be more respectful.”
    - Clients ask for empathy in cases of late payments: “If I can’t pay the installment, I’d like them to understand… be more empathetic.”
5. Credit: Requirements, Interest Rates, and Flow
    - “Too many requirements for a small loan,” complaints about interest/late fees (“too high”), and a case of frustrated disbursement due to ID signature issue.
    - Inclusive credit: “They didn’t mention the insurance” (again highlighted as a source of misinformation).
6. Non-Adoption of FP Due to Cost / Phone-Based Service
    - “Didn’t get the insurance because it’s expensive,” “they don’t answer calls promptly and I don’t have credit to call.”
    - Points to financial and channel barriers (e.g., call costs) in low-income segments.
7. Unanswered Administrative Requests
    - “No response regarding loan insurance refund,” “they don’t reply to new requests.”
    - Impacts trust in the institution.

CORE MESSAGE

Complaints are concentrated around **telemedicine/medications** and **in-branch service experience**. They do not question the existence of the benefit, but rather its **usability**. With targeted improvements in **communication channels** (e.g., WhatsApp/callbacks), **closer service networks**, **service-level agreements (SLAs)** with providers, and **queue management/empathy at branches**,

BVFE can turn a pain point into a key differentiator for the FP insurance and overall service experience.

CONCLUSIONS

The following conclusions arise from the data analysis conducted across the various dimensions covered. First, a summary of the general landscape is presented, structured by key focus areas of the questionnaire. Then, a brief synthesis addresses the research questions that guided the analysis, complementing the impact evaluation. Finally, a set of recommendations based on field findings is presented for short-, medium- and long-term action.

SUMMARY OF THE GENERAL LANDSCAPE

- **Coverage and profile:** 44.4% of the sample holds FP insurance; self-employed workers from the agricultural and commercial sectors predominate, with most households having children (61.3%). This context shapes both the types of risks faced (variable income, health and transport expenses) and the coping strategies used (savings, loans, family support).
- **Awareness vs. usage:** There is relatively high awareness of benefits like telemedicine/pharmacy and ambulance, but actual usage over 12 months is low or sporadic (telemedicine 38%, ambulance 44%; most did not use any service). The main reasons for non-use are "did not need it," lack of knowledge on how/when to use it, and operational difficulties ("I tried but couldn't use it"). A clear pattern emerges that those who activate FP tend to know more about its benefits, while non-users are marked by uncertainty, lack of understanding, and no direct experience, resulting in neutral or low perceived usefulness.
- **Quality of life:** Between 2024 and 2025, GHQ indicators (sleep, tension, enjoyment of activities, mood, and happiness) show high stability (87–92% "no change"). Net improvements are small and mostly associated with households that experienced income increases. The effect attributable to FP is positive but marginal. When disaggregated by FP use, changes remain small and unsystematic: effective use is not clearly linked to better sleep, mood, or stress, though it may help prevent major deterioration in some cases. In summary, FP appears to play more of a buffering role than a transformational one in psychosocial wellbeing.
- **Children and adolescents:** Use of FP benefits for children and adolescents are limited, and perceived improvements focus mainly on facilitating access to consultations/medications. There is little evidence of change in housing, water/sanitation, or nutrition. School attendance remains generally high (>81%), with a slight increase in difficulties (10.0% → 12.9%). Cases of colds decreased slightly (39.6% → 37.8%). When analyzed by FP usage, improvements in child health are seen almost exclusively in households that activate the insurance: higher reported access to medications, consultations, and usage of Orange Ambulance, Telemedicine, and Medical Brigades. In contrast, non-users commonly report that "children's wellbeing has not improved."
- **Financial resilience:** 64.4% of households managed to save some money in the past 12 months, but 1 in 3 did not save at all. 30.2% faced an economic emergency, resolved mostly through loans (37.6%), savings (33.2%), and family support (27%). FP was rarely used to cover non-medical emergencies (1.1%). In health emergencies, the public health system remains dominant (49.6%), followed by the private sector (21.8%); BVFE services (brigades/ambulance/telemedicine) account for just 2.7% of reported resolutions. Usage-

based segmentation shows significant differences: FP users demonstrate greater saving capacity and are less likely to have zero savings. They also tend to avoid erosive strategies (like selling assets) and more frequently resolve health emergencies through the BVFE network. In contrast, non-users rely more on family networks, loans, and public health.

- **Perceived value of FP during emergencies:** Among those with FP and who experienced an emergency, 22.4% say the insurance helped (a lot or somewhat), 34.1% say it had no influence, 26.8% didn't use it or found it unhelpful, and 16.7% didn't know it could help. This shows clear underuse due to information gaps and operational disconnection. The sharpest contrast is between actual users (most report positive support) and non-users (neutral or negative perception). The differences stem from lack of operational knowledge and absence of direct experience that would allow users to appreciate the insurance.
- **Key differentials:** The best results (greater subjective improvements and less stress) are found where income increased. Households with 1–3 children show more needs but are also more responsive to improvements in healthcare access. Patterns are similar across countries of origin; while sample sizes for Venezuelan migrants are smaller and don't allow firm conclusions, they show no major disadvantages compared to Ecuadorians once access/use is accounted for. When segmented by FP use, two distinct groups emerge among the insured: those who activate FP have greater needs but also better service access and more perceived support and those who do not activate it, whose behavior closely resembles the uninsured (lower access, perceived usefulness, and higher reliance on informal strategies). This indicates that the value of FP depends critically on effective activation, not just on coverage.

