How microfinance can work for the poor

The case for integrating microfinance with education and health services

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The power of microfinance

In the past few years, microfinance has been widely heralded as a successful contributor to the alleviation of poverty and a valuable tool for achieving the Millennium Development Goals (MDGs). And with good reason: scores of studies have shown the positive impact that microfinance can have on the lives of poor people. A World Bank study of three microfinance institutions (MFIs) in Bangladesh, for example, found that 40% of the entire reduction of rural poverty over 14 years was directly attributable to microfinance.[1]

Microfinance provides people with access to credit and other financial services to start and grow businesses, build productive assets, and better cope with financial shocks—at interest rates typically well below those charged by traditional moneylenders. Moreover, microfinance institutions strive to serve those most in need. Of the more than 113 million microfinance clients around the world, it is estimated by the Microcredit Summit Campaign that about 84% are women and about 72% are "very poor" (in the bottom half of those living below their country's poverty line, or below US$1 a day).

Microfinance alone is not enough

While access to financial services is undeniably powerful, credit and savings products address only one factor of many constraining the poor—a lack of liquidity. Increasing income and assets alone is a slow and insufficient strategy for combating serious issues such as childhood malnutrition, avoidable maternal and neonatal mortality, the spread of HIV/AIDS and suffering due to preventable illness such as diarrhea and malaria. The poor need access to a coordinated combination of microfinance and other development services to increase income, build assets and improve health, nutrition, family planning, education, social support networks and more. The integration of complementary services intended for the same population can lead to enhanced operational efficiencies and synergies of benefits. The question is how to develop a scaleable strategy for delivering integrated microfinance and other services that meet the multifaceted needs of poor people.

New era of integrated development services

At the halfway point on the MDG timeline, overall progress has been disappointing. Achievement of the goals by 2015 will call for new and innovative ways of working rather than more of the same. A strategic, overarching strategy to address poor people's interrelated needs through creative partnerships that build on the best of different development sectors has the potential to lead to exponential rather than incremental reduction of poverty in the developing world.

Ideally, the over 3,000 existing microfinance institutions worldwide could provide an infrastructure or platform for reaching the poor through a coordinated combination of services. MFIs recognize the need, hear the demand and have a vested interest in cultivating a healthy, successful clientele with strong microenterprises.

Poverty and ill health

Poverty and ill health are intertwined and, as such, must be addressed in tandem. In the 2002 World Bank study, *Dying for Change*, illness was the most commonly cited reason for "a downward slide into poverty… ahead of losing a job, which took second place. The poor are more likely to be exposed to health risks because their work is physically demanding and often dangerous. But they are least likely to be able to afford health care when they are injured or fall ill."

[1] Khandker, Shahidur. 2005. "Micro-Finance and Poverty: Evidence Using Panel Data from Bangladesh." *World Bank Economic Review* 19(2): 263-286.

Yet people often have no choice but to spend what little they have when injury or illness strikes. In a study conducted in Kenya, it was found that households in the bottom 20% of the socioeconomic scale spent more than 10% of their total expenditures on acute illnesses and that about 30% of households faced "potentially catastrophic cost burdens" as a result of illness.[2] In research conducted by Freedom from Hunger in Bénin and Burkina Faso in 2006, it was found that poor microfinance clients spent an average of 30% of their annual income to combat malaria alone. And according to another study in Thailand, 35% of households experiencing an AIDS-related death "felt a serious impact on agricultural production, leading to a 48% reduction in family income.[3]" Ill health leads to lost productivity, which leads in turn to reduced earnings with which to prevent and treat illness. Neither improved financial stability alone nor better access to health education, products and services alone can solve the problem. The inextricable link between poverty and ill health makes a multisectoral solution paramount.

Microfinance as a development platform

While microfinance is not a development panacea, it offers a robust platform for the delivery of complementary services that are needed—and frequently requested—by poor people. MFIs serve millions of poor people, especially women, on a regular basis, often extending their services to isolated, hard-to-reach places. What is more, the microfinance sector is focused on market-based business principles and financial self-sufficiency—providing demanded services at a price that is affordable to clients but also covers the institution's operational costs. MFI clients repay their loans at astonishingly high rates, and their loyalty to and trust in the institution tend to be very strong. Many MFIs provide financial services to groups of clients, who mutually guarantee each other's loans. These groups meet frequently to make loan repayments and deposit savings with the guidance of MFI field staff. Such regular meetings offer excellent opportunities for the provision of add-on services, such as training in health or financial management.

This combination of a vast and rapidly growing network of distribution to hard-to-reach, loyal, economically active groups of poor people, a steady revenue flow from interest earnings, and the drive to develop market-based products that pay for themselves, makes microfinance an attractive core component of a development program that draws on the principles of self-help to alleviate poverty.

