2011 Global Microcredit Summit
Commissioned Workshop Paper
November 14-17, 2011—Valladolid, Spain

Integrating Microfinance and Health

Benefits, Challenges and Reflections for Moving Forward

Sheila Leatherman
Gillings School of Global Public Health
The University of North Carolina
United States of America

and

Christopher Dunford, Marcia Metcalfe, Myka Reinsch,
Megan Gash and Bobbi Gray
Freedom from Hunger, United States of America

July 2011

TABLE OF CONTENTS

Integrating Microfinance and Health
Benefits, Challenges and Reflections for Moving Forward

We realized that simply microfinance can't achieve our ultimate goal of poverty alleviation and women's empowerment….The need of the hour was to ensure holistic development of the poor…and that was possible only through credit plus interventions.

C.S. Ghosh, Bandhan, India

Executive Summary

Access to financial services is undeniably important to poor families, but it is insufficient on its own to address the multi-dimensional challenges of poverty. Ill health and the inability to access health care are key factors both leading to and resulting from poverty. Microfinance clients and staff frequently report that the cost of illness causes difficulties with loan repayment and savings deposits, often requiring clients to use their business loans and other household assets to pay for healthcare expenses. Clients report low usage of health services and delays in seeking care, stemming from barriers of cost, geographic access, cultural beliefs and lack of trust in health providers. Inadequate information about how to prevent and treat illness is a common and pressing concern.

Microfinance service providers with long-term, routine and trusting relationships with clients are well positioned to play a cross-sectoral role in improving access for the poor to a range of important health-related services. Microfinance providers are keenly aware of the health needs, which can prevent their clients from repaying on time, from growing their own businesses financed by loans, from depositing savings, or even push their clients to drop out altogether. Many microfinance leaders would like to respond to the common and debilitating health problems of their clients—but only if they can see what they are getting into beforehand. They want evidence that others have done this and succeeded—evidence that it will make a real difference in their clients' lives and perhaps create greater client satisfaction and loyalty, leading to improved repayment performance and increased volume.

In this paper, we document available experience and evidence to help guide the growing number of microfinance practitioners, policymakers and development organizations interested in this emerging arena of integrated microfinance and health. In order to have impact, there are three major barriers to health that must be addressed:

- Inadequate health information
- Insufficient geographically accessible, affordable and effective healthcare services
- Inadequate financing for health

Research so far indicates that all three of these barriers can be positively modified through health-related programs that can be offered by microfinance providers in a cost-effective manner.

Health education is by far the most common health service offered by microfinance providers, for several reasons: the relative ease of implementation, the availability of numerous adaptable delivery models and the existence of supporting technical guides, curricula and evaluation tools. Multiple studies show that adding health education alone, usually delivered during the routine microfinance group meetings, improves knowledge that leads to behavioral change. These behaviors are known to be associated with positive health outcomes that are critically important for improving the health status of the poor and for achieving the Millennium Development Goals in areas such as maternal and child health.

Direct delivery of healthcare services by microfinance providers and/or the linkage of clients to independent care providers are far less common than health education. However, multiple studies show that the integration of microfinance and health programs can affect important aspects of health and well being, such as family planning (higher contraceptive use and lower fertility), preventive services (e.g., increased access to immunization), care of childhood illnesses and management of acute health problems (e.g., diarrhea and respiratory infections).

Documented and researched examples of microfinance providers offering their clients access to health products are sparse. However, these few have succeeded in cost-effectively providing access to products that are beneficial to family health (such as medications, oral rehydration salts, mosquito nets, paracetamol, de-worming pills, antiseptic lotion, oral contraceptive pills) or even life saving, such as insecticide-treated bednets.

The poor use a variety of mechanisms for financing direct health costs—most often borrowing, selling assets and avoiding health care—but often with negative consequences. Microfinance clients want and can benefit from health-financing products such as health savings, health loans and health micro-insurance. We found that microfinance providers can be crucial partners for helping the poor in developing countries cope with health costs to improve the financial stability of households, because they have the advantage of an existing client base and requisite competencies in administration of financial services.

This paper shares the evidence to date that integrating microfinance with health protection services actually works for clients and can be practical for microfinance providers. We show the range and variety of options for health-related programs and services that are currently offered by microfinance providers around the world and can be adopted more widely. Moreover, the research literature and recent product development (with field experiments and impact research) indicate that integration of microfinance and health protection services can be a multiple win for microfinance providers, for clients and their families, for healthcare providers and for the larger communities in which the clients reside.

Overview and Background

Intersection of Microfinance and Health

Access to financial services is undeniably important to poor families, but it is insufficient on its own to address the multi-dimensional challenges of poverty. Ill health and the inability to access health care are key factors both leading to and resulting from poverty (Narayan et al. 2000). The financial costs of illness and seeking treatment are a large burden on poor households, accompanied by the simultaneous threat of reduced income due to a loss of productive labor. Generally, health costs are reported as a proportion of annual income or expenditure; catastrophic health spending is considered in the literature to be anywhere from 10 percent of income (Russell 2004; McIntyre et al. 2006) to 40 percent of income (Xu et al. 2003). In addition to direct costs of illness, loss of productive time for labor due to illness or the need to serve as a caregiver for a sick household member also adds to the burden of total health costs for poor families.

Microfinance clients and staff frequently report that the cost of illness causes difficulties with loan repayment and savings deposits, often requiring clients to use their business loans and other household assets to pay for healthcare expenses. Clients report low usage of health services and delays in seeking care, stemming from barriers of cost, geographic access, cultural beliefs and lack of trust in health providers. Inadequate information about how to prevent and treat illness is a common and pressing concern.

The thesis of this paper is that microfinance service providers with long-term, routine and trusting relationships with clients are well positioned to play a cross-sectoral role in improving access for the poor to a range of important health-related services. There are clearly significant opportunities to integrate the expertise from the microfinance and health disciplines to support the self-help efforts of poor households.

In this paper, we document available experience and evidence to help guide the growing number of microfinance practitioners, policymakers and development organizations interested in this emerging arena of integrated microfinance and health. We start with acknowledging the expertise and perspectives of both the health and the microfinancing sectors, which can be brought to bear to shape this field of endeavor.

The Health Sector's Perspective

Reducing the burden of illness, the associated costs and avoidable human suffering are all top priorities in the global health community. Worldwide, the poor carry a disproportionate share of the burden of disease. Low- and middle-income countries have a "double burden" of treating and preventing both communicable and non-communicable chronic diseases (Anderson 2009). Policymakers and providers in the health sector fully understand that poverty is a root cause of ill health and that predictably improving health status globally can only be done in conjunction with poverty alleviation efforts.

Significant inequities exist in the amount and quality of care sought (Makinen et al. 2000; Onwujekwe et al. 2000; Russell 2004) and survey data from multiple countries indicate that the

non-use of care ranges from 20 to 86 percent with the avoidance of treatment frequently explained by financial or time constraints (Xu et al. 2007; Chuma et al. 2007; Russell 2004). Unfortunately, the poor often delay seeking care until the health situation is an emergency, putting themselves at risk and resulting in more expensive and possibly lower-quality care (Whitehead 2001; Onwujekwe 2005).

The global health community is well aware of the dire need for and overwhelming challenges involved in increasing access to effective health-related services to all those in need. Historical and current programs, though making some difference, have often failed to demonstrate the needed improvements in reliable access and quality, and scalability is challenging in all countries.

The network of microfinance providers around the world represents a new opportunity for global health. More than 3,500 microfinance providers provide credit, savings and other financial services to more than 190 million households worldwide in support of income generation and consumption (Reed 2011). According to conservative estimates from poverty measurement studies by the United States Agency for International Development (USAID 2010), at least 43 million of these households are very poor, many of whom live in remote areas beyond the reach of health agencies, both private and government. From a global health perspective, collaboration with microfinance providers could tap into existing, mostly self-financing distribution channels to reach millions of unserved and underserved households. Microfinance service-delivery systems offer unique opportunities for distribution of health education and services as well as provision of healthcare financing options to millions of the hard-to-reach poor worldwide. In essence, integrating microfinancing and health programs makes intuitively good sense.

The Microfinance Sector's Perspective

Expanding access to financial services for all people to support poverty alleviation is the top priority of the global microfinance community. Providing sustainable access for large numbers of people is usually enabled by building and maintaining profitable business operations that recover costs from interest and fees charged to the financial service clients, including the poorest clients.

In data collected in three countries by Freedom from Hunger, among those households reporting a member being sick in the last 30 days, the average duration of an illness ranged from 6.9 days in Bénin to 10.8 days in Bolivia (Leatherman et al. in review, 2011). Households with a sick member in Bénin missed almost four days of work in the prior month; in Bolivia, 26 percent of these households missed six days or more of productive work due to illness. Clients' health problems commonly mean potential financial losses for the microfinance provider, which loses efficiency in pursuing sick, late-paying clients or having to replace them with new clients who take some time to build up to taking larger, more profitable loans. Households often pay the costs of illness by using current income and savings, reducing consumption, borrowing money or selling assets (Russell 2004; McIntyre et al. 2006; Leive and Xu 2008). Borrowing and selling assets result in additional costs, such as very high interest rates and asset devaluation (e.g., livestock sold at low prices), sacrificing future income streams (Leive and Xu 2008; Kruk et al. 2009). These financing and coping mechanisms may have lasting effects on the ability of households to withstand future shocks, creating a cycle of compromised health, economic vulnerability and poverty (Whitehead et al., 2001; Leive and Xu 2008).