CLOSING REMARKS

The FP includes high-potential components (telemedicine, ambulance, medication access), but its overall impact is currently limited by low activation and referral, as well as the predominant influence of economic factors (like income) on quality of life. To convert coverage into results, BVFE should simplify usage, strengthen care pathways, and make the benefits more visible to households with children. Doing so would likely lead to measurable improvements in healthcare access, wellbeing, and economic resilience in future assessments.

Broadly speaking, comparisons between FP users and non-users show that insurance only makes a difference when it is used. Users are more aware of benefits, report better access to healthcare, greater expense reduction and savings capacity, and are more likely to evaluate the insurance positively during emergencies. In contrast, non-users resemble those without insurance, with lower perception of support, less expense reduction, and weak appreciation of the insurance as a tool for crisis management.

Meanwhile, differences in psychological wellbeing (GHQ-5) are small and inconsistent, suggesting that FP primarily plays a supportive medical and financial role rather than driving deep psychosocial change. In short, FP's added value emerges only when it is actively used, simply holding the insurance without activating it yields very limited benefits.

Table 6. Summary of Fieldwork Results

Indicator	Users of FP Services (%)	Non-Users of FP Services (%)	Difference
Knowledge of benefits	95	80	15
Perceived improvement in health access (yes, yes a lot)	40	15	25
Perceived reduction in expenses (a bit, a lot)	17	9	8
High Satisfacción (satisfied, very satisfied)	51	18	33
Ability to save (some, a lot)	86	66	20
Faced an economic emergency (yes)	28	25	3
Emergency solved with insurance	2	0	2
Positive evaluation of insurance in emergency (some, a lot)	43	13	30
GHQ-5: Sleep (improved)	7	5	2
GHQ-5: Stress (improved)	7	6	1
GHQ-5: Activities (improved)	3	5	-2
GHQ-5: Depression (improved)	3	4	-1

APPENDIX 5

INTERNATIONAL AND REGIONAL LITERATURE HEALTH MICROINSURANCE PRODUCTS LOSS RATIOS

Paper / Reporte	**País / Región**	**%**Claim/ **Siniestralidad**	Source
The Landscape of Microinsurance in Latin America and the Caribbean 2014 **- Full Report**	Latin America and the Caribbean	**25% (median) for health microinsurance products.** **Claims ratios are calculated as claims paid/written premium.**	**"Claims data from nine health microinsurance products in the region show that claims are manageable and even low, with a median of 25% […]. This reflects typical utilization patterns in health products aimed at vulnerable populations."**
The Landscape of Microinsurance (2023)	Global (includes LATAM)	**23% (median) for health**	**"Globally, health microinsurance products exhibit a median claims ratio of 23%, suggesting moderate levels of use that are consistent with schemes designed to cover** **low-frequency but high-impact health events."**

Analysis of a Large Micro Health Insurance Programme in Pakistan (Cheema et al., 2020)	**Pakistán**	**28.86% in health microinsurance**	**"The large-scale health microinsurance program recorded a claims ratio of 28.86%, indicating a stable level of utilization for hospital coverage among low-income populations, aligned with the expected results for this type of product.**

CONTEXT

International and regional literature consistently indicates that health microinsurance products typically exhibit loss ratios between 20% and 30%. This range reflects moderate but expected levels of utilization, characteristic of products aimed at vulnerable populations and designed to cover low-frequency health events. In Latin America, data from nine health microinsurance programs show a median loss ratio of 25%, while global evidence points to a median close to 23%, reinforcing that this range represents a healthy, sustainable, and standard performance benchmark for the sector. Even large-scale initiatives in developing countries—such as in Pakistan—report loss ratios around 29%, confirming that this margin is widely accepted as a technical norm.

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APPENDIX 6

RESPONSES TO COMMENTS AND OBSERVATIONS

VISIONFUND ECUADOR- EGES

– HEALTH INSURANCE (FP-FAMILIA PROTEGIDA)

METHODOLOGY

Category	Source 1 : **Administrative Data**
What I keep	• To understand how the FP insurance product influences the lives of BVFE's clients, was conducted a detailed analysis of administrative data spanning from August 2021 to June 2025: This dataset includes **210,806 loans granted to 108,694 clients**, **providing a rich basis for evaluating the program's implementation and impact.** • Main types of administrative data: 1. Loan and Client Data: 108,694 clients from January 2021 to June 2025, covering demographic details (gender, age, location, nationality), credit characteristics (loan maturity, credit history), and socioeconomic indicators (employment, income, education). 2. Insurance Usage Data: complete database of FP compensations, covering the period from January 2022 to June 2025, with a total of 13,039 compensations corresponding to 6,584 clients. 3. External source**:** secondary national source statistics from Ministry of Public Health of Ecuador. Specifically, hospital discharge databases for the years 2022, 2023, and 2024, which provide detailed information on diagnoses, age, province of residence, and other health indicators about province-level panel such as pneumonia cases to study the role of insurance in times of heightened health risk
Questions/ comments	1. Loan and client data and insurance usage data would not be better to take from the same range of time January 2022-June 2025? Is it change something the result?
Answer	No, it is not better to align both datasets to January 2022–June 2025, because you lose valuable data for: • Loan and client characteristics, the analysis includes a full year (2021) before the insurance product's operational impact (FP launched in August 2021). • For insurance usage, data is only available from 2022 onward, because compensations and services take time to appear in the system after enrollment.

