Many microfinance institutions (MFIs) have witnessed the significant impact that all-too-common health shocks can have on their clients’ ability to repay loans, save, and flourish in their microenterprise endeavors. In 2006, Freedom from Hunger and five MFIs set out to design and test client-focused, health-related services that could be practically and sustainably offered by MFIs. Market research with MFI clients in Bénin, Bolivia, Burkina Faso, India, and the Philippines during the initial stage of the project provided valuable insights on the current landscape of health services, financing and client behavior, as well as client demand and willingness to pay. The results of this research confirmed the overwhelming burden of ill health on the poor and informed the development of five unique and integrated microfinance and health protection packages.
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Enhancing the Impact of Microfinance:
Client Demand for Health Protection Services on Three Continents

Introduction

Microfinance client and family illness is the most common cause of unsuccessful business performance, low savings rates, late repayments and microfinance client dropout. The poorer the clientele, the higher the morbidity and mortality rates, and the more difficult it is to obtain basic preventive and curative health services. MFI performance is clearly, and sometimes dramatically, affected by client health problems. While microfinance services can result in significant economic advances, when illness strikes every resource is directed toward recovery, and a downward slide back into poverty is a common result.

In 2006, Freedom from Hunger launched the Microfinance and Health Protection initiative (MAHP) with funding from the Bill and Melinda Gates Foundation. The program expands on the proven Credit with Education model to provide microfinance clients with access to crucial health-related products and services.

Freedom from Hunger is recognized for its expertise in integrating financial and non-financial services to equip the chronically hungry poor to lift themselves out of poverty. Microfinance institutions (MFIs) cannot be all things to all people, but Freedom from Hunger has demonstrated that microfinance holds tremendous potential as a platform for the delivery of complementary services that—when combined with financial services—can effectively address the social missions of most microfinance institutions. And, on the business side, MFIs have a vested interest in protecting their clients from health-related financial shocks, so they can increase assets and become more informed and stable consumers of microfinance services.

Through MAHP, Freedom from Hunger set out to innovate and experiment with a range of health protection products and services that respond to the requirements of poor microfinance clients and their families, while being practical and realistic for a microfinance institution to deliver. The health protection innovations developed under MAHP are designed to be financially sustainable, scalable (by the MFI itself) and replicable (by another MFI facing similar client needs and circumstances).
Five microfinance institutions from three continents signed on to participate in this experiment. This report presents a synthesis of the findings of those MFIs’ qualitative market research and describes the five health protection packages currently being tested. Our purpose in sharing this report is to:

- shed light on the current status of microfinance clients’ health, healthcare access and strategies for coping with health-related expenses in their everyday lives;
- share common trends in health protection issues as well as strategies from five countries to contribute to the evolving understanding and interest of the microfinance sector in the inextricable link between poverty and health;
- describe health protection innovations being tested with five MFIs in Bénin, Bolivia, Burkina Faso, India and the Philippines; and
- inspire other such research and knowledge-sharing in this critical area of international development.

**About the Market Research**

MAHP market research was conducted with MFIs in Bénin (Projet d’Appui au Developpement des Micro-Entreprises—PADME), Bolivia (Crédito con Educación Rural—CRECER), Burkina Faso (Réseau des Caisses Populaires—RCPB), India (Bandhan) and the Philippines (Center for Agriculture and Rural Development—CARD) from June through September 2006. The first step in the market research was to determine—in a systematic manner—the actual health situation, requirements and demands of the clients. The MFIs undertook market research with financial and technical support from Freedom from Hunger and Microfinance Opportunities, using Participatory Rapid Appraisal (PRA) tools and focus-group discussions to gather information, opinions and suggested solutions from about 1,200 clients and dozens of healthcare institutions and providers worldwide.

Interactive education sessions about the costs and benefits of health microinsurance were developed by CARD for their clients in the Philippines, based on MAHP market research.

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1 Please see Annex 1 for more information on the participating MFIs.
2 In addition to direct market research in the field, Freedom from Hunger’s MAHP market research process included significant secondary research on health and health financing in these countries (see published series of Health Economy Profiles, ©2006 Freedom from Hunger).
The objective of the research was to enhance the MFIs’ and Freedom from Hunger’s understanding of the following key themes, as related to the target population.