Microfinance providers take an interest in the health of their clients for both business reasons and because they care about their social welfare. The severely limited financing and coping mechanisms may have wide-ranging and long-lasting negative effects on the ability of households to withstand future shocks. They may create a cycle of economic vulnerability and poverty and leave households in debt for a considerable time after the illness has subsided. When confronted with illness-related costs, the chances of a poor household ever moving out of poverty diminish. As a result, a growing number of microfinance providers feel compelled to participate in finding solutions to the health problems encountered by clients and their households.

The Opportunity for Collective Impact

While health and microfinance perspectives are indeed different, they converge in a shared concern for the inextricably related economic and health status of microfinance clients, their families and communities. This convergence creates a common understanding, motivation and opportunity to generate collective impact by assuring that both microfinance and health services are simultaneously available and affordable in poor communities.

In order to have impact, there are three major barriers to health that must be addressed. All three of these barriers can be positively modified through health-related programs that can be offered by microfinance providers:

- Inadequate health information
- Insufficient geographically accessible, affordable and effective healthcare services
- Inadequate financing for health

There are programs and approaches that have been implemented in various countries that can address one or more of these barriers. Ideally, all three barriers would be addressed with a cohesive approach for example, health education can produce changes in knowledge and behavior, but without reliable access to health services and the financial means to pay, health problems will remain inadequately addressed. Admittedly, the learning and wisdom derived from past and current experience is sometimes uneven or hard to access. However, there are now enough examples and evidence to guide practitioners willing and eager to move in this direction.

Global Experience in Integrating Microfinance and Health

Recognizing the vulnerability of their clients to health shocks, a small but growing number of microfinance providers have developed ways to respond to client demand for health protection. Table 1 shows how the three barriers to health can also be viewed as clients' needs or market demand and lists specific examples of interventions that microfinance providers are offering their clients, often in coordination, even collaboration with healthcare providers.

Table 1: Principal barriers to health protection and examples of interventions

Client Need or Barrier	Examples of Interventions
Knowledge—Awareness and information	• Health education • Health promotion and screening • Trained community health volunteers • Health fairs
Availability of effective products/ services	• Direct delivery of clinical patient care • Contracts and linkages with providers • Community pharmacies/drug dispensaries • Referrals to health providers • Loans to health providers for capital investment • Micro franchising of health-related businesses
Financial ability to pay	• Loans for medical care • Community and personal savings accounts • Health micro-insurance

To better understand the integrated financial and health programs currently available, we conducted an informal global survey of organizations offering both. This is a "convenience sample," which we identified through a voluntary online survey in 2009 and supplemented with information from secondary sources (personal contacts, news reports, articles from sector publications, etc.) in 2011. The 89 organizations in this dataset (appendix A) provide both microfinance and health interventions; they are well-dispersed geographically, with 37 percent in Asia, 26 percent in Sub-Saharan Africa and 29 percent in Latin America and the Caribbean.

Table 2 shows the percentages of organizations offering different categories of health interventions with some offering more than one type. Health education is the most commonly offered (80%) with all other types being offered by less than one-quarter of the organizations.

Table 2. Frequency of types of health protection interventions by microfinance providers

Group-based health education sessions	80%
Referrals to healthcare facilities	22%
Direct delivery of health services and counseling	22%
Contracts with public/private healthcare providers	20%
Health micro-insurance	20%
Health promotion events	16%

Additional interventions were mentioned, such as facilitating access to affordable medicines, healthcare vouchers, support for community water and sanitation, mobile services or treatment for a single health condition such as tuberculosis. Twenty-eight of the 89 organizations included in this survey of the industry shared their principal motivations for offering health protection services (Figure 1). Most expressed their concerns in terms of client needs; slightly less than one-half of the organizations explicitly cited their concern about the impact of health problems on client performance, such as repayment of loans. This may or may not reflect an institutional priority given to social vs. business goals in the majority of this group of 28 organizations.

Figure 1

Examining Health Interventions by Microfinance Providers—Models, Impact and Costs

We have been guided by three sources of experience and expertise:

- Published literature to learn from synthesized evidence,
- Microfinance providers with which we worked in a five-country demonstration via the Microfinance and Health Protection (MAHP) initiative directed by Freedom from Hunger and supported by The Bill & Melinda Gates Foundation, which produced a diverse set of health-related programs combined in varied delivery models.
- Three multinational organizations—BRAC, Freedom from Hunger and Pro Mujer—which have long histories of integrating microfinance and health. Given the scope and scale of their programs, we have written detailed case descriptions (Appendix B) to supplement the briefer discussion in the paper.

We focus on describing the diversity of programs that address the growing market for health-related services to microfinance clients. For programs to both meet client needs and be feasible and sustainable for microfinance providers, three questions need to be addressed:

- What specific services and products are needed? Need can be understood in relation to the three barriers or constraints encountered by the poor in preventing or treating illness and injury—insufficient knowledge, which can be addressed through education; inadequate geographic access to effective healthcare providers and products, which can be improved by linking microfinance clients and their families to health care and products; and lack of affordability, which can be addressed through health-financing products.

- What impact is observable? Impact is defined in terms of health-related benefits that accrue to the clients and their households and, in some cases, to the wider community. Programs must have demonstrable impact as well as meet client needs.

- What health protection options can be provided by microfinance providers and through what delivery models? Capacity of microfinance providers to offer health options is understood in terms of the direct (money) and indirect (time) costs of the various models—which fall into three generic types (Dunford 2001):
  - Unified (generalist staff within one organization deliver both microfinance and health services to the same people)
  - Parallel (specialized microfinance and health/education staff within one organization deliver the different services to the same people)
  - Linked (distinct, specialized organizations coordinate to deliver the different services to the same people)

Health Education

Health education is by far the most common health service offered by microfinance providers for several reasons: the relative ease of implementation, the availability of numerous adaptable delivery models, and the existence of supporting technical guides, curricula and evaluation tools.

Studies of microfinance providers delivering health education increasingly show evidence of positive impact. Multiple studies (Leatherman and Dunford 2010) show that adding health education alone, usually delivered during the routine microfinance group meetings, improves knowledge that leads to behavioral change. These behaviors are associated with positive health

outcomes (Box 1) that are critically important for improving the health status of the poor globally and for achieving the Millennium Development Goals in areas such as maternal and child health.

Box 1.

Areas with positive outcomes from health education combined with microfinance

- Reproductive health
- Preventive and primary health care for children
- Child nutrition
- Breastfeeding
- Child diarrhea
- HIV prevention
- Domestic abuse/gender-based violence
- Sexually transmitted disease
- Malaria

(Leatherman and Dunford 2010)

Benefits can be observed across varied health issues and countries. In Bolivia and Ghana, MkNelly and Dunford (1999) found that mothers' health and nutrition practices can be changed by a "unified" delivery of village banking and child-survival education, with resulting behavioral changes in breastfeeding, complementary feeding and management of diarrhea that lead to significant increased height-for-age and weight-for-age for children of participants. In South Africa, Pronyk et al. (2006) found positive impact of a comprehensive training and education program on microfinance group members, for whom the risk of physical or sexual abuse by intimate partners was reduced by more than one-half as compared to a control group of microcredit-only members and to the general community. In Ghana, de la Cruz et al. (2009) found that MFIs can effectively contribute to community and national malaria initiatives by increasing knowledge of malaria prevention and treatment, leading to increased insecticide-treated net ownership and use by vulnerable members of the household (children under the age of five and pregnant women). In Uganda, Barnes et al. (2001) found that 32 percent of women

receiving education about HIV/AIDS prevention through their microcredit groups tried at least one HIV/AIDS prevention practice, compared to 18 percent of non-clients.

The literature shows that providing health education with microfinance has potential for benefit to clients, their families and even wider communities. This integrated delivery is increasing in frequency, but can such integration be financially sustained by microfinance providers? Costs to microfinance providers for providing health education vary according to how the education is delivered. Some microfinance providers deliver education using their own credit staff (unified model), or through separate specialized staff who provide the education (parallel model). Still others may contract or partner with outside organizations to deliver the education (linked model). The total combined costs of microfinance and education delivery are usually lowest in the unified model; however, quality of education is likely to be lower when delivered by generalist field staff rather than by specialist education staff. Nonetheless, many of the positive impacts reported in the literature were found among clients served by the unified-delivery model.

For the unified model, Vor der Bruegge et al. (1999) used three consecutive years of financial data to attribute costs to the delivery of health, nutrition and business education to village banks in rural areas in Bolivia, Burkina Faso, Mali and Togo. These costs varied between 5 and 10 percent of total program costs for four microfinance providers. Based on 2005 financial data, Crédito con Educación Rural (CRECER) in Bolivia updated this costing exercise to determine the percentage of total costs that would be ascribed to the educational component to be 8.4 percent (Rueda at al. 2006).

Some microfinance providers are extending beyond the more conventionally delivered health education during group-lending meetings to multifaceted programs that reinforce and build on health education. In a current case example from West Bengal State in **India, Bandhan** has developed a parallel-delivery model inspired by BRAC. It provides practical health education to its clients and other non-client community members through optional, monthly, hour-long sessions conducted by specialized education staff of Bandhan. This non-formal education is reinforced by a network of *Shastho Shohayikas* (SS)—community health volunteers from Bandhan's credit groups—who make home visits to reinforce the health education messages, sell

MFI-sourced over-the-counter health products at market prices and encourage people to use local health services when appropriate. By the end of 2010, this initiative was offering both education and the SS to 120,000 women clients and their households, as well as to the larger community.

Research (Metcalfe et al. 2010) showed that the combination of community health education with health volunteer visits in the home was associated with major increases in health knowledge (e.g., care of newborns and the importance of exclusive breastfeeding) and with significantly positive changes in health behaviors (e.g., treatment of child diarrhea with oral rehydration solution). Of women randomly selected for interviews, 81 percent had received active advice and referrals from the health volunteers regarding children with diarrhea and 77 percent received advice and referrals regarding neonatal care. In addition, 40 percent of new mothers had been visited by a local volunteer within 48 hours of childbirth, and 41 percent of all women interviewed had purchased oral rehydration salts (for diarrhea management) from a volunteer.