	External source secondary data is monthly base, and it is consistent with the insurance data range. This will be clarified in the final version of the document.
Category	Source 2 : **Representative Survey**
What I keep	• The survey was organized around **six core dimensions**: 1. Sociodemographic and household characteristics 2. Effective use of BVFE services 3. Perceived quality of life and well-being 4. Children's well-being 5. Financial resilience and economic stability 6. User experience, awareness, and suggestions for improvement • The sample was drawn from BVFE's administrative database, using **stratified random sampling to ensure proportional representation across**: 10. Insurance status (with vs. without FP) 11. Gender (male/female) 12. Migrant estatus (Ecuadorian vs. Venezuelan) • Additional eligibility filters were applied to define the survey population: 13. Clients active between January 2024 and December 2025[14] 14. Only one client interviewed per household 15. Age between 18 and 65 years 16. Only current loan holders were included (up-to-date, overdue, or fully overdue loans); clients with cancelled, written off, or foreclosed loans were excluded 17. Clients must have had all their loans either with or without FP coverage, to ensure clear categorization
Questions/ comments	2. Different range of time **[Administrative data]** January 2022-June 2025 vs **[Representative survey]** January 2024 and December 2025 Is it change something the result?

Answer	Why the survey uses a shorter (more recent) timeframe?
	
	This is intentional and valid for several reasons:
	• The survey seeks to measure current perceptions and experiences, not historical data.
	• Only clients active in 2024–2025 were eligible to participate. This helps ensure:
	  ○ High recall accuracy for service use, satisfaction, and well-being
	  ○ Relevant feedback for current programming and decision-making

[14] Clients enrolled in the FP program must have maintained uninterrupted insurance coverage during the entire study period.

	• Survey questions (e.g. "Have you used the insurance in the last 12 months?") refer to recent behavior, not historical trends. The survey focused on the most recent two-year window (2024–2025) to ensure relevant and high-quality insights from active clients, while the administrative data covered a broader range (2022–2025) to enable robust trend and impact analysis

WHO ARE YOU REACHING?

Category	**Health care access**
What I keep	• **[Administrative data] Clients with FP demonstrate slightly greater seniority in their relationship with BVFE, with an average of 3.1 years** compared to 2.9 years for those without the insurance. • **[Administrative data]** On average, clients had **1.4 children, and 0.7 medical attentions were provided to children per policy, with some households receiving up to 10 services for their children** • **[Administrative data] 70% of insured users were women**, highlighting a strong gender focus in both enrollment and utilization. "Inclusion of Women Despite Lower Enrollment Probability: Although women make up 63% of insured clients, being female—as well as being older or having a university-level education—is associated with a lower likelihood of enrollment, indicating that participation varies across demographic groups; however, among those who do enroll, women, especially single women, tend to use the insurance primarily to benefit their children and families rather than for personal use, highlighting the insurance's significant indirect impact through women's caregiving roles. • **[Administrative data] The average age of insured clients was 37.3 years**, with a wide range from 19 to 77 years, confirming the program's relevance across **working-age adults and caregivers** • **[Administrative data]** Approximately **8% of insurance users were Venezuelan migrants**, a group of particular interest due to their limited access to public health systems. The presence of migrant clients in service usage data indicates that FP is effectively reaching excluded populations, consistent with VisionFund's inclusion. goals. **Venezuelan clients are 6.5 percentage points more likely to enroll in FP compared to Ecuadorians**. Telemedicine Preference: **Venezuelan clients demonstrate a higher use of telemedicine compared to other remote services**. • **[Administrative data]** Higher levels of income and wealth, as well as ownership of financial instruments, are negatively associated with insurance enrollment "This suggests the pro-poor, inclusive design of the FP insurance." • **[Administrative data]** Insured individuals make more frequent use of **telemedicine, medications, and compensation services—especially during periods of heightened health risk (e.g., pneumonia outbreaks).**

	This confirms the program's central promise: to reduce barriers to timely, affordable health care for low-income households.
Questions/ comments	3. The report mentioned that clients had 1.4 children, and 0.7 medical attentions were provided to children per policy, with some households receiving up to 10 services for their children with insurance services or in general?
Answer	This 0.7 figure refers specifically to medical services accessed through the FP insurance, not general health services. This is confirmed by: • The source being administrative data from insurance usage (i.e., claims and services delivered through FP). The phrasing "per policy" – which refers to FP-insured clients, not the general population. This will be clarified in the final version of the document.
Category	**Type of services used**
What I keep	• **[Administrative data]** It is demonstrated by **the insurance product's multi-dimensional utility, with clients accessing both financial protection and direct health services.** a) Compensation services (e.g., payouts following accidents or health emergencies) are the most utilized, with an average of 2.2 claims per user. b) **Telemedicine consultations**, a key part of the FP offering, show solid uptake with 1.1 uses per client, reinforcing the value of remote healthcare access. c) **Pharmacy benefits** (medication delivery or reimbursement) have a mean usage of 0.6, suggesting that not all consultations result in prescriptions, or that clients may access medications through other means. d) E-doctor services (digital medical interactions) are used less frequently, with a mean of 0.2, but some clients used this service intensively (up to 16 times). • **[Representative survey**]: **Awareness highest for Telemedicine and Pharmacy (66%) and accidental death benefit (61%);** lower for family income support (23%), scholarship (21%), and health brigades (24%). • **[Representative survey]:** 30% of insured clients have used at least one of the services. **Most used services were Orange Ambulance (44%) and Telemedicine/Pharmacy (38%);** the rest ≤21%.
Questions/ comments	4. What is the correlation in this category between administrative data and representative data? 5. Terms "user" and "client are used on several occasions. Please clarify, especially in "Compensation services (e.g., payouts following accidents