### Table 1: Key MAHP Market Research Themes

| Health Issues | Most common health issues in the area, and trends in types and frequency of illnesses
|              | Knowledge about causes and prevention of common illnesses
|              | Most important health issues in terms of impact on the lives, activities and financial situation of microfinance clients in the area
| Available Health Services | Accessibility of healthcare services (existence, proximity, range of services, choices, perceived quality and affordability for clients)
|                          | Sources of health education and information
| Health Seeking Behavior | Community’s current approach to prevention and treatment of common health issues
|                          | Preferred health services – where people do and do not go for health care, and why
|                          | Barriers to obtaining preventive and curative health care
| Health Financing | Estimated expenditures on health care compared to household cash flow throughout the year
|                  | Usual sources of money to pay for healthcare needs (savings, loans from relatives, moneylenders, liquidation of assets, etc.)
| Health Protection Solutions | Target population’s interest in mechanisms to share/mitigate health-related financial risks (e.g., insurance)
|                                     | Suggested MFI products or interventions – including relative priority, desired attributes, and clients’ willingness to pay

Within each MFI’s target area, samples of 200 to 275 clients (for a total of 1,205 participants), the majority of them women ages 20–45, were selected to provide a diverse and representative client group that could participate in a one- to two-hour small-group discussion session on the same day as one of their regularly scheduled credit group meetings. Most of the MFI clients included in the market research were poor, living on less than US $3 per day—and in many cases less than $1 per day. Sources of family income included small retail operations (vegetable vendors, small stores), daily labor, agricultural activities, food service, and earnings from the employment of a spouse.

Small teams comprised of MFI and Freedom from Hunger staff, trained and led by an outside market research specialist, employed Participatory Rapid Appraisal tools adapted for health-related topics from MicroSave’s toolkit. These techniques enabled interviewers to engage clients in active dialogue, analysis and brainstorming. Market researchers also met with representative healthcare providers and other stakeholders (local public health workers, advisors, and other MFIs) to obtain a more complete understanding of local healthcare issues and utilization patterns.3

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3 Note that this research was qualitative in nature and intended to provide a snapshot of the general health and health financing situation in the areas studied. Samples were not scientifically randomized, and although efforts were made to “triangulate” responses within groups, across groups and using secondary health and other data, the information presented in this report represents, unless otherwise noted, the opinions, perceptions and ideas of a relatively small group of microfinance clients in particular and limited areas.
Respondents highlighted the most common diseases within their communities, focusing on both lower-cost/high-frequency and higher-cost/low-frequency illnesses. Diarrhea, cough, fever, skin diseases, malaria, typhoid, gynecological and obstetric problems, high blood pressure and cancer were the most common illnesses cited across all the countries. In terms of the impact of disease on the lives and livelihoods of the respondents’ communities, infectious diseases (notably and overwhelmingly malaria) tended to carry a heavier burden in Bénin and Burkina Faso, while chronic diseases figured more prominently in Bolivia and the Philippines. Indian respondents appeared to grapple with both infectious and chronic diseases fairly equally. (Annex 2 provides details on the most common diseases cited in each country.)

Trends in various diseases were also explored. West African respondents reported a decrease in several infectious diseases, including HIV, meningitis, measles and typhoid fever, which they attributed to increased knowledge and immunizations. Malaria, however, was perceived as being about the same or on the rise, as were coughs and high blood pressure. In Bolivia, CRECER clients reported increased rates of feminine health issues such as vaginal infections, sexually transmitted diseases, family planning, and menopause. In the Philippines, CARD clients perceived a higher incidence of high blood pressure, cancer, diabetes, and urinary tract infections. In India, Bandhan clients also reported an increase in gynecological problems, skin diseases, colds, fever, cough, and work-related eye problems, and a decrease in infectious diseases such as diarrhea (as a result of using the cleaner municipal water supply), tuberculosis and malaria.

Discussions with local providers and analysis of national health data confirmed the reported increase in chronic diseases in all of the countries. Diabetes, high blood pressure, heart disease, and chronic respiratory disease are growing problems, especially in Bolivia, the Philippines and India. In Bolivia, chronic diseases are the leading causes of death. The Philippines appears to have the most reported morbidity and mortality related to chronic disease.