Bandhan earns a small margin on the health product sales to SS, which helps offset the cost of training and managing volunteers. Reinsch et al. (2010) estimated (from incomplete financial data) the annual net cost of this program to be US$1 per client in terms of direct costs only, (and $1.73 when including allocated overhead and management expense). According to the MIX market, in 2008, Bandhan realized a 40.5 percent profit margin on its credit operations, which (also based on MIX data) would translate to approximately $13 in annual net profit per client. Although a $1 net cost per client might thus theoretically be borne by the MFI with low impact on overall profit margin, in fact, the costs of Bandhan's health program are borne by a charitable organization established by Bandhan and funded from Bandhan microfinance profits at annual levels decided by the boards of directors of the two sister organizations.

Improving Access to Health Services

Direct delivery of healthcare services by microfinance providers and/or the linkage of clients to independent care providers are far less common than provision of health education. Correspondingly, research on the cost-benefit of these interventions is relatively sparse. Four studies from Bangladesh demonstrate how MFIs offer essential health or primary care through a parallel-delivery model by their own community health workers (staff or client volunteers) as

well as linked to independent public health services. These studies show how the integration of microfinance and health programs can affect important aspects of health and well being, such as family planning (higher contraceptive use and lower fertility), preventive services (e.g., increased access to immunization), and even management of acute health problems (e.g., respiratory infections) (Leatherman et al. 2011).

In **Bolivia, CRECER** uses an outreach and mobilization approach in rural areas where the supply of health providers is limited. CRECER's field officers schedule "health days," called *jornadas*, in which doctors and/or nurses from the closest clinic(s) offer diagnostic and a few curative services, as well as referral "prescriptions" for further tests and treatments at the clinic(s) or higher-skilled medical facilities. The *jornada* is attended by CRECER clients and others from surrounding communities (with a very small fee sometimes required for participation). Notably, research showed that 24 percent of a random sample of women who had participated in CRECER *jornadas* reported that this had been their first visit ever to a medical provider. Over a two-year period, increases occurred in the percentage of clients seeking preventive care and other services for themselves and their families. However, after two years, less than 15 percent of interviewed women had actually attended, showing both significant need and opportunity (Metcalfe et al. 2010). A cost analysis of the *jornada* program showed the annual net cost per client to be only $0.52 in direct costs. Taking these costs into account, CRECER's overall profit margin would in theory decline slightly from 25.5 percent (as per the MIX market in 2008) to about 25 percent, if *jornadas* were offered to all clients (Reinsch et al. 2011).

Since its inception in Bolivia in 1990, **Pro Mujer** has provided women micro-entrepreneurs from impoverished communities with a multidimensional and holistic package of services, which include microfinance, business and empowerment training, preventive health education and high-quality, low-cost primary health care. In subsequent years, Pro Mujer has expanded its innovative model into Argentina, Peru, Mexico and Nicaragua. Depending on the local infrastructure and capacity, Pro Mujer offers primary healthcare services directly through its own medical staff (parallel-delivery model) or local healthcare providers (linked-delivery model). A 2006 qualitative evaluation report (Junkin et al. 2006) showed improvements in many areas key

to women's health. One such area is the increase in Pap smear rates from 36 percent of women before joining Pro Mujer to 95 percent since joining. In 2009, more than 140,000 medical consultations and 26,000 Pap smears were conducted by the organization.

Pro Mujer in Nicaragua is leading a health pilot with the collaboration of Global Partnerships, PATH and Linked Foundation to test a new model for service delivery. The pilot focuses on early diagnosis of cervical and breast cancer, non-communicable chronic conditions such as diabetes and hypertension, as well as anemia and a number of other common diseases. With this model of delivery, there is parallel provision of healthcare services by medical staff and unified provision of financial services and business, empowerment and preventive health education by credit officers who moderate communal bank association meetings. At Pro Mujer's operations in Nicaragua, the monthly "premium cost" to the client is $2.40 or an annual cost of $29.00 (Salvador 2011). After six months of pilot operations (November 2010), 3,287 clients were participating in the new health service package. Pro Mujer projects that it will be able to cover all of its costs to provide this revised health service package in less than two years. Currently, this service is offered to the client only, but the eventual plan is to open the services to the client's children and other family members as well.

In the Philippines, the Center for Agriculture and Rural Development (CARD) has addressed access barriers, particularly in rural areas, by developing a network of private healthcare providers, available through a "Healthy Pinoy" membership card, which entitles CARD members to discounts of 10 to 40 percent on primary and diagnostic healthcare services offered by physicians, dentists, hospitals, laboratories, optometrists and midwives. The CARD staff assess basic aspects of quality before signing up providers. By the end of 2010, CARD clients and family members were making approximately 10,000 visits per year to CARD's "Healthy Pinoy" providers, who report that this preferred provider program has helped them reach more patients and strengthened their services; for example, such as improving follow-up with patients. For CARD, the annual direct cost per client is only $0.10 (and $0.17 total annual cost per client including allocated overhead). If CARD were to offer this program to all of its members, the total cost per client would cause a reduction in institutional profit margin of about .5 percent—from the 12 percent reported in 2008 to 11.5 percent. This program was never

intended to be profitable and no offsetting revenue is collected. It is strictly a social benefit for members to improve their health, build their loyalty and increase the capacity of the local healthcare system for the benefit of whole populations of Filipinos.

Improved Access to Health Products

Compared to published studies of the models, benefits and costs of microfinance providers increasing client access to health education and services, there are few documented and researched examples of microfinance providers offering their clients access to health products. Although this may seem of secondary concern, access to products beneficial to family health (such as medications, oral rehydration salts, mosquito nets, paracetamol, de-worming pills, antiseptic lotion, oral contraceptive pills) is a major need, and some products—such as insecticide-treated nets—are life saving.

In **Bénin**, Freedom from Hunger and Innovations for Poverty Action worked with the microfinance provider **Projet d'Appui au Developpement des Micro-Entreprises (PADME**) to conduct a randomized, controlled trial to evaluate the impact of health education for the prevention and treatment of malaria and HIV/AIDS (Metcalfe et al. 2010). The education was conducted in combination with village banking meetings. To complement the malaria education, some of the same PADME field agents also distributed insecticide-treated nets (ITNs) to village banking clients at $2 per net (subsidized by separate donor funding). They simply carried and sold a small supply of nets with them to the weekly *Credit with Education* meetings in the villages. While the education alone was probably sufficient to increase ITN possession and use in the household (de la Cruz et al. 2009), the distribution of ITNs no doubt increased availability and thereby was partly responsible for the observed increase (16%) in the number of households possessing an ITN in good repair (significantly more than households without access to either the malaria education or the ITN distribution). PADME's *Credit with Education* program with ITN distribution could not disaggregate the cost of village banking from education or from ITN distribution. However, the marginal costs of ITN distribution (time to obtain the nets, inventory and distribution to field agents, and process payments) was at least partially offset by the revenue from ITN purchased.

As described above, research with **Bandhan in India** found that health product distribution was instrumental in improving availability to meet clear health needs, such as the 41 percent of 180 randomly selected women in communities served by Bandhan who had purchased oral rehydration salts for treatment of diarrhea from the local trained community health volunteer in the previous year. In addition to oral rehydration solution, the community health volunteers sold antacid, paracetamol, oral contraceptive pills, cotton, pregnancy tests, adhesive bandages, de-worming pills, antiseptic lotion and sanitary napkins. Bandhan's relationship with a low-cost supplier for many of its products enables purchase at wholesale rates that allow for markups to achieve parity with the recommended retail price in the community and therefore to contribute to coverage of Bandhan's costs, while generating income for the community health volunteer to retain. While it is tempting to hope that the community health workers could make a living from this product distribution, for most of the community health workers these earnings are not significant additions to their family incomes. After the first year of operation, community volunteers report average earnings of less than $1 per month, with earnings of $10.00 monthly at the high end. Although further study is warranted to understand the financial benefit to the community volunteers over a longer period of time, it is notable that there has been negligible turnover in the community volunteers during the more than three years that the program has been operational. The primary motivation for community volunteers is not financial; the most commonly cited reasons are to help people and to enjoy enhanced community respect and self-esteem.

The benefits of greater availability of health products at affordable cost seem obvious, and some microfinance providers (such as Bandhan and PADME) have the structure to sustain staff and/or volunteers to distribute health products at modest cost to the organization. However, it is not clear that many microfinance providers are well positioned to be effective product distributors; much depends on lack of alternative local sources of these products and on having a network of field agents (potential retail distributors) who serve a larger purpose for the microfinance provider. More experience and evidence are needed to assess the sustainability or commercial viability of health product distribution for both MFIs and community health volunteers or other agents.

In the global health community, much attention is being given to what is termed "health systems strengthening," with the understanding that population health, worldwide, is predicated on access to effective and appropriate healthcare services. MFIs can contribute to this cause in multiple ways, as described above. This capacity-building role can be even more direct, as highlighted by one study of a program in Uganda that shows how microfinance loans to local private medical clinics, combined with business-skills training, can significantly improve the quality of care, as perceived by local users of clinical services. Users were more likely to choose clinics, which invested small enterprise loans in drug stock, clean premises and patient confidentiality (Seiber et al. 2007). Another similar innovation in health systems strengthening is the partnership in rural Tanzania between Microensure, offering health micro-insurance and managing a health plan for the Kilimanjaro Native Cooperative Union (KNCU), and PharmAccess Foundation, which is funding specialists to provide training to local medical staff with the goal of facilitating an increasing number of health conditions to be treated at a primary care facility rather than referral to a hospital outside the coverage of the health plan (http://www.microensure.com/tanzania/).