	or health emergencies) are the most utilized, with an average of 2.2 claims per user. and Telemedicine consultations, a key part of the FP offering, show solid uptake with 1.1 uses per client, reinforcing the value of remote healthcare access"
Answer	A.- The survey data and administrative data are generally consistent: o Both show high usage for telemedicine. o Pharmacy is well-known but not always used. o E-doctor and other services are underutilized. • Compensation data is only tracked in administrative systems, offering more precise info than surveys. • Ambulance Naranja and Brigadas Médicas are captured only in the survey, not in admin service logs. This confirms that combining both sources is essential to understand both actual behavior and perceived value. It's important to note that the survey representative asked clients to report services used in the last 12 months, limiting responses to recent experiences. In contrast, the administrative data covers all service usage since enrollment. This difference in timeframes explains some of the variation in usage rates between the two data sources B.- Throughout this report, when referring to the "use" of services, we are specifically referring to clients enrolled in the Familia Protegida (FP) insurance product who have actively used or activated at least one of the covered services. This includes clients who have accessed services such as telemedicine, medication delivery, e-doctor consultations, psychological/legal assistance, or who have received compensation for health events. Clarification on Administrative Insurance Usage Data: The Insurance Usage Data derived from administrative records only includes clients who actively used at least one service under the Familia Protegida (FP) insurance product. This dataset does not represent the full universe of insured clients, but rather the subset of insured clients who triggered or activated a service — such as telemedicine, pharmacy, compensation claims, or legal/psychological assistance. Therefore, any figures derived from this data (e.g., average number of services used) should be interpreted as referring to users, not all enrollees.
Category	**Valid reasons for non-use**

What I keep	• **[Representative survey]: 55.9% "didn't need it";** 12.6% didn't know they could use it; 9.7% received care elsewhere; 7.6% tried but couldn't.
Questions/ comments	6. It is not clear why one of the opportunities for improvement is strengthen communication and **simplify procedures to increase service activation**. Why? "A significant portion of insured clients were unaware of the insurance's potential role, with 16.7% reporting they "no sabía que podía ayudar en ese tipo de situaciones" Pg. 25
Answer	Lack of need is the dominant reason, but there is a preventable gap (≈22–30% of valid responses) related to lack of information and usage friction — including unawareness, failed activation attempts, and service unavailability: 14% of women and 10% of men said they "didn't know they could use the services" (≈12.6% overall and gender gap), 7–8% tried to use the insurance but couldn't, 0–1% couldn't find a doctor available when needed. In summary, there are three reasons alone account for at least 22% of non-use. When adding other related factors such as fear of cost, distrust, or preference for other services, the share rises to ≈30%. Strengthening communication and simplifying procedures is necessary. Although "not needing the service" was the most cited reason, a significant share of clients (30%) did not use FP due to lack of information**,** confusion about coverage, or difficulty accessing services.

WHAT IMPACT ARE YOU HAVING?

Category	**Health care access**
What I keep	• **[Administrative data]** "**Clients with insurance are more likely to respond quickly to health shocks.** They rely on services instead of resorting to asset sales or emergency borrowing. **This is particularly evident during spikes in respiratory illnesses, when service usage increases significantly.** FP effectively serves as a protective mechanism during unexpected health events, providing both financial support and access to medical services when aggregate health conditions deteriorate.
Category	**Financial resilience**
What I keep	• **[Representative survey]:** Savings: **64.4% managed to save something**; 33% did not save; among the insured, fewer reported "no savings at all." **Greater**

	saving capacity is observed among those who use the FP—85.5% of individuals who have used insurance services report having been able to save “a lot” or “some” money over the past 12 months. • The FP insurance contributes to preparedness by fostering financial stability: 86% of active users reported an ability to save "algo" (some) or "bastante" (a lot) of money, compared to 66% of insured non-users. This greater saving capacity and utilization of savings during shocks suggests enhanced financial resilience. Furthermore, active users avoid highly erosive strategies like selling assets (0% of users) when facing an emergency, compared to 12.8% of insured non-users, indicating better protection of assets and thus, better future preparation.
Category	**Emotional Well-being**
What I keep	• **[Representative survey]:** Well-being has remained stable overall, with slight emotional improvements observed**. A recent increase in income stands out as the strongest positive factor—54.8% of insured individuals reported income growth, compared to 35.9% of the uninsured**. Among those who used FP services (users), 65.4% saw income increases, versus 50.4% of non-users. These results underscore the potential of insurance coverage and service utilization to contribute to financial and emotional well-being
Category	**Child Well-being**
What I keep	• **[Representative survey]:** The utilization of the **FP microinsurance leads to significantly improved health access for children in insured households**, particularly when compared to insured clients who do not activate or use the services. • Access to Medicines: Households that use the FP services are significantly more likely to report that their children have more access to medicines. **53% of users declared this improvement, compared to only 19% of non-users.** • Easier Doctor Visits: Users report that their children can go to the doctor with more ease when they are sick (**18% of users reported this benefit) compared to only 7% of non-users.**

Category	**Service Awareness and Perception**
What I keep	• Users are more aware of the benefits, report better access to health services, some reduction in expenses, and greater savings capacity, and their positive evaluations of the insurance are concentrated in emergency situations. In contrast, those who do not use it are very similar to those without it: a lower perception of support, minimal reduction in expenses, and little appreciation of the insurance as a tool for coping with crises.