Multifaceted and sustainable solutions to poverty alleviation

Recognizing the vicious cycle of poverty and ill health, and witnessing its impact on clients' ability to repay, flourish, build assets and pull themselves out of poverty, some microfinance institutions have added nonfinancial services, such as dialogue-based education and linkages to health products and providers, to impressive effect. Image 1 shows a range of health-related needs, as expressed by poor women in developing countries, and the complementary products and services that MFIs can offer in response, alongside microfinance services. The following provides an example of a cohesive, integrated approach that uses microfinance as a platform for providing an array of complementary services that enable poor women and their families to lift themselves out of poverty and improve their health.

Health education

Equipped with more income and decision-making authority, microfinance clients have choices—often for the first time in their lives. As a result, coupling microfinance with behavior-change education can be especially powerful. Many MFIs are offering training in topics such as the

[2] Chuma, J., L. Gilson and C. Molyneux. "Treatment-seeking behaviour, cost burdens and coping strategies among rural and urban households in Coastal Kenya: an equity analysis." *Tropical Medicine & International Health*. 2007. 12(5):673–686

[3] Russell, S. "The economic burden of illness for households in developing countries: A review of studies focusing on malaria, tuberculosis and HIV/AIDS." *American Journal of Tropical Medicine and Hygiene* v.7. 2004. (suppl 2), pp.147–155

Image 1. Microfinance and Health Protection initiative, Freedom from Hunger

prevention and treatment of diarrhea, malaria, and HIV/AIDS; breastfeeding; rational use of local health services; as well as self-esteem, microenterprise management and financial planning. The combination of greater knowledge of sound health practices and the increased income to act on that knowledge leads to dynamic, positive change.

Considerable evidence of impact has been documented for integrated microfinance and education, or "Credit with Education" programs. Rigorous studies conducted in Ghana and Bolivia showed significantly improved health and nutrition practices by mothers who attended regular meetings where microfinance transactions and health education were provided by the same field agent. Participating mothers were more likely to breastfeed their children and delay the introduction of other foods until after six months. They were also more likely to properly rehydrate children who had diarrhea by giving them oral rehydration solution. These changes in nutrition and health protection practices were manifest in outcome measures such as increases in height-for-age and weight-for-age for children of participants.[4] Notably, a study of Credit with Education clients in Uganda showed that 32% of clients had tried at least one HIV/AIDS prevention practice, compared to 18% of non-clients.[5]

Health financing and insurance

Having more income and increased knowledge of sound health practices can only go so far. Unexpected health expenses can still wipe out a family's savings and force an MFI client to sell her productive assets. So, in recognition of client demand to protect against health-related financial shocks and the MFI's own interest in protecting its portfolio from illness-induced defaults, some organizations—such as Réseau des Caisses Populaires in Burkina Faso—are going beyond Credit with Education to deliver health financing mechanisms, such as dedicated health savings accounts and emergency health loans.

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[4] MkNelly, Barbara and Christopher Dundford. 1998. *Impact of Credit with Education on Mothers and Their Young Children's Nutrition: CRECER Credit with Education Program in Bolivia*. Freedom from Hunger; MkNelly, Barbara and Christopher Dundford. 1999. *Impact of Credit with Education on Mothers and Their Young Children's Nutrition: Lower Pra Rural Bank Credit with Education Program in Ghana*. Freedom from Hunger, http://www.ffhtechnical.org.

[5] Barnes, Carolyn, Gary Gaile, and Richard Kimbombo. 2001. *Impact of Three Microfinance Programs in Uganda*. Washington, D.C.: AIMS.

Health microinsurance takes this solution a step further. In Rwanda and the Philippines, enrollment in microinsurance programs is becoming easier, thanks to the availability of loans from MFIs to spread annual premium payments over time. According to a World Bank report, linkages between MFIs and health microinsurance schemes in Rwanda have increased opportunities for scheme members to access credit for income-generating activities[6]

Although these health financing products look promising and align well with MFIs' core competencies, they do call for new expertise on analyzing health-seeking behavior, needs and costs, and designing efficient management mechanisms to prevent fraud, among others. The tremendous need and technical complexity associated with health microinsurance make this a particularly crucial area for additional investment and experimentation to devise templates for programs that could be widely adopted and adapted.

Links to health care providers

If good local health care is not available, then a microfinance client's increased earnings, good preventive health practices and health financing products will only go so far. Distance, quality and affordability can be major barriers to timely health care—particularly in rural areas, where providers are sparse, transportation is difficult, and public services are not well funded. Rather than develop expertise in health care, MFIs can leverage their local influence and business acumen to create reliable linkages with providers, negotiate rates, and advocate for better quality and accessibility of health care.