Health Financing

The direct costs of health care when needed, as well as the indirect costs in lost productivity, represent risk and vulnerability for the poor worldwide. Research in Bolivia, Bénin, and Burkina Faso found that spending on direct health costs was very high, ranging as a percentage of some low-income households' annual income from 22 percent in Bolivia to 67 percent in Burkina Faso, with medications accounting for the highest proportion (Metcalfe and Reinsch 2008). Evidence also consistently points in the direction of healthcare financing making a difference in timely treatment-seeking. For example, a study in Uganda (Blanchard-Horan 2007) demonstrated that enrollment in a health micro-insurance scheme affected how quickly microfinance clients sought professional medical treatment for malaria (particularly at a hospital); it was also associated with lower hospital admission rates, presumably because of earlier treatment.

The poor use a variety of mechanisms for financing direct health costs—most often borrowing, selling assets, and avoiding health care—but often with untoward consequences. Microfinance clients want and can benefit from health-financing products such as health savings, health loans

and health micro-insurance. Furthermore, innovative health financing products offered through the global network of microfinance providers is a scalable approach.

In the MAHP initiative, four MFIs—in Bolivia, Burkina Faso, India and the Philippines—developed and tested healthcare financing approaches.

In Burkina Faso, the credit union federation **Réseau des Caisses Populaires du Burkina** (RCPB) offers a voluntary health savings product. The client may not access her or his deposited funds for six months or until $20 is saved. After the six-month capitalization period, clients may withdraw savings with proof of health expense (a receipt or a doctor's order). Clients with active health savings are entitled to apply for a health loan in cases of a verifiable, major health cost for the client or any family member. The health loan, offered at a 6 percent annual flat interest rate (slightly below regular business loan rates), helps RCPB to deter use of microenterprise loans, business assets or expensive moneylenders to address health issues—thus protecting repayment capacity for existing RCPB loans. Research data from randomly selected members with and without access to health savings and health loans revealed that the members with access reported higher use of preventive care than members without access, were 2.6 times more likely to report feeling satisfied with their preparations to meet future health expenses and were 3.7 times more likely to feel confident that they would be able to save for future healthcare expenses. For the RCPB health savings and loans, the cost analysis shows the annual net marginal cost per member to be only $0.03 (or as much as $4.57 when existing costs are allocated to the product based on portfolio volume). Reinsch et al (2010) estimated that the impact of the total cost-per-client cost on profit margin would be about 2 percent—theoretically reducing institutional profit margin from 28 percent (as reported to the MIX for 2008) to 26 percent, if all clients had access to the products.

> *Neither health savings nor health loans have created extra work for staff. The health savings accounts do not present more challenges or difficulties than any other financial products at RCPB.*
>
> **RCPB credit union director**

In the Philippines, CARD tested a partner-agent model of health micro-insurance involving the national hospitalization insurance program, PhilHealth. CARD promotes and facilitates optional group enrollment for its clients in PhilHealth and provides a loan to cover the $26 annual premium so that clients pay in small, weekly installments. CARD charges 24 percent interest (flat, annual rate on par with CARD's regular business loan rates) on the PhilHealth premium loan, plus a 1.5 percent Loan Redemption Fund (LRF) fee; the resulting payment of about $.60 per week is added to the member's regular business loan and savings deposit payment, which is made at regular credit group meetings . CARD receives a 9.7 percent discount from PhilHealth on the premiums, providing a margin that helps cover management costs. Interviews conducted by CARD with 40 randomly selected members who had enrolled in PhilHealth revealed that 88 percent of the sample thought that the insurance "helped a lot," 97 percent indicated that it gave them protection from health emergencies, and 35 percent said that the insurance covered more than one-half of their total medical expenses, while 58 percent said that it covered one-half or less of their expenses. For CARD's micro-insurance premium loan product, the cost analysis shows an annual net gain to CARD of $0.19 per participating member (considering direct costs only) and a net cost of $0.57 when allocated overhead costs are included. In 2008, CARD showed an overall profit margin of 12 percent; assuming total (including allocated) costs, if CARD had offered the product to all members that year, its profit margin would have been 10.5 percent. As scale of member participation increases, this product will quickly become profitable even accounting for the product's fair share of allocated overhead and management.

From two other MFIs, MAHP research found that health-financing products could have positive impact on timely care seeking and managing household finances. In **India**, 62 percent of health loan recipients reported they were able to afford other necessities as a result, and 33 percent indicated that without the health loan, they would have delayed treatment. In **Bolivia,** where **CRECER** offers emergency loans to individual clients, interviews revealed that clients who had a health loan were less likely to use regular loans for health purposes, and that merely having access to a health loan reduced the likelihood that costs prevented people from seeking medical treatment in the past year.

Microfinance providers clearly can be crucial partners for helping the poor in developing countries cope with health costs to improve the financial stability of households. MFIs can play an important role in health financing as they have the advantage of an existing client base worldwide, expertise in administration of loans and savings, and a social mission to support their clients' financial stability. Offering health-financing products can be motivated by both social mission and business self-interest. Health-financing products need to be carefully designed and implemented to optimize value and minimize risk to clients and to the microfinance providers.

Integrating Microfinance and Health; Benefits, Challenges and Reflections

> *The benefits of healthy clients, healthy bodies will all come back to you (microfinance leaders). This is all very sustainable. It is an investment of time and resources that …will reap the benefits over time*.
>
> **Aris Alip, CARD, the Philippines**

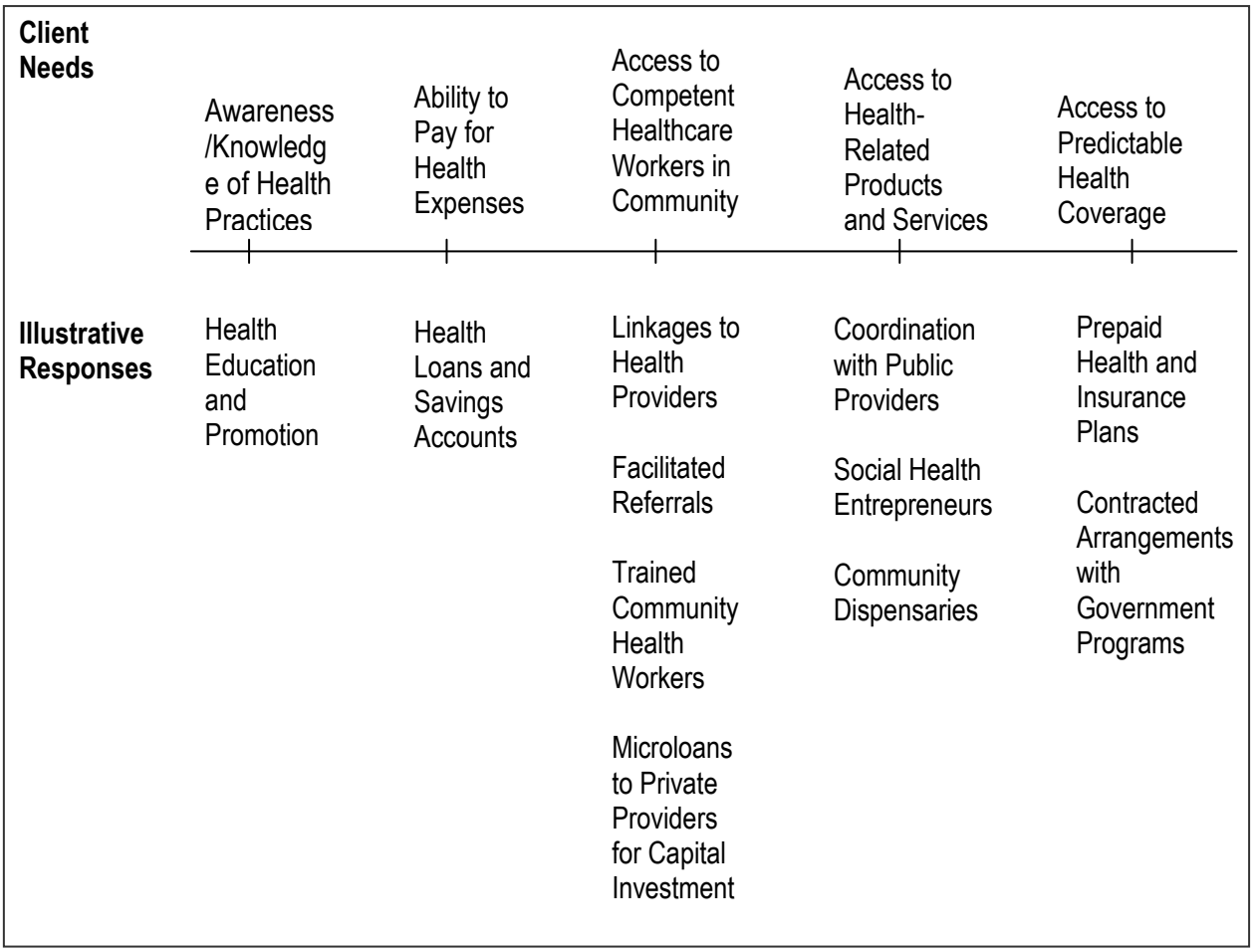
Poverty has diverse causes and consequences. But we have a fundamental problem—while causes of poverty are multidimensional, the solutions often are not. Service delivery is specialized along sector lines—health care, finance, education, agriculture, housing—requiring the vast majority of the poor to navigate multiple paths to meet their needs. This is especially challenging in poor, rural or marginalized urban communities where, if the residents can get any services at all, they come from some sectors but not others. Families may have access to a microfinance service provider but no one to help them deal with illness or injury. Or they may have access to good health care, but no credit or savings to pay for transportation to the clinic or to buy the medicines prescribed for treatment.