	Knowledge of benefits	**95**	**80**	**15**
	Perceived improvement in health access (yes, yes a lot)	40	15	25
	Perceived reduction in expenses (a bit, a lot)	17	9	8
	High Satisfacción (satisfied, very satisfied)	51	18	33
	Ability to save (some, a lot)	86	66	20

- Linear regressions reveal that using **FP increases the probability of saving in the past year by 8 to 16 percentage points, highlighting its meaningful contribution to financial resilience.** These results remain robust after accounting for a wide range of client, household, and agency-level factors.
- The analysis shows a **positive and statistically significant association between well-being challenges (such as health, educational, and mental health issues) and the likelihood of using FP services**. In particular, **families facing mental health difficulties are notably more likely to activate insurance benefits, even after controlling for a comprehensive set of covariates**. This underscores FP's role as a support mechanism for vulnerable households confronting complex, interrelated welfare issues
- Taken together, the findings suggest that microinsurance like **FP functions not only as a financial safety net but also as a behavior-shaping instrument**. It encourages preventive healthcare use**, promotes household-level savings, and facilitates access to integrated health and social services**. These pathways highlight the potential of microinsurance to bridge financial inclusion with public health goals, and to serve as an effective policy tool for improving the resilience and well-being of underserved populations
- **66% of clients are aware of services like telemedicine**, but only 30% used any service in the past year. Perceived financial relief is moderate: **40% reported no reduction in out-of-pocket spending**, while only 22.4% of those who faced emergencies felt the insurance helped

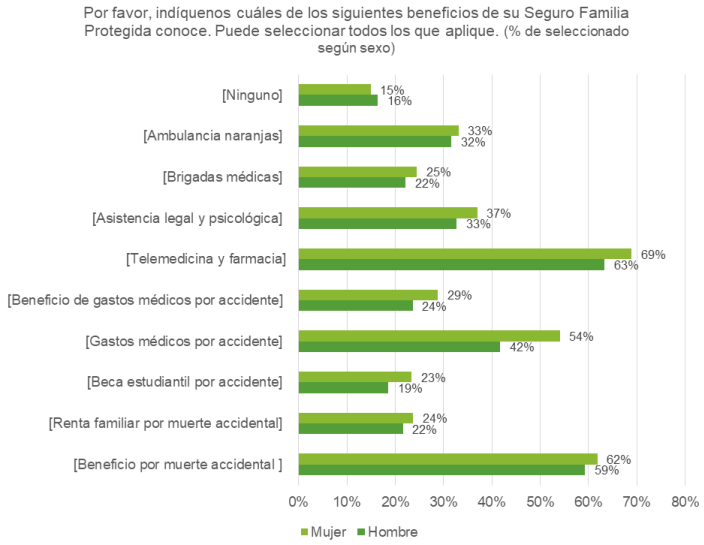
Questions/ comments	7. 40% reported no reduction in out-of-pocket spending, that it means that 60% reported reduction of out-of-pocket spending? Better to show the positive result
Answer	Although 40% of the total surveyed population reported no reduction in out-of-pocket spending (with 18% of Don't know / No answer) , it's important to distinguish between users and non-users of FP services. When we look only at those who actually used the insurance, the results are much more favorable: 15% of users said FP helped them reduce costs "a lot" or "quite a bit" 29% said it helped "more or less" 27% said it helped "a little"

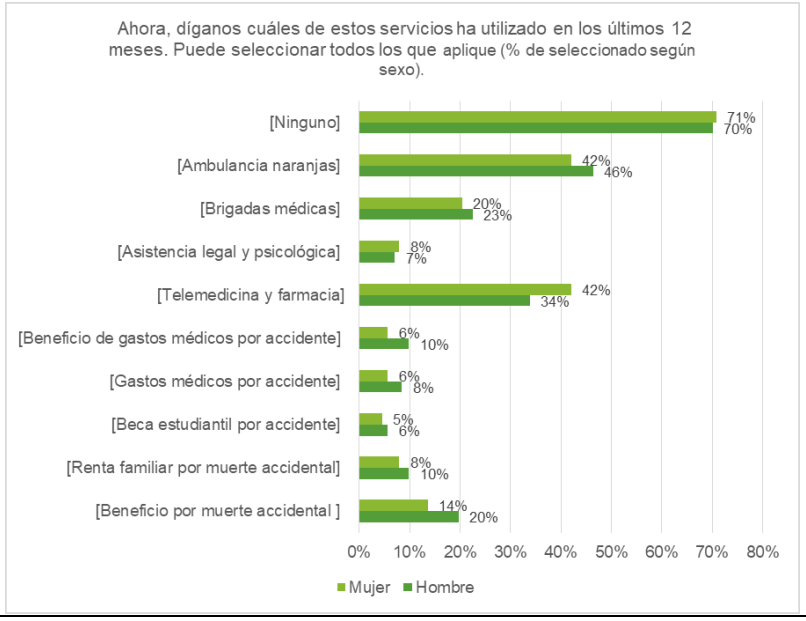
	That means that among FP users, over 70% perceived some level of financial relief thanks to FP coverage. This will be clarified in the final version of the document. ..