The largest MFI in the Philippines, CARD, has negotiated exclusive discounts for its clients with private providers in rural areas to increase access to more affordable primary care. The Bolivian MFI, CRECER, contracts with doctors who travel to isolated areas to conduct "health days" during which general check-ups, blood-pressure testing, Pap smears and other essential services are offered en masse. In Cambodia, the MFI-run GRET-SKY health insurance project uses its leverage to improve the quality of care in public facilities and helps channel poor people away from inappropriate and expensive care delivered by private (often traditional) providers and toward local public health centers. Such provider linkages also help to leverage and sustain local medical services, thereby leading to broader community development outcomes.

Access to health products

A package of services to address the poverty and ill health of very poor people is incomplete without access to crucial health products. Increased financial resources and knowledge about preventive health measures cannot help microfinance clients avoid malaria when insecticide-treated bednets are not sold in their community, prevent HIV if condoms are not available, protect children from diarrhea when treatment tablets for contaminated water cannot be found, or buy the prescribed antibiotic when the supply is outdated, the quality of medicines sub-optimal or the prices exorbitant.

In response to such needs, BRAC in Bangladesh uses a network of health workers to sell essential but scarce health products door-to-door, and the fast-growing Indian MFI, Bandhan, is experimenting with a similar model. Some West African credit union networks have purchased insecticide-treated bednets and sold them at group meetings. The Bénin MFI, PADME, is

[6] Diop, Francois and Jean D. Butera. "Community-Based Health Insurance in Rwanda," *World Bank Findings Report, #256*. World Bank, Geneva. November 2005.

developing a partnership with Population Services International to ensure that essential health products are distributed to shops in target communities and encourages its clients with suitable shops to offer such products.

Conclusions

A careful analysis of the local service gaps, consumer demands, institutional capabilities and business incentives leads to the development of a package of context-specific, cohesive, interrelated services that can be provided directly by MFIs, or through strategic partnerships with other public or private organizations. The integrated package of microfinance and nonfinancial services does not need to be costly or unduly complex; for example, in Credit with Education, the addition of dialogue-based education to the village-banking type of microfinance service costs the MFI only about 6%–10% more than without education, and benefits the MFI through increased client retention.

Evidence now supports the integration of microfinance with nonfinancial services as an approach that has potential for enormous contribution to the achievement of the Millennium Development Goals. However, high-level support is needed to extend integrated services at a large enough scale to achieve outcomes on national and global levels. Promotion of integrated approaches via leadership briefings, statements of national policy and advocacy through individual country development agencies would signal the importance of applying this approach more widely. Governments and development agencies can expedite achievement of the Millennium Development Goals by supporting the integration of poverty-focused microfinance and nonfinancial services.

Author biographies

Christopher Dunford (Ph.D. in ecology from the University of Arizona, Tucson) is President of Freedom from Hunger. He has worked worldwide with the UN Environment Program, the Office of Arid Lands Studies, and since 1984 with Freedom from Hunger in the design of rural development services and impact research focused on the chronically hungry poor.

Sheila Leatherman is Professor of Public Health at University of North Carolina and London School of Economics. She is an elected Member of the Institute of Medicine of the U.S. National Academy of Sciences and in 2007 was awarded the honour of Commander of the British Empire (CBE) by Queen Elizabeth for work over the past decade in the National Health Service.

Ellen Vor der Bruegge (MPH, MSc Education, M.T. ASCP) is Vice President, Program Initiatives of Freedom from Hunger. She is one of the co-creators of the *Credit with Education* methodology and is currently leading their efforts to develop strategies to sustainably reach the very poor with new products and services.

Myka Reinsch Sinclair (MBA from Columbia University) is Director, Microfinance and Health Protection at Freedom from Hunger. She leads a Gates-funded initiative to design and test new products that combine microfinance and health services to better meet the needs of the poor while enhancing the viability of microfinance.

Marcia Metcalfe is a consultant to Freedom from Hunger's Microfinance and Health Protection initiative, contributing to innovations in integrated microfinance and health services. She is an adjunct professor in the Center for Political Participation at Allegheny College and has over 20 years of senior management experience in nonprofit health care management and managed care.

Bobbi Gray is Research and Evaluation Specialist at Freedom from Hunger, responsible for designing and directing impact evaluations of the organization's innovations. Bobbi's work has helped establish the positive impact of integrated microfinance and health education services on clients' food security levels in numerous countries around the world.

Organization information

Founded in 1946, Freedom from Hunger brings innovative and sustainable self-help solutions to the fight against chronic hunger and poverty. For nearly 20 years, the California-based organization has been training local partner organizations throughout West Africa, Asia and Latin America in the Credit with Education methodology, which continues to be regarded as a major innovation in the field of microfinance for its self-sustaining combination of financial and practical training services. Success with this program has led Freedom from Hunger to develop other innovations that combine microfinance with education and health to achieve lasting food security.