Infectious diseases (notably and overwhelmingly malaria) tended to carry a heavier burden in Bénin and Burkina Faso, while chronic diseases figured more prominently in Bolivia and the Philippines. Indian respondents appeared to grapple with both infectious and chronic diseases fairly equally.
Hypertension is among the top five causes of morbidity in that country, while cardiovascular disease, including hypertension and stroke, account for more than 25 percent of all deaths. In India, while infectious diseases (primarily malaria and tuberculosis) are the major causes of morbidity across the country, the burden from cardiovascular disease, cancer and diabetes is increasing. Even in Bénin and Burkina Faso, high blood pressure is an increasing and alarming threat. Since chronic diseases such as high blood pressure and diabetes can go undetected for a while, especially with infrequent routine medical care, it is likely that the incidence of these diseases is more common than is so far reflected in national public health statistics or client self-reporting.

Many respondents correctly identified the causes of these common diseases, as well as preventive measures, although such knowledge often did not translate into regular practice. Numerous clients expressed the value they place on health education and a need for more information about how to prevent and manage disease.

“...we know more about caring for our livestock’s health than we know about caring for our own.”

(CRECER client, Bolivia)

In short, microfinance clients in these countries face a variety of both low- and high-impact health threats, requiring varying degrees of treatment (and thus expense) to cure. Knowledge about health is gradually improving, but there is demand for more information and education on health protection. The rise of chronic disease around the world is a harbinger of the more complex and expensive solutions that may be needed in the years to come.

**AVAILABLE HEALTH SERVICES**

**Health Care**

Although the specific health issues varied by country, all of the respondents evoked the same, persistent challenge of access to quality, timely and affordable health services in their local communities. In all of the countries, there exists a publicly-funded, multi-tiered health care system with first-level care provided in local health clinics, and specialized and diagnostic care provided at regional or national referral clinics and hospitals. Services provided in the public facilities are usually provided for free or for a small fee. For the most part, funding for these systems has been inadequate when compared to need. Severe shortages of physicians exist in Bénin, Burkina Faso, and Bolivia, where physician-to-population ratios fall below the WHO standards of 1/10,000.

“They don’t get good care at the health centers...the doctor isn’t there. Many women treat their illnesses with healers or do nothing at all.”

(CRECER client, Bolivia)
India and the Philippines have more providers, but poor people, especially in rural areas, still have limited access since physicians and other trained providers tend to be located in more urban, populous, and higher-income areas. Clients of each MFI, with the exception of Bandhan (India), reported that the local public health facilities are too often under-resourced in terms of staff, supplies, equipment and medicines, and that they are often not open and available to patients when needed.

“They treat us well at the rural health center, but they don’t have any medicines.”
(CRECER client, Bolivia)

Many clients also bemoaned the low quality of services received. Perceptions of quality were based not only on the availability of trained staff, supplies, equipment, and medicines, but also courteous treatment—including respect for cultural beliefs, courteous two-way communication, and experience of effective diagnosis and treatment.

“[at health centers]…you use up your money [on tests and inappropriate prescriptions] before you even know what is wrong with you.”
(RCPB client, Burkina Faso)

In some countries (notably Bolivia and Burkina Faso), there were reports of discrimination and unkinder or subpar treatment of poor customers on the part of public health providers, which made respondents unwilling to seek care at those facilities unless absolutely necessary.

Public funding of disease-specific prevention and treatment programs also exists. For example, respondents in the Philippines reported regular use of the local health station for immunizations and prenatal care; Bandhan clients in Bagnan province access government-supported centers for immunizations, supplemental child feeding and child health monitoring; and both Bolivian and Burkinabé respondents credited government immunization campaigns with significantly reducing disease in their communities. Other examples include publicly supported treatment for tuberculosis and programs operated by NGOs or public/private partnerships for family planning and AIDS prevention and treatment.

Alternatives to the public health system are private facilities, NGO or religious clinics and hospitals, and traditional practitioners, all of which exist to varying extents in each country and region.