Understandably, microfinance providers place a great deal of emphasis on the business case for innovations and the importance of sustainability as a market-responsive business. As in many business situations, the attitude can become, "It's not our business to concern ourselves with the other needs of our clients. We have to stick to our knitting to keep our firm solvent and growing." However, many microfinance providers have created and continue to maintain and grow their organizations for social development purposes, which they manage to keep as a

priority despite the daily struggle for business survival. They do ask, "What more can be done to help our clients to help themselves, their families and communities to relieve the multiple burdens of poverty, not just their liquidity constraints?" When they see an opportunity to offer other, even non-financial services to their clients at an affordable cost, they are open and willing to rise to the challenge.

Even the owners, managers and staff of MFIs with little or no explicit social purpose are responsive to their clients as fellow human beings. They become ever more keenly aware of their needs when these prevent their clients from repaying on time, from growing their own businesses financed by loans, from depositing savings, and especially when these needs drive their clients to drop out altogether. Leaders are often interested in responding to the common and debilitating health problems of their clients—but only when they can see what they are getting into beforehand. They want evidence that others have done this and succeeded—evidence that it will make a real difference in their clients' lives, thereby create greater client satisfaction and loyalty and perhaps even improved repayment performance and increased volume. We are sharing the evidence to date that indicates that integrating microfinance with health protection services actually works and is "workable" for microfinance providers. Figure 2 shows the range and variety of options for health-related programs and services that are currently offered around the world and can be adopted more widely.

Figure 2. Range of health-related interventions to serve microfinance client needs



(Leatherman and Dunford 2010)

There is still more evidence needed to answer all the questions microfinance leaders have about the various types of integration that are possible. However, a characteristic of many microfinance leaders is that they are entrepreneurs, often social entrepreneurs, with a willingness to committing to action before they have sufficient evidence that their success is guaranteed. In the course of the literature review, product development with field experimentation and impact research that, in summary are reported here we discovered that integration of microfinance and health protection services can be a "multiple win" for microfinance providers, for clients and their families and even for the larger communities in which the clients reside (Table 3).

Table 3. Integrating Microfinance and Health Benefits Multiple Stakeholders

Microfinance Provider • **Low cost or even marginal profits** • **Competitive advantage** • **Healthier, financially more stable clients** • **Social mission achievement**
Clients, households and communities • **Improved healthcare knowledge and behaviors** • **More access to health providers and products** • **Greater financial protection and choice for households** • **Enhanced ability to use MFI loans and to save**

There is more evidence for some of these benefits than for others. Particularly at the level of community health benefits and at the level of the microfinance provider (competitive advantage, client performance and costs/revenues), there will be legitimate demand for more evidence from experimentation and replication in new contexts and further research on client behavior, costs and revenues. There is plenty of opportunity for microfinance providers to pioneer novel health programs, and their bold trial-and-error and successes will be a benefit to the global microfinance and health communities of practice. For others less willing to take on the considerable risks of innovation but interested in adopting already implemented models, there are various forms of technical guides, training and consultation available (e.g., see materials available at http://www.ffhtechnical.org/resources/microfinance-health).

Undoubtedly, there is considerable extra cost of time and money for a microfinance provider in developing or adopting health programs as part of its portfolio of client services. Health programs, even if just financial products focused on providing access to health care, require understanding and working with a new perspective, that of the health community. This is necessary for both execution by the microfinance provider itself and for the required collaboration with health service providers. This is not financial service business as usual. It requires different content knowledge and skills for appropriate needs assessment and marketing, delivery of health-related education and the necessary collaboration and negotiation with public-

and private-sector health professionals. Obviously, this requires long-term, sincere commitment and leadership support. Without both, the natural tendency of a financial services provider is to withdraw from what may feel foreign to the basics of banking. But there are substantial net benefits for those who understand that good business management means looking beyond the immediate commercial opportunities to embrace the need to contribute in a broader way to the clients and communities.

Acknowledgements

A great deal of the work represented in this paper was supported by a generous grant from The Bill & Melinda Gates Foundation for the Microfinance and Health Protection (MAHP) Initiative led by Freedom from Hunger in close collaboration with five microfinance institutions: Bandhan (India), CARD-MRI (Center for Agriculture and Rural Development-Mutually Reinforcing Institutions—the Philippines), CRECER (Crédito con Educación Rural, Bolivia), PADME (Promotion et l'Appui au Développement de Micro-Entreprises, Bénin) and RCPB (Réseau de Caisses Populaires du Burkina, Burkina Faso). The authors particularly want to acknowledge the leadership and commitment of key staff of the five partner institutions who made partnership with Freedom from Hunger in the MAHP Initiative productive for all concerned, especially the women and families who participated in the pilot projects of these microfinance providers: Chandra Shekar Ghosh, Maneeta Rathore and Trideep Roy of Bandhan; Jaime Aristotle Alip, Cleofe Montemayor-Figuracion, Marilyn Manila and Aniceta Alip of CARD-MRI; José Auad Lema, Isabel Rueda, Nelly Copari and Patricia Claure of CRECER; René Azokli, Didier Djoi and Mohamed Sadikou of PADME; and Daouda Sawadogo and Célestine Toé of RCPB.

The authors are indebted to many other staff of Freedom from Hunger who have been instrumental in the accomplishments of the MAHP Initiative: Cassie Chandler, Sheila Chanani, Mahamadi Cissé, Soumitra Dutta, Teddy Ekoué-Kouvahey, Laura Fleischer Proaño, Edouine François, Rossana Ramírez, Beth Porter, Christian Loupeda, Kathleen Stack and Lisa Kuhn Fraioli. We also thank the many others who played critically important roles in producing the MAHP publications: John Brett, Fabiola Cespedes, Stephanie Cole, Benjamin Crookston, Sharon Devine, Kimberley Geissler, Ingrid Giffin, Ramona McCord, Guillermo Monje, Dwight Parker, Scarlett Reeves, Martin Rotemberg, Frédéric Ruaz and Somen Saha.

We also take pleasure in acknowledging the kind cooperation of the BRAC Health Program (particularly Abdus Salam Sarker and Fariduzzaman Rana) and Pro Mujer (particularly Joshua Cramer-Montes, Gabriela Salvador and Lynne Randolph Patterson) in preparing the case descriptions presented in Appendix B.

Bibliography

Anderson GF. Missing in action: International aid agencies in poor countries to fight chronic disease. *Health Affairs*, 2009; 28**,** 202–205.

Barnes C, Gaile G, Kibombo R. Impact of three microfinance programs in Uganda. Washington, DC: US Agency for International Development, 2001. Available from: http://pdf.usaid.gov/pdf_docs/PNACL035.pdf (July 5, 2011)

Blanchard-Horan C. Health microinsurance in Uganda: affecting malaria treatment seeking behavior. *International Journal of Public Administration*, 2007; 30: 765–89.

Chuma J, Gilson L & Molyneux C. Treatment-seeking behaviour, cost burdens and coping strategies among rural and urban households in Coastal Kenya: An equity analysis. *Tropical Medicine and International Health*, 2007; 12**,** 673–686.

De la Cruz N, Crookston B, Gray B, Alder S & Dearden K. Microfinance against malaria: Impact of Freedom from Hunger's malaria education when delivered by rural banks in Ghana. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, December 2009; 103:1229–1236.

Dunford C. Building better lives: Sustainable integration of microfinance and education in child survival, reproductive health, and HIV/AIDS prevention for the poorest entrepreneurs. *Journal of Microfinance*, 2001; 3 (2): 1–25.

Junkin R, Berry J & Perez ME. *Healthy women, healthy business: A comparative study of Pro Mujer's integration of microfinance and health services*. New York, NY: Pro Mujer. 2006. Available from: https://promujer.org/dynamic/our_publications_1_Pdf_EN_English%20Version-Jan07.pdf (July 15, 2011)

Kruk ME, Goldmann E, & Galea S. Borrowing and selling to pay for health care in low- and middle-income countries. *Health Affairs*, 2009; 28(4):1056–66.

Leatherman S & Dunford C. Linking health to microfinance to reach the poor. *Bulletin of the World Health Organization*, 2010; 88(6):470–471.

Leatherman S, Geissler K, Gray, B & Gash M. Health financing: A new role for microfinance institutions? in review with *Journal of International Development*, 2011.

Leatherman S, Metcalfe M, Geissler K & Dunford C. Integrating microfinance and health strategies: examining the evidence to inform policy and practice. *Health Policy and Planning*, 2011; 1–17.

Leive A & Xu K. Coping with out-of-pocket health payments: empirical evidence from 15 African countries. *Bulletin of the World Health Organization*, 2008; 86(11):849-56.

Makinen M, Waters H, Rauch M, Almagambetova N, Bitran R, Gilson L, Mcintyre D et al. Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition. *Bulletin of the World Health Organization*, 2000; 78**,** 55–65.

McIntyre D, Thiede M, Dahlgren G, & Whitehead M. What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science & Medicine*, 2006; 62:858–65.