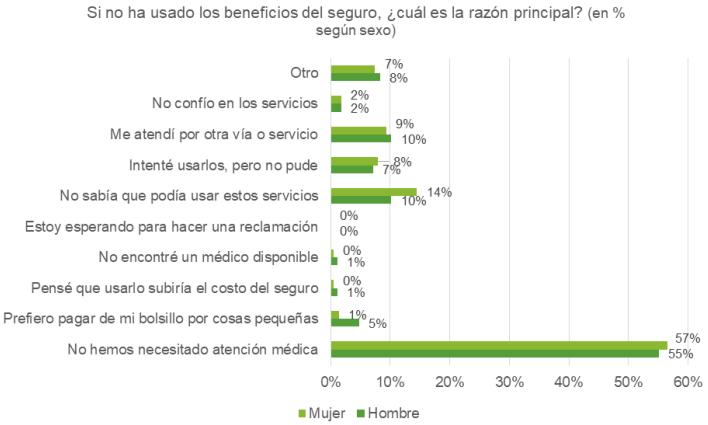
Category	**Inclusion of Women and Migrants**
What I keep	• Although women—especially those with higher education—are less likely to enroll, 63% of insured clients are female. **Migrant clients, particularly Venezuelans, are more likely to enroll and activate services**. The product successfully reaches underserved and excluded groups
Questions/ comments	8. Is it because of the low price or the culture? Any reason
Answer	The higher enrollment and service usage among migrant clients, especially Venezuelans, can be attributed to a combination of structural needs and pragmatic motivations, rather than cultural preferences alone. FP's higher uptake among migrants is likely driven by limited access to public health services and the perceived value of affordable protection. As noted in the literature (Annex 1), insurance reduces health-related expenses and promotes awareness, making it particularly relevant for excluded populations such as migrants.

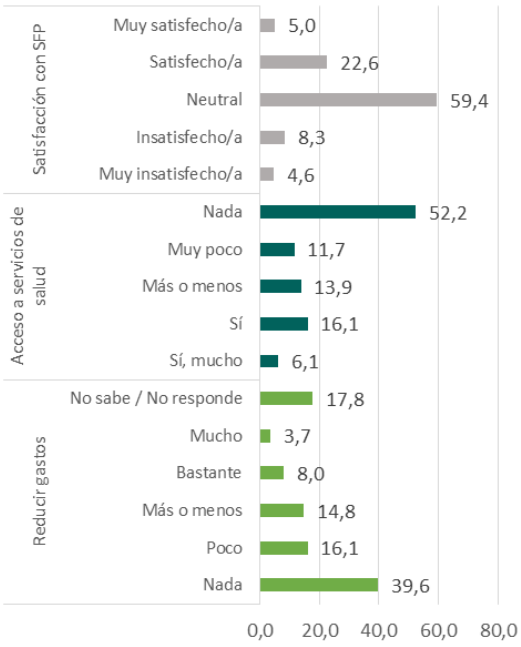
Category	**High Satisfaction Among Users, with Positive Perceptions Extending to Non-Users**
What I keep	• **Clients who actively use FP report notably positive levels of satisfaction (43%** versus 13% non-users), **reflecting the program's effectiveness in delivering valued services.** Among all surveyed clients, **28% expressed satisfaction, and 59% reported a neutral perception, indicating overall positive sentiment.**

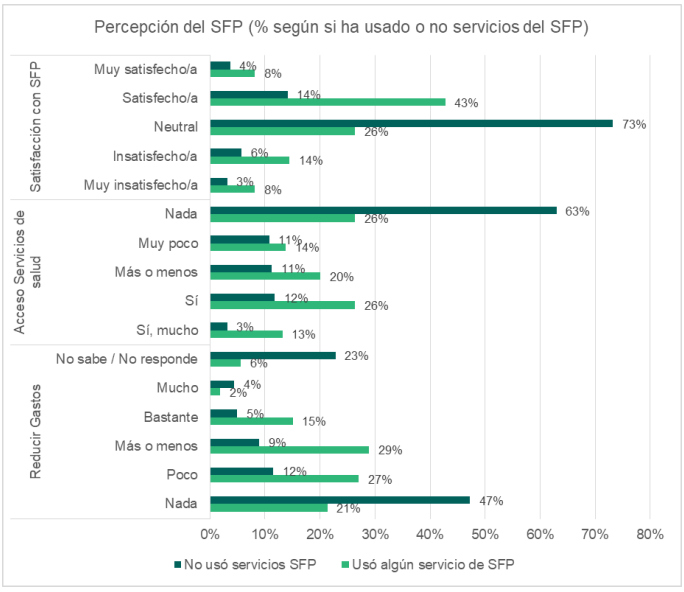
Questions/ comments	9. How is the level of understanding of insurance terms: Insurance coverage and claim process? 10. These graphs are in the annexes and not in the principal report and in Spanish version. It would be great to have a combination between speech and graphs during the whole report






Si no ha usado los beneficios del seguro, ¿cuál es la razón principal? (en % según sexo)
Otro
No confío en los servicios
Me atendí por otra vía o servicio
Intenté usarlos, pero no pude
No sabía que podía usar estos servicios
Estoy esperando para hacer una reclamación
No encontré un médico disponible
Pensé que usarlo subiría el costo del seguro
Prefiero pagar de mi bolsillo por cosas pequeñas
No hemos necesitado atención médica
7%
8%
2%
2%
9%
10%
8%
7%
14%
10%
0%
0%
0%
1%
0%
1%
1%
5%
57%
55%
0%
10%
20%
30%
40%
50%
60%
Mujer
Hombre


Satisfacción con SFP
Muy satisfecho/a
Satisfecho/a
Neutral
Insatisfecho/a
Muy insatisfecho/a
5,0
22,6
59,4
8,3
4,6
Acceso a servicios de salud
Nada
Muy poco
Más o menos
Sí
Sí, mucho
52,2
11,7
13,9
16,1
6,1
Reducir gastos
No sabe / No responde
Mucho
Bastante
Más o menos
Poco
Nada
17,8
3,7
8,0
14,8
16,1
39,6
0,0
20,0
40,0
60,0
80,0