**Health Products**

In general, and especially in remote areas, poor clients have very limited access to healthcare products, as well as services. Not only are healthcare services poorly distributed, but they tend to be under-resourced to meet the needs of the population, especially in rural areas. Essential drugs are often in short supply at local public health centers, and prescription drugs from pharmacies are reported to be very expensive.
This leads to dangerous practices such as self-prescription and medication with dangerous counterfeit drugs purchased at the local markets in West Africa, and the purchase of fewer antibiotic pills than prescribed in the Philippines.

Over-the-counter products that could have an enormous impact on common diseases, such as insecticide-treated mosquito nets, oral rehydration solution, water purification tablets and condoms, are simply unavailable for purchase in many rural areas. As a result, MAHP partner MFIs resolved to design services that would work within the existing healthcare and retail infrastructure, while also using their influence and leverage to encourage improvements and create markets for needed products.4

**Health Education**

The market research also looked at where clients received preventive health information, the topics covered, and how well they understood and used this information to protect and improve their health. Respondents identified a variety of sources of health information and education, including training provided by their own or another MFI, government health workers, NGOs, media, and relatives. (Annex 3 lists the most common sources of information about health, topics covered, and additional information and training desired by clients.) The quality of this information and its delivery varied – from some patently erroneous information being handed down within families (e.g., anemia is caused by evening showers; withholding fluids cures diarrhea), to broadcast messages that people learned practically by rote but failed to apply in their daily lives (e.g., on preventing HIV/AIDS and malaria), to interactive training that led to reported behavior change.

Some evidence drawn from the market research and later MAHP site visits suggested a continuing dearth of effective health protection communication and the successful translation of that information into appropriate practices at the household level. Despite Indian government campaigns promoting oral rehydration treatment of diarrhea, a Bandhan client shared that she had lost a child to dehydration due to diarrhea, but that with new knowledge and understanding gained from the MFI’s new dialogue-based health education program, she was confident that the whole community would avoid such tragedy in the future. In Bénin, PADME clients demonstrated an understanding of malaria prevention, yet their use of mosquito nets was extremely rare – probably at least in part because none were available for sale in the area.

4 Examples of this are: (1) consumer education about minimum health standards and practices as established by the WHO, so that clients know what to expect and are more confident demanding adequate service; (2) education about malaria and diarrhea and direct or indirect sale of complementary products, to demonstrate effectiveness and encourage local entrepreneurs and retailers to stock such goods; (3) informal and formal linkages between MFIs and healthcare providers, with opportunities for feedback on services and discontinuation of the relationship in case of negative experiences; (4) MFI referral database with providers that have been “approved” by clients in the past, as well as notes on providers who are not recommended due to negative feedback.
These examples tragically highlight two lessons. First, health information needs to be conveyed in a way that is accessible and meaningful enough for participants to change generations-old practices. And secondly, such education must be combined with the means to implement the recommended practices. Even the best health education will not be effective in reducing illness and its impacts if clients lack the ability to secure products such as mosquito nets and essential medicines, as well as timely access to competent health care providers.

**HEALTH SEEKING BEHAVIOR**

Microfinance clients, especially those who also receive health education, are some of the most active and productive members of their communities. They recognize that health is one of their most important assets, and (as the title of one of the market research reports put it) that “staying healthy means fighting poverty.” Many work hard to stay healthy and to protect the health of their families.

“In these difficult times, we cannot allow ourselves to get sick, so we have to take care of ourselves.”

(CARD client, Philippines)

Yet despite their best efforts to avoid illness, MFI clients remain as vulnerable as their peers in poor communities. When sickness or injuries inevitably happen, the health seeking behavior of members is dictated by the limitations of both the availability of providers and the resources available to pay for care. Although the types of services available to MFI clients are somewhat different across the settings, their patterns of obtaining health care are very similar.

The first response to minor or common illness is often prayer and/or self-treatment, which are free or low-cost. People use herbal or folk remedies, or may go to the local pharmacist or herbalist for medicines.

“At home we use homemade, traditional medicine. We prescribe ourselves herbal remedies.”

(CRECER client, Bolivia)

There were also frequent mentions of various types of traditional or faith healers as an early line of defense. Traditional practitioners are usually nearby and easily accessible for treatment at low cost, with flexible repayment terms and sometimes for free unless healed.