Metcalfe M, Leatherman S, Dunford C, Gray B, Gash M, Reinsch M & Chandler C. Health and microfinance: Leveraging the strengths of two sectors to alleviate poverty. Freedom from Hunger Research Paper No. 9. Davis, CA: Freedom from Hunger, June 2010; 27pp. Available from: http://www.ffhtechnical.org/resources/microfinance-amp-health/health-and-microfinance-leveraging-strengths-two-sectors-alleviate (February 28, 2011)

Metcalfe M & Reinsch Sinclair M. Enhancing the impact of microfinance: Client demand for health protection services on three continents. Freedom from Hunger discussion paper. 26pp. April 2008. Available from: http://www.ffhtechnical.org/resources/microfinance-amp-health/enhancing-impact-microfinance-client-demand-health-protection-serv (July 12, 2011)

MkNelly, B & Dunford C. 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 Research Paper No. 4. Davis, CA: Freedom from Hunger, July 1999; 72pp. Available from: http://www.ffhtechnical.org/system/files/02-24-2010/Ghana_Nutrition_Impact_Study_3-98-eng.pdf (July 15, 2011)

MkNelly, B & Dunford C. Impact of *Credit with Education* on mothers and their young children's nutrition: CRECER *Credit with Education* program in Bolivia. Freedom from Hunger Research Paper No. 5. Davis, CA: Freedom from Hunger, December 1999; 122 pp. Available from: http://www.ffhtechnical.org/system/files/02-24-2010/Bolivia_Nutrition_Impact_Study_12-99-eng.pdf (July 15, 2011)

Narayan D & Patesch P, eds. *Voices of the Poor: From Many Lands*. Washington, DC: World Bank; 2000.

Onwujekwe O, Chima R & Okonkwo P. Economic burden of malaria illness on households versus that of all other illness episodes: A study in five malaria holo-endemic Nigerian communities. *Health Policy*, 2000; 54**,** 143–159.

Onwujekwe O. Inequities in healthcare seeking in the treatment of communicable endemic diseases in Southeast Nigeria. *Social Science & Medicine,* 2005; 61**,** 455-463.

Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet* 2006; 368:1973–83. doi:10.1016/S0140-6736(06)69744-4 PMID:17141704

Reed, LR. *State of the Microcredit Campaign Report 2011*. 84pp. Microcredit Summit Campaign, Washington, DC. Available from: http://www.microcreditsummit.org/pubs/reports/socr/2011/SOCR_2011_EN_web.pdf (July 5, 2011)

Reinsch M, Dunford C & Metcalfe M. The business case for adding health protection to microfinance. Freedom from Hunger Research Paper No. 10. Davis, CA: Freedom from Hunger, June 2010; 35pp. Available from: http://www.ffhtechnical.org/resources/microfinance-amp-health/business-case-adding-health-protection-microfinance (February 28, 2011) (also *Enterprise Development and Microfinance*, in press)

Rueda I with Wagenblatt R & del Carmen Sahonero M. The marginal cost of integrating microfinance with education using the unified approach. CRECER. La Paz, Bolivia, 2006. Available from: http://www.microcreditsummit.org/papers/Workshops/26_Rueda.pdf (February 28, 2011)

Russell S. The economic burden of illness for households in developing countries: A review of studies focusing on malaria, tuberculosis, and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. *American Journal of Tropical Medicine and Hygeine*, 2004; 71**,** 147-155.

Salvador G. *Wealth and health: Leveraging microfinance for better health outcomes*. 2011. ProMujer PowerPoint presentation at Global Health Council.

Seiber EE, Robinson AL. Microfinance investments in quality at private clinics in Uganda: a case-control study. *BMC Health Serv Res*. 2007; 7:168. doi:10.1186/1472-6963-7-168 PMID:17945024.

U.S. Agency for International Development. *Microenterprise Results Reporting: Annual Report to Congress Fiscal Year 2009*. June 2010. USAID, Washington, DC. Available from: http://pdf.usaid.gov/pdf_docs/PDACQ103.pdf (July 5, 2011)

Vor der Bruegge E, Dickey JE & Dunford C. Cost of education in the Freedom from Hunger version of *Credit with Education*. Freedom from Hunger Research Paper No. 6. Davis, CA: Freedom from Hunger, July 1997; 7pp. Updated September 1999. Available from: http://www.ffhtechnical.org/resources/research-reports/cost-education-freedom-hunger-version-credit-education-0 (February 28, 2011)

Whitehead M, Dahlgren G & Evans T. Equity and health sector reforms: Can low-income countries escape the medical poverty trap? *The Lancet*, 2001; 358:833-6.

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J & Murray CJL. Household catastrophic health expenditure: A multicountry analysis. *The Lancet*, 2003; 362(111–117).

Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P & Evans T. Protecting households from catastrophic health spending. *Health Affairs*, 26, no. 4, 2007; 972–983.

Appendix A

List of 89 Microfinance Providers Offering Health Protection Options

Organization	Health Services	Country
AFRICA		
ACFB	Health education, health promotion events	Bénin
ASPI	Health education, direct delivery of health services, contracts with health providers, health promotion events	Ghana
CECA Togo	Health education, direct delivery of health services, health promotion events	Togo
Children, Communities, and Care (PC3) Program, CARE Ethiopia	Microenterprise development for HIV/AIDS-affected populations	Ethiopia
Famer MF	Health education, health promotion events	Togo
FECECAM	Health education	Bénin
FUCEC	Health education	Togo
Jamii Bora	Contracts with health providers, micro-insurance, health vouchers, microenterprise development for HIV/AIDS-affected populations	Kenya
Kibara Hospital HIV Project, CRS Tanzania	Direct delivery of health services, microenterprise development for HIV/AIDS-affected populations	Tanzania
Kondo Jigima	Health education	Mali
Kupfuma Ishungu	Microenterprise development for HIV/AIDS-affected populations	Zimbabwe
Nyèsigiso	Health education	Mali
OTIV	Health education, referrals to healthcare facilities	Madagascar
PADME	Health education	Bénin
PlaNet Finance	Health education, microenterprise development for HIV/AIDS-affected populations	Bénin, Burkina Faso
Presbyterian Agricultural Services	Health education, micro-insurance, ultra poor program	Ghan
RCPB	Health education, health savings, health loans, support for community water and sanitation	Burkina Faso
Relief Society of Tigray (REST)	Health education, referrals to healthcare facilities, ultra poor program	Ethiopia
SEF	Health education	South Africa
Sinapi Aba Trust	Health education, micro-insurance	Ghana
Tiavo	Health education	Madagascar

Organization	Health Services	Country
ASIA		
Bandhan	Health education, referrals to healthcare facilities, microenterprise in health products, health loans, access to affordable medicines, ultra poor program	India
BISWA	Contracts with health providers, health promotion events, access to affordable medicines	India
BRAC	Health education, individual health counseling, direct delivery of health services, referrals to healthcare facilities, mobile services for remote locations, microenterprise in health products, micro-insurance, trained community health workers, community pharmacies, health promotion events, access to affordable medicines, support for community water and sanitation	Bangladesh
CARD	Health education, contracts with health providers, micro-insurance, health loans, access to affordable medicines	Philippines
Cashpor	Health education	India
CCDA	Health education, direct delivery of health services, referrals to healthcare facilities, contracts with health providers, micro-insurance	Bangladesh
CHC Limited	Health education, individual health counseling, direct delivery of health services, contracts with health providers, microenterprise in health products, micro-insurance, health loans, trained community health workers	Cambodia
DAMEN	Health education, individual health counseling, community pharmacies, referrals to healthcare facilities	Pakistan
Dushthat Shashya Kendra (DSK)	Health education, direct delivery of health services, referrals to healthcare facilities, mobile services for remote locations, micro-insurance, access to affordable medicines	Bangladesh
Gonoshasthaya Kendra (GK)	Direct delivery of health services, micro-insurance	Bangladesh
Grameen Kalyan	Health education, direct delivery of health services, referrals to healthcare facilities, mobile services for remote locations, micro-insurance	Bangladesh

Organization	Health Services	Country
ASIA (continued)		
Gram-Utthan	Health education, trained community health workers, community pharmacies, access to affordable medicines	India
Hand in Hand	Health education, direct delivery of health services	India
KAS Foundation	Health education, health savings	India
Kashf	Micro-insurance	Pakistan
MIDS	Health education	India
Pakistan CGAP–Ford Foundation Graduation Pilot (5 organizations)	Health education, referrals to healthcare facilities, microenterprise in health products, ultra poor program	Pakistan
Pioneer Trad	Health education	India
PMD	Health education	India
READ	Health education, individual health counseling, micro-insurance	India
Sarala Women Welfare	Health education, direct delivery of health services, micro-insurance, community pharmacies, access to affordable medicines	India
SB Bank/Center for Self-Help Development	Health education, support for community water and sanitation	Nepal
SEWA	Health education, referrals to healthcare facilities, micro-insurance	India
SKS India	Direct delivery of health services, health promotion events, ultra poor program	India
SMSS	Health education	India
Swarnambal Trust (Tamil Nadu)	Health education	India
Trickle Up India	Health education, referrals to healthcare facilities, ultra poor program, support for community water and sanitation	India
Ujjivan	Health education, contracts with health providers, referrals to healthcare facilities, health loans, micro-insurance, community pharmacies	India
Uplift (Opportunity)	Health education, micro-insurance	India
Vision Fund	Health education	Cambodia
VWS	Health education, direct delivery of health services, referrals to healthcare facilities, health promotion events, access to affordable medicines	India
WORTH–Nepal	Health education	Nepal