Percepción del SFP (% según si ha usado o no servicios del SFP)
Satisfacción con SFP
Muy satisfecho/a
Satisfecho/a
Neutral
Insatisfecho/a
Muy insatisfecho/a
4%
8%
14%
43%
73%
26%
6%
14%
3%
8%
Acceso Servicios de salud
Nada
Muy poco
Más o menos
Sí
Sí, mucho
63%
26%
11%
14%
11%
20%
12%
26%
3%
13%
Reducir Gastos
No sabe / No responde
Mucho
Bastante
Más o menos
Poco
Nada
23%
6%
4%
2%
5%
15%
9%
29%
12%
27%
47%
21%
0%
10%
20%
30%
40%
50%
60%
70%
80%
No usó servicios SFP
Usó algún servicio de SFP

Answer	A.- How is the level of understanding of insurance terms: coverage and claim process? While the report confirms high satisfaction (satisfied, very satisfied) levels among users (51% of users vs. 18% of non-users), there are also clear signals of partial or limited understanding of the insurance product — especially among non-users or those who failed to activate services. Key evidence from the data includes: • 12.6% of non-users said *"I didn't know I could use it"* • 16.7% (of those who had an emergency and FP) said *"I didn't know the insurance could help in that situation"* • 7.6% of those had FP tried to use the insurance but couldn't — suggesting difficulties in navigating the process These insights indicate that while satisfaction is high among those who use FP, there is a need to improve the overall level of understanding of: • What services are covered • When and how to activate them • How to navigate the claims process B.- It is right that combining visuals with narrative enhances clarity and engagement. In this version of the report, most graphs were placed in the annexes — especially in the Spanish version — for two main reasons: 1. Focus on evaluation questions: The main body of the report was carefully structured to respond directly and clearly to the core evaluation questions, using concise text, key findings, and methodological rigor. 2. Length limitation and prioritization: To ensure the report remains accessible to a wide range of stakeholders and stays within a maximum of 30 pages, we opted for a more compact format. To support this, a summary table of key indicators for users vs. non-users has been included, allowing for quick comparisons without overloading the body with visuals. 3. The new version includes, Appendix 4 in English.

Category	**Program Performance**

What I keep	• Statistical evidence confirms that the **insurance enhances resilience to adverse aggregate health shocks.** When respiratory illnesses, such as pneumonia cases, rise across provinces, insurance holders significantly more often use compensation payments, telemedicine, and medication benefits. This increased utilization suggests a quicker and more effective response during critical periods. This responsiveness enhances not only individual health outcomes but encourages earlier treatment and reduces delays in seeking care. **For insured clients who faced a health-related emergency, those who used FP services were far more likely to resolve the emergency through BVFE's medical services (such as Brigade, Ambulance, or Telemedicine) (18.2%), compared to non-users (1.1%)** or those without insurance (0.4%). This direct and rapid channeling of care via the **insurance network facilitates faster recovery.** • **With a claim ratio of approximately 20%, FP operates below the Latin American median (25%) and the global average (23%).** This indicates strong financial sustainability, aligned with global benchmarks. The low loss ratio also presents an opportunity to expand impact through improved service activation and outreach.
Questions/ comments	11. BVF Ecuador told us the average in claim ratio was 38%, it has changed? 12. It is important to include in the speech additional services. Take it into consideration 13. How do you evaluate into the claim ratio the additional services? In VFI is calculated with this formula: $\text{Claim \& Services ratio} = \frac{\text{Value of claims paid + value of other services provided to beneficiaries}}{\left(\text{Total premium amount provided to the insurance partner(s)} - \text{Commission received from insurance partner}\right)}$
Answer	A.-Yes, it is possible that the claim ratio has changed over time. While BVF Ecuador reported an average claim ratio of 38%, this figure may have shifted given the most recent data available: • The complete insurance usage database covers the period January 2022 to June 2025 • It records 13,039 compensations corresponding to 6,584 individual clients B.- While this evaluation focused on the impact of the Familia Protegida (FP) insurance product, complementary services such as medical brigades and Ambulancia Naranja were captured through the survey. These services, though not contractually part of FP, contribute to the overall client experience and may influence perceptions of protection and value. This insight will be added to the conclusions. C.- Thank you — this is an important methodological point that will be clarified more explicitly in the final version of the report.

	In the current draft (page 3), the "20%" figure refers to the proportion of unique FP clients who appear in the administrative compensation database — that is, clients who used at least one FP-covered service. Specifically: 6,584 unique users appear in the compensation records. Out of an estimated ~30,000 unique FP-insured clients, this represents approximately 20% who have activated at least one service during the period analyzed. It is not a claim ratio in the actuarial sense, but rather an activation rate based on service usage records. By contrast, in the representative survey, about 30% of FP-insured respondents reported having used at least one service. This slightly higher figure is likely reflected: Self-reporting over a 12-month window. Inclusion of non-compensation services, such as telemedicine or medical brigades

HOW CAN YOU IMPROVE?