“Due to financial constraints, people take a chance on albularios [traditional practitioners] and some may actually be restored to health.”

(CARD client, Philippines)

“The herbalist is good, he provides quality service…he explains what the illness is about and we can trust him.”

(CRECER client, Bolivia)

If the illness does not improve, then people go to nearby public health clinics or hospitals where consultations and medicines are provided for free or a small fee. In the case of accidents or serious illness, people often travel long distances to regional or national hospitals located in urban areas, or they seek services from private providers, clinics, or hospitals.
Market research group participants were likely to describe private health care providers as more qualified and better able to diagnose and treat serious or complicated illness. They were also seen as more reliable than public sources of care, with clinics and facilities that were better resourced and with shorter wait times. Private practitioners, however, are not often available in rural areas, and their market-rate fees limit use by poor clients. NGO and religious hospitals are uncommon but favorably viewed, particularly when care is free or repayment terms are flexible.

The challenge of accessing quality, affordable and proximate care leads to delays or the failure of most respondents to seek treatment. Many women acknowledged that without prompt and appropriate treatment, even relatively minor or controllable conditions could become more serious and result in greater suffering, disability, lost productivity, and more expensive treatment.

“…the longer the illness is in your body, the harder it is to treat it.”
(RCPB client, Burkina Faso)

Thus, people do not lack understanding of the risks involved. Given their weak financial resources and the absence of appropriate healthcare services in their local communities, they simply have little choice.

HEALTH FINANCING

Health Expenditures
The market research next turned to examining how much microfinance clients and their families were typically spending on health-related issues (including both financial and nonfinancial costs), and the sources of money to cover those expenses. While most microfinance clients have regular sources of income from their microenterprises, healthcare expenses often impede their ability to consistently meet their families’ needs for food and other necessities. Routine, minor expenses accumulate over time, adding up to a serious cost burden, while serious illnesses can devastate a family slowly working its way out of poverty.

Direct financial expenses related to health represent a significant proportion of many microfinance clients’ overall budgets, although most spend so frequently in small amounts that they do not realize how quickly the costs accumulate. Using simple PRA tools, clients in Bénin, India and Burkina Faso calculated that between 20% and 50% of their family budgets are spent on health. In the West African countries, it was found that the treatment of malaria alone typically consumes almost a third of a family’s annual income. Despite these figures, people tend to be more focused on the potential for accidents or serious illness and the high costs associated with their treatment. Hearsay and estimates of such expenses were far out of reach of the clients interviewed. Most simply prayed that such a situation would never arrive, and that if it did, free or low-cost treatment would somehow be available.
The table below summarizes information from clients regarding direct healthcare costs relative to total income, as well as national data on private healthcare expenditures and out-of-pocket payments. Client estimates of expenses do not include transportation costs or opportunity costs, such as lost work time.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bandhan (India)</td>
<td>$60 - $100</td>
<td>$12 - $20 (20%)</td>
<td>78.7%</td>
<td>98.5%</td>
</tr>
<tr>
<td>CARD (Philippines)</td>
<td>$25 - $250</td>
<td>Not reported</td>
<td>61%</td>
<td>45%</td>
</tr>
<tr>
<td>CRECER (Bolivia)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>40.2%</td>
<td>81.3%</td>
</tr>
<tr>
<td>PADME (Bénin)</td>
<td>&lt; $95</td>
<td>$24 - $31 (33%)</td>
<td>53.5%</td>
<td>90.3%</td>
</tr>
<tr>
<td>RCPB (Burkina Faso)</td>
<td>Not reported</td>
<td>(40%)</td>
<td>54.1%</td>
<td>98.9%</td>
</tr>
</tbody>
</table>

The indirect costs of treating illness are also substantial and largely under-recognized. Care provided at national clinics or hospitals for major health problems such as cancer, stroke, and complications from childbirth often require long journeys. In such cases, in addition to the transportation costs, families lose valuable productive time as they travel and wait for treatment, stay to attend to the needs of the patient, and/or recuperate or provide follow-up care after hospitalization. Even the common and relatively minor illnesses of children or other family members lead to significant opportunity costs for the mothers who must care for them.