Organization	Health Services	Country
CARIBBEAN		
ACLAM	Health education	Haiti
Esperanza	Health education, contracts with health providers	Dominican Republic
FONKOZE	Health education, referrals to healthcare facilities, ultra poor program	Haiti
EASTERN EUROPE/FORMER SOVIET STATES		
WOMAN AND DEV	Health education	Georgia
LATIN AMERICA		
Al Sol	Health education	Mexico
ARARIWA	Health education, referrals to healthcare facilities, ultra poor program	Peru
CACPECO	Health education	Ecuador
CEDES	Contracts with health providers, referrals to healthcare facilities, health vouchers, access to affordable medicines	Ecuador
Cooperativa San Cristobal	Direct delivery of health services, health vouchers	Peru
Cooperativa Santa Ana	Health education	Ecuador
Cooperativa Santa Maria	Direct delivery of health services, micro-insurance, health vouchers	Peru
CRECER	Health education, contracts with health providers, referrals to healthcare facilities, health loans	Bolivia
Diocesis de Ambato Pastoral	Direct delivery of health services, referrals to healthcare facilities, health promotion events	Ecuador
FACES	Health education, individual health counseling, direct delivery of health services	Ecuador
FAPE	Health education, contracts with health providers, access to affordable medicines	Guatemala
Financiera Confianza	Health education	Peru
Finca Peru	Health education	Peru
Fondesurco	Health education	Peru
Friendship Bridge	Health education	Guatemala
Fundacion ESPOIR	Health education, individual health counseling, direct delivery of health services, contracts with health providers, health vouchers	Ecuador
FUNDAP	Health education, direct delivery of health services, trained community health workers	Guatemala
Makipura Microfinanzas	Micro-insurance	Peru
Manuela Ramos	Health education, individual health counseling, health promotion events	Peru

Organization	Health Services	Country
LATIN AMERICA (continued)		
ODEF and Plan Honduras	Health education, referrals to healthcare facilities, ultra poor program	Honduras
PRISMA	Health education	Peru
Pro Mujer	Health education, individual health counseling, direct delivery of health services, contracts with health providers, health promotion events	Bolivia, Nicaragua, Peru
MIDDLE EAST/NORTH AFRICA		
Microfund for Women (WWB)	Micro-insurance	Jordan
Zakoura Foundation	Health education, contracts with health providers, health promotion events	Morocco

Appendix B

Three Case Descriptions: BRAC, Pro Mujer and Freedom from Hunger

BRAC Health Program

Health interventions have been part of BRAC's work since its inception in 1972. By improving the health of the people, especially the poor, and promoting the capacity of a community to deal with health problems, the health program contributes to achieving BRAC's twin objectives of poverty alleviation and empowerment of the poor. Over the years, BRAC's health programs have evolved in step with the national and global health priorities and changing knowledge base. BRAC has shaped and reshaped health interventions from a small to larger scale national interventions keeping pace with national and global priorities. Throughout the eighties, BRAC's hard toil to fight back diarrheal deaths through oral rehydration has created an outstanding exemplar in the world. The over decades of experiential learning have made BRAC to scale up health interventions across the country. In nineties, women and child health were dealt with various project-based interventions, such as, Women's Health and Development, Reproductive Health and Disease Control, National Nutrition and Family Planning Facilitation Programmes. Currently the health program combines preventive, curative, rehabilitative and promotional health services with focus on improving maternal, neonatal and child health, as well as combating communicable diseases and common health problems. BRAC has also piloted and continues to develop a health micro-insurance program to help clients afford the cost of healthcare services. Health services are organized under the umbrella of BRAC's Health Program, which is one component of its non-financial services programs available to clients that also include education, water, sanitation and hygiene, advocacy for human rights and gender equity, agricultural and food security, disaster preparedness and response, and enterprise development.

The program reaches clients and others in communities served by BRAC nationwide in Bangladesh. BRAC works closely with the Government of Bangladesh and international donors to support wide-scale prevention and health promotion campaigns such as Treatment of Tuberculosis through Directly Observed Treatment, Short course (DOTS), malaria control and school health programs. BRAC is also incorporating elements of its health programs as it

expands and assists development organizations in other countries, such as Afghanistan, Pakistan, Uganda, Tanzania, Liberia, Sierra Leone, Southern Sudan and Haiti.

Health services include education, community health promotion using trained community volunteers ,who also provide access to health products, and programs directed at specific diseases and health problems such as tuberculosis and malaria, maternal, neonatal and child health, and the reduction of cataract-related blindness. BRAC owns and operates health facilities and a limb and brace center. At the end of 2010, BRAC reported that it was reaching over 100 million people with a wide range of health services.[1] One of the most important components of many of BRAC's health programs is the use of trained community volunteers called *shastho shebikas* (SS) who provide health outreach and health product distribution. Some of the SS receive more specialized training equipping them to work with the DOTS program as screeners and distributors of reading glasses.

BRAC has a large in-house research capacity and evaluates its programs for their responsiveness to client needs, quality of services provided, and to measure and document the impact of its health interventions on client and community health status. BRAC routinely collects information about progress towards key health indicators to ensure quality and to continuously improve the quality and effectiveness of its services. Its research and monitoring have shown the following[2]:

- In 2002, 33 percent of pregnant women surveyed in BRAC's village organizations had received antenatal care and by 2007, the figure had risen to 72 percent, as compared to 60 percent nationally.

- Studies in 2007 indicated that 96 percent of children were fully immunized (versus 86 percent nationally) and 62 percent of women were currently using contraceptives (versus 56 percent nationally).

[1]BRAC Annual Report 2010. BRAC: Dhaka, Bangladesh. http://www.brac.net/sites/default/files/BRAC-Annual-Report-2010.pdf

[2] Salam S, Khan M, Salahuddin S, Choudhury N, Nicholls P, Nasreen H. Maternal, neonatal and child health in selected northern districts of Bangladesh: Findings from baseline survey. BRAC: Bangladesh. 2008; Choudury N and Nasreen H. Newborn care practices in Nilphamari district of Bangladesh after a year of maternal, neonatal and child health intervention. December 2009.

- Rigorous studies conducted in 2008 and 2009 on maternal health and newborn care practices further confirm positive impact on antenatal visits, birth preparedness, and appropriate care of newborn and that newborn care practices can be promoted through a community-based health worker with existing health services.

BRAC indicates that it considers the health program to be fully integrated with its other services and products (financial and non-financial) and cross-subsidizes non-revenue generating programs with revenue from MFI operations. Other funds are provided by donors (especially for new programs) such as The Bill & Melinda Gates Foundation (for the maternal and child health programs), the Global Fund to Fight AIDS, Tuberculosis and Malaria, DFID, AusAid and others. For 2010, the total cost of the health programs was about $49 million,[3] and revenue is generated from fees and grants to cover 72–93 percent of the costs of specific health programs (depending on the program, and as reported to Freedom from Hunger representatives during a visit in 2008). The health centers operate on average 73 percent cost recovery and the more specialized centers are self-sustaining.

As for future plans, BRAC intends to continue to address the main health and financial protection challenges members face with respect to access to affordable and quality health services, which includes a shortage of functional health facilities; lack of healthcare financing; universal health coverage; and qualified professionals in remote areas. Effective referral facilities with adequate human resources and logistics are essential for reducing maternal and neonatal mortality. BRAC also indicated that its Essential Health Care (EHC) program would continue as its mainstream health initiative but that the package may differ to accommodate the emerging needs of non-communicable diseases, elderly health care, climate change and nutritional initiatives. It continues to work to design and implement a more effective health insurance program for microcredit group members to ensure universal health coverage.

[3] BRAC Annual Report 2010. BRAC: Dhaka, Bangladesh. http://www.brac.net/sites/default/files/BRAC-Annual-Report-2010.pdf

Pro Mujer in Nicaragua

Pro Mujer was founded in 1990 in Bolivia by two visionary women—American Lynne Patterson and Bolivian Carmen Velasco—with the overarching goal of alleviating poverty and empowering women. The organization's approach to these complex issues is to provide its clients with a multidimensional and holistic package of services, which includes microfinance, business and empowerment training, preventive health education and high-quality, low-cost primary health care. Over the course of its 20-year history, Pro Mujer has disbursed more than $950 million dollars in small loans—that today average $324—and has reached more than 1,000,000 women microentrepreneurs and their 5,000,000 children and family members. Currently, Pro Mujer reaches more than 200,000 women in impoverished communities in Argentina, Bolivia, Mexico, Nicaragua and Peru.

Depending on the local infrastructure, Pro Mujer offers health services directly through its own medical staff or by partnering with local healthcare providers to serve its clients. Its primary goal is to help women protect their health and that of their family through primary health care and regular examinations. At the end of 2009, more than 200,000 clients of Pro Mujer had participated in health education, almost 26,000 of them had had a Pap smear, 49,000 pediatric and 124,000 medical consultations were conducted and 12,000 sexually transmitted diseases were detected, among other health interventions.

As of September 2010, Pro Mujer in Nicaragua (PMN) was serving more than 25,000 women micro-entrepreneurs. Because PMN works to reach the very poor, it acknowledges that clients face many obstacles, one of which is health, in pulling themselves out of poverty. In the beginning, PMN focused on education to promote family planning and to prevent cervical and uterine cancer and intra-family violence because these were leading causes of death among women.[4] Its clients became more knowledgeable on these two fronts but did not have access to health services to fully address these problems. Therefore, in 2001, PMN decided to put a clinic in each of its neighborhood centers, which are staffed with a doctor and several nurses, to serve

[4] Solis D, Fredy and Gadea P, Adilia. "Estudio sobre Servicios Integrales en Salud, Pro Mujer Nicaragua," Pro Mujer Nicaragua, León. 1999.

its clients. The doctors worked at the clinics, but the nurses would travel into the communities to discuss family planning.