Category	**Information and use of FP Insurance (most frequent topic in the open space for suggestions)**
What I keep	• "More information about insurance," "clearly explain the benefits," "reminders," "informative talks," "where to call, where to go," "indicate the benefits at the time of credit." • They ask for simple channels and materials: reminders, brochures with benefits and phone numbers, clearer mobile banking, and trained advisors to explain. • They request expanded coverage/speed: higher pharmacy allowance or cumulative allowance, more medications, pediatric dentistry, in-person care, and more frequent brigades (including weekend care in some areas). • Blind spots: people who "did not know the insurance existed" or who "did not know how to use it in an emergency."
Questions/ comments	14. Why if information and use were the most frequent topic in suggestions "there is a high level of awareness of services such as telemedicine/pharmacy and ambulance"?
Answer	While survey results indicate relatively high awareness of services like telemedicine and pharmacy benefits (66%) and reported use of Ambulancia Naranja (44% among insured users), open-ended suggestions frequently pointed to gaps in information and service use. This finding is consistent with other survey sections that reveal knowledge gaps, suggesting that awareness does not always translate into clear understanding or effective activation. Awareness does not necessarily equal understanding or effective use. Clients may have heard of a service but still lack clarity on how to access it, what it covers, or when it applies.

	Because this information comes only from survey data, and we lack administrative records for services like Ambulancia Naranja and Brigadas Médicas, it limits deeper analysis. We will include this as a key insight in the final conclusions and recommend that VFE begin collecting administrative data on these services to strengthen monitoring and future evaluations.

Category	**Children wellbeing**
What I keep	• Among insured households that do not use the FP services, **84.0% reported that their children did not utilize any of the FP's services.** This indicates that in **households where the parent does not activate the insurance, the children are largely excluded from the benefits package** • Health Access (Improved): Households that used FP services reported significantly greater improvements in pediatric health access compared to insured non-users: o Access to Medicines: **53% of users reported that their children had more access to medicines, versus only 19% of non-users.** o Easier Doctor Visits: **18% of users reported that their children could go to the doctor with more ease when sick, compared to 7% of non-users.** o **Services like telemedicine (26% utilization) and ambulance services (36% utilization) were the most used services for children**. The use of these services for children is strongly concentrated in households where the insured adult activates the service

Category	**Financial Resilience and Stability**
What I keep	• Main coping mechanisms during shocks are credit, savings, and family. The dichotomy highlights that for the FP to be an effective financial and health protection tool, its activation and subsequent service delivery is an active resource for resilience: Evaluation of FP during economic emergencies (N = 138 only FP and emergencies): **22.4% said it helped (a lot/somewhat); 34.1% said it didn't help; 26.8% didn't use it or it wasn't useful**; 16.7% were unaware it could help. • While the FP program effectively reaches **Venezuelan migrants, their responses regarding satisfaction and financial relief tend to show lower levels of satisfaction and more neutrality compared to the larger Ecuadorian segment**, likely reflecting different expectations and **potential frictions in access.**

Summary of causal relationship:

- **Users have significantly greater access to healthcare, special under health risk:**

    1. Insured individuals make more frequent use of **telemedicine, medications, and compensation services—especially during periods of heightened health risk (e.g., pneumonia outbreaks).** This confirms the program's central promise: to reduce barriers to timely, affordable health care for low-income households.

Note: Methodological approach: Difference-in-Differences (DiD) techniques to estimate causal effects.

- **Clients who use FP are more likely to save**.

    - Savings: **64.4% managed to save something**; 33% did not save; among the insured, fewer reported "no savings at all." **Greater saving capacity is observed among those who use the FP—85.5% of individuals who have used insurance services** report having been able to save "a lot" or "some" money over the past 12 months.

Note: Methodological approach: Correlation analysis.

- **Households facing well-being challenges (health, school, or <u>mental health issues</u>) are more likely to rely on FP services.**

    1. The analysis shows a **positive and statistically significant association between well-being challenges (such as health, educational, and mental health issues) and the likelihood of using FP services**. In particular, **<u>families facing mental health difficulties</u> are notably more likely to activate insurance benefits, even after controlling for a comprehensive set of covariates**. This underscores FP's role as a support mechanism for vulnerable households confronting complex, interrelated welfare issues

Note: Methodological approach: Correlation analysis

Opportunities for Improvement

- Strengthen communication and simplify procedures to increase service activation (with migrants focus too).

    - Prioritize strategies that promote the active use of insurance services

- Expand client education campaigns on service availability and activation procedures, especially during health risk periods
- Reinforce FP's role as a financial resilience tool through financial literacy programs that help clients manage savings and emergencies
- Documenting and promoting positive behaviors (e.g., clients saving instead of selling assets by social media) as case studies for peer learning.
- Expand communication around the economic value of the insurance, not just the health aspects.

- **Increase visibility of psychological assistance already included in the benefit package and consider adding more holistic psychosocial support (e.g., group sessions).**

    - Strengthen the visibility and uptake of existing psychological assistance services by implementing targeted communication strategies that raise awareness among clients.

- **Tailor outreach strategies for families with children and migrant clients to improve child-focused service use.**

    - Strengthen communication to highlight child-related benefits, especially in households where the insured adult may not recognize available services
    - Prioritize expansion of child-focused health services within the insurance, such as telemedicine for pediatric cases and accessible medication delivery.
    - Explore pilot programs that link insurance with school health campaigns or nutrition awareness through Ambulancia Naranja/Brigadas Medicas services.

- **Improve messaging around emergency assistance and financial protection benefits to reinforce client understanding.**

    - Maintain and strengthen inclusive enrollment strategies for migrants.
    - Tailor communication to emphasize services that migrants are more likely to use, such as telemedicine.
    - Conduct qualitative follow-ups with migrant clients to better understand satisfaction levels and hidden barriers.

Note:
This highlights the main recommendations