“…when someone in your family is sick you stay with them to look after them…you can't go anywhere”

(PADME client, Bénin)

Other indirect costs cited by clients were increased anxiety about family welfare, family disharmony, and general stress on the household. The market research showed that when illness strikes any member of the household, the entire family is affected, but the heaviest burden tends to fall on the women.

Sources of Money for Health

As illustrated in the table above, most healthcare costs in these countries are borne directly by individuals through out-of-pocket payments, with the exception of the Philippines (where a government health insurance program has achieved impressive coverage among middle-class salaried workers, and CARD is working to provide its clients in the informal sector with greater access to this coverage). A very small number of CRECER clients in Bolivia also have health insurance through their spouse’s employment. However, for most microfinance clients in the MAHP target areas, insurance to cover health costs is not available.
So when illness strikes, and free or low cost services are not available or effective, microfinance clients resort to several means to pay for services, depending on available cash from earnings or savings, the stage of the illness, and the expected cost and length of treatment. During months when income exceeds expenses, costs for minor illnesses and medicines can be more easily paid, even though this can create hardship in future months, when reserves are needed.

However, poor microfinance clients often experience wide swings in income and expenses over the course of the year due to their dependence on agriculture, climates with extremes of drought and rain, school calendars, and various annual celebrations and festivals with long-established social requirements. Unfortunately, times of higher revenue for the family do not necessarily coincide with times of the highest incidence of illness and thus need for health care. For example, in Bénin and Burkina Faso, women reported that illness is more prevalent during the rainy period of June through September, which are also the months of lowest income. At CRECER, Bandhan, and CARD, income and disease patterns were not quite as incongruous, and as a result these clients may be better able to cover the costs of minor illnesses out of income.

During times when there is no surplus revenue from business activities, savings are usually the next place to obtain resources to pay for consultations, hospital services, and medicines. However, savings specifically set aside for health is uncommon. In some places, there is a belief that saving for health invites sickness. Participants across all of the MFIs allocate their small incomes primarily to food, other household needs and school fees for the children; little remains for savings or health.

“Saving for health would invite negative energies to come to the household.”
(CARD client, Philippines)

Further, clients are understandably very reluctant to dip into savings set aside for a specific other purpose, such as a major asset investment. For some, it is easier and preferable to borrow (even if it means paying exorbitant interest), rather than have to build up such a sum again to achieve a long-term goal.

When extra income and savings are unavailable or exhausted, clients turn to working capital, including MFI loan proceeds, and/or they borrow from family members or friends.

“We take money from our business...there's nothing else we can do.”
(CRECER client, Bolivia)

“We swallow our pride; we approach whomever we think could help us bring the family member for treatment.”
(CARD client, Philippines)

“We borrow from family members, with no interest or collateral...they have to loan to us.” (CRECER client, Bolivia)
Family loans, while usually provided without collateral or interest, have an implied reciprocity; those receiving a loan today are expected to extend a loan to another family or community member who needs it in the future. Burkinabé respondents saw this approach as a last resort, because it meant that:

“…the next day everyone in the village knows you have a problem.”
(RCPB client, Burkina Faso)

Another common way to obtain cash to pay for health care is to leverage family or business assets by selling or pawning valuable goods such as livestock, crops, homes, jewelry, mobile phones, bicycles, or business equipment. Clients reported that the sale price of these assets in an emergency situation often did not reflect the real value of the goods, generating significant losses for the families.

“We sell our sheep, our products…when there are accidents, there is no other way.”
And “They sell their livestock cheaply…they give it away.”
(CRECER clients, Bolivia)

Another alternative that seemed quite common is to seek loans from someone other than a family member or friend. Loans are sometimes obtained from informal community savings schemes, such as “tontines” (West Africa) or “paluwagan” (Philippines). But others in need of quick, unsecured loans resort to moneylenders or loan sharks who make loans at exorbitant interest rates (20% or more per month) and require very short repayment periods.

Unfortunately, times of higher revenue for the family do not necessarily coincide with times of the highest incidence of illness and thus need for health care.
Table 3 summarizes the ways in which microfinance clients obtain cash to cover the costs of medical expenses.

<table>
<thead>
<tr>
<th>MFI Clients</th>
<th>Sources of Cash (as mentioned by clients)</th>
</tr>
</thead>
</table>
| **Bandhan**     | - Personal funds  
                    - Loans from relatives  
                    - Loans from friends and neighbors, or employers  
                    - Moneylenders  
                    - Sale and mortgage of possessions  |
| **(India)**     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| **CARD**        | - Earnings from livelihood  
                    - Working capital from business (including loan funds)  
                    - Public assistance from local elected officials  
                    - Savings (from CARD, banks, and informal savings plans)  
                    - Loans from friends, relatives, and neighbors  
                    - PhilHealth (for a very few whose husbands are employed)  
                    - Cash advances from employers or for future sale of agricultural products  
                    - Credit from CARD  
                    - Pawn or sell valuables (mobile phones, jewelry, and productive assets)  
                    - Loans from loan shark  |
| **(Philippines)** |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| **CRECER**      | - Business earnings  
                    - Working capital from business  
                    - Spouse earnings (small number of women)  
                    - Savings  
                    - Loans from extended family members  
                    - Selling or pawning goods (livestock, crops, homes)  
                    - Payment plan with title deed as security  
                    - Credit (loan from CRECER)  |
| **(Bolivia)**   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| **PADME**       | - Profits from income generating activity  
                    - Household income  
                    - Loans from coworkers or friends  |
| **(Bénin)**     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| **RCPB**        | - Personal savings  
                    - Help from husbands  
                    - Tontine (informal local savings group)  
                    - Business funds (both credit and working capital)  
                    - Selling or mortgaging household assets such as bicycles, animals, household goods, and home  
                    - Informal loan from extended family or friends  |
| **(Burkina Faso)** |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
The lack of funding for health care affects both the physical, financial and emotional health of microfinance members and their families. Without financial resources, people delay or sometimes completely eschew care, leading to complications, disability and at times, death.

“There's no money to spend on getting illnesses cured.”
(CRECER client, Bolivia)

For the great majority of respondents, healthcare expenses are not planned or prioritized, but instead are considered unexpected and thus directly impact a family’s cash flow. When clients use working capital, sell productive assets, or obtain additional credit to cover medical expenses, there are serious repercussions on future earnings and cash flow. That said, and although one coping strategy mentioned by many of the respondents was to use free services whenever available, most clients also indicated that they would be willing to pay something for quality medical services that were available nearby when needed.

“We can pay a fair amount for fair treatment…” And “We can set aside savings at each meeting.”
(CRECER clients, Bolivia)

DESIGNING HEALTH PROTECTION SOLUTIONS

In order to develop solutions that could address the health protection gaps revealed through market research, the five MAHP partner MFIs and Freedom from Hunger took into account market needs (as revealed through an objective assessment of gaps), client demands (as expressed by respondents), and MFI goals and capacity.

Market needs
Analysis of the market research data indicated a need for several interrelated health products and services in each target area. To protect health and maintain economic progress, research showed that clients would need health care services and financing products that worked together to improve access to preventive and routine care, while also protecting from the financial shock of a potential major health care event. Three main areas of mutually reinforcing health protection services emerged: health education, health financing mechanisms, and access to health products and/or services.

Health Education. First, market research around the globe showed that microfinance clients needed and demanded more information and training on how to prevent illness and treat common diseases so that they would not become serious. Behavior-change health education can help reduce preventable illness and related expenses, and is therefore a logical foundation for any health protection package. In addition to education on the causes, prevention and treatment of specific illnesses, the MAHP market research pointed to a lack of awareness about how much those little, regular health-related expenses add up and the possibility that saving ahead specifically for health would enable faster treatment, thereby reducing the overall cost of a health incident. Furthermore, by comparing respondent descriptions of the public health system and quality with visits to and assessments of those facilities, research in several countries suggested that training for microfinance clients on how their health system works, how and where to access certain services, what to expect, and what minimum quality treatment to demand
would be extremely beneficial.

**Health Financing.** Next, while inadequate healthcare services are often a barrier, the lack of financial means to access services (even when available) appeared to be a more immediate issue for all clients – not to mention one that MFIs might be better equipped to address. For example in India, the research team concluded that “