Beginning in 2005, the doctors and nurses would travel together into the communities to organize "health days," during which they would focus their attention on sexual and reproductive health issues by training women and providing them related services, such as Pap smears and family planning consultations. In a one-month period alone, the PMN medical staff processed a total of 35 abnormal Pap smears, of which 30 were pre-malignant and 5 were cancerous. Of the 35 cases, 16 were treated directly in the communities. The cost to the client for a Pap smear through PMN was approximately $1.80 (40 córdobas), whereas it might have cost the client $19 in a clinic. However, the fees paid by the clients to Pro Mujer combined with donor subsidies together covered only 60 percent of the costs actually incurred to provide these services. The difference was covered by cross-subsidization by revenue from the financial services. A costing study published in 2006 indicated that it cost $156,099 to make these health services available to 17,413 clients and their families.[5]

This same study revealed that there was a high level of satisfaction among the clients with the integrated offering of microfinance, business and empowerment training, preventive health education and primary health services. Clients noted improved self-esteem, access to more affordable health services, improved access to medical providers and appreciation of the convenient "health days." Clients also revealed improved knowledge and practice of cancer prevention through Pap smears. Thirty-six percent of women in the focus groups reported to have had a Pap smear before joining Pro Mujer and 95 percent of them had had one since joining.

Between 2008 and 2010, PMN began partnering with Global Partnerships, PATH and Linked Foundation to improve its health service offerings. Although already offering an impressive product, PMN wanted to find a way to make its health services more financially sustainable. Pro Mujer led an initiative supported by Global Partnerships, PATH and Linked Foundation to

[5] Junkin R, Berry J, Perez ME. Healthy Women, Healthy Business: A Comparative Study of Pro Mujer's Integration of Microfinance and Health Services. New York, NY: Pro Mujer. 2006. https://promujer.org/dynamic/our_publications_1_Pdf_EN_English%20Version-Jan07.pdf

develop a new model for service delivery and launched a pilot with revised content aiming at the early detection of chronic non-communicable conditions and primary care services. The health model was designed to test the financial viability of the revised service package. Through the pilot, it decided to focus on providing medical services that focus on preventing, detecting and treating the following illnesses: breast and cervical/uterine cancer, diabetes, hypertension, domestic violence, diarrhea, respiratory ailments, kidney disease and ailments caused by parasites. Pro Mujer is now piloting a preventive care/diagnostic package that includes blood and urine tests, body mass index, diabetes screenings, blood pressure tests and three medical consultations. This package also includes training to the clients by the credit officers to help them understand the causes of and how to prevent the diseases listed above. In addition to the care that will be provided by two medical doctors and nurses in each branch, PMN is establishing alliances and discounted pricing with specialized doctors and pharmacies to cover further treatment when necessary. Thus, with this model of delivery, there is a parallel medical staff for the provision of healthcare services, but a unified model of integration where the credit officer provides both financial services and health education. Pro Mujer is able to expand the services it provides by negotiating cheaper rates with other medical providers and specialists.

The annual cost to the client for this new model of health care is $29 (580 córdobas), or $2.40 per month. During this pilot phase, this cost and service are obligatory. In April 2011, after six months of pilot operations, 3, 287 clients were participating in the new health service package.[6] Pro Mujer estimates it will be able to cover all of its costs to provide this revised health-service package in two years and it also plans to open the services up to the client's family as well, as currently, this service is for the client only.

Pro Mujer's lessons learned are that clients are willing to pay for services as long as their needs are satisfied, that there is a need to achieve a balance between what clients need and what the institution views as its needs, and that by providing health services directly, Pro Mujer can build trust and strengthen relationships with its clients.

[6] Salvador, G. Wealth and Health: Leveraging Microfinance for Better Health Outcomes. Presentation made at Global Health Conference, June 13, 2011.

All programs are currently participating in testing out new models of health service provision, working to improve their education sessions and standardizing their monitoring and data processes.

Freedom from Hunger

Freedom from Hunger was established in 1946 as Meals for Millions, the organization that developed and introduced Multi-Purpose Food, a high-protein powdered food supplement still used today in relief efforts around the world. In the 1970s, Freedom from Hunger began implementing applied nutrition programs, focusing almost exclusively on the health and nutrition of mothers and children. In 1989, Freedom from Hunger developed the integrated microfinance, health and nutrition education program known as *Credit with Education*, as a self-help response to chronic hunger around the globe.

Between 1989 and 2005, Freedom from Hunger partnered with existing microfinance and non-governmental financial organizations across Latin America, Africa and Asia to integrate health, business and financial education with a village-banking model of financial services that includes savings and credit. At the end of 2005, approximately 45 MFIs were providing *Credit with Education* in 14 countries worldwide, serving more than 362,000 poor women. By December 2010, over 3.2 million clients among 132 MFIs and non-governmental organizations were being served across 19 countries. The majority of these institutions were covering all the costs of providing education services with the financial margin on the credit operations of this integrated service.

Credit with Education programs integrating financial services and health education have undergone continuous and rigorous evaluation for over ten years. Rigorous studies conducted in Ghana and Bolivia showed significantly improved health and nutrition practices by mothers who attended regular meetings in which 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 measurements for children of participants.[7] Two randomized controlled trials conducted in Ghana and Bénin on integrated financial service and malaria education programs showed significantly improved practices by clients who attended sessions on malaria prevention, detection and treatment. Participants in the malaria education had improved malaria knowledge and were more likely to own insecticide-treated mosquito nets and report sleeping under them.[8] Two randomized controlled trials conducted in India and Bénin to study the impact of similarly designed HIV/AIDS education interventions showed improved HIV/AIDS knowledge such as causes of HIV/AIDS, where to purchase condoms and seek out an HIV/AIDS test among adult women participants in both India and Bénin and among adolescent girls in India.[9]

In 2006, with funding from The Bill & Melinda Gates Foundation, Freedom from Hunger launched the Microfinance and Health Protection (MAHP) Initiative. Together with five well-established MFIs in Bénin (PADME), Bolivia (CRECER), Burkina Faso (RCPB), India (Bandhan) and the Philippines (CARD), Freedom from Hunger sought to design and offer health-related products and services with positive health and economic impacts on clients while also being practical, cost-effective and even profitable for the MFIs. Freedom from Hunger assisted each MFI to develop its own "package" of health protection options, including health education, health financing and health micro-insurance, linkages to healthcare providers and distribution of health products. By December 2010, the health protection services and products of these five MFIs plus five new organizations in India and Vietnam were reaching a combined total of more than 1 million microfinance clients. This makes up approximately one-quarter of Freedom from Hunger's global outreach and does not account for the additional microfinance organizations providing health education.

---

[7] MkNelly, B & Dunford, C. Using microfinance to improve health and nutrition security. *Global HealthLink*, 2002; 118: 9, 22.

[8] De la Cruz N, Crookston B, Gray B, Alder S & Dearden K. Microfinance against malaria: Impact of Freedom from Hunger's malaria education when delivered by rural banks in Ghana. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 103:1229–1236. December 2009; Gray B & Ekoue-Kouvahey T. Microfinance and Health Protection Initiative Research Summary Report: PADME. Freedom from Hunger Research Paper No. 9d. Davis CA: Freedom from Hunger, 2010.

[9] Gray B & Ekoue-Kouvahey T. Microfinance and Health Protection Initiative Research Summary Report: PADME. Freedom from Hunger Research Paper No. 9d. Davis CA: Freedom from Hunger; 2010; Spielberg F, Crookston B, Chanani S, Kim J, Kline S & Gray B. Leveraging microfinance networks to impact HIV and financial behaviors among adolescents and their mothers in West Bengal: A cluster randomized trial. Davis CA: Freedom from Hunger, 2010. (Also, *AIDS and Behavior*, in review).

The MAHP initiative found that health protection services and products have a positive impact not only on clients but also on the financial bottom line of the MFI. Twenty-four percent of CRECER clients in Bolivia had never seen a doctor before participating in organized "health days" during which clients received diagnostic and treatment services, such as Pap smears and diabetes detection, for a small fee. In Burkina Faso, the percentage of RCPB clients seeking preventive health care increased from 9 to 24 percent in the program area that received access to health savings and health loan accounts.[10] The costing analyses revealed that the various services designed by the participating MFIs resulted in a net cost to the MFI of $1.59 per client per year, on average. Some health protection products, such as health loans, were found to be profitable for the MFI. Other products (such as CRECER's "health days") may never generate direct revenue for the MFI but can contribute significantly to the social mission at very low cost. Evidence also suggested that increases in client growth and retention occurred in MAHP areas compared to areas where the MFIs were not yet offering the products. It was estimated that if these products resulted in 5 percent more new or retained clients, then they would effectively result in a net profit for the MFIs—meaning that the health protection products were cost-neutral or better.[11]

Freedom from Hunger is continuing to work with partners to innovate around the integration of microfinance and health. Although health micro-insurance was represented among the MAHP innovations, Freedom from Hunger continues to experiment with helping MFIs link their clients to existing national health insurance schemes and is testing out the role that consumer education plays in informing clients about health insurance, how to access it and benefit from it. New partners across Latin America, Africa and Asia continue to integrate health education and many are beginning to experiment with the additional services such as health loans, savings, health products and insurance. In addition to these services, Freedom from Hunger is exploring the role

[10] Metcalfe M, Leatherman S, Dunford C, Gray B, Gash M, Reinsch M & Chandler C. Health and microfinance: Leveraging the strengths of two sectors to alleviate poverty. Freedom from Hunger Research Paper No. 9. 27 pp. Davis, CA: Freedom from Hunger. June 2010. http://www.ffhtechnical.org/resources/microfinance-amp-health/health-and-microfinance-leveraging-strengths-two-sectors-alleviate (also *International Health,* in review).
[11] Reinsch M, Dunford C & Metcalfe M. The business case for adding health protection to microfinance. Freedom from Hunger Research Paper No. 10. 35pp. June 2010. Davis, CA: Freedom from Hunger. http://www.ffhtechnical.org/resources/microfinance-amp-health/business-case-adding-health-protection-microfinance (also *Enterprise Development and Microfinance,* in review).

that technology can play in improving health outcomes among microfinance clients and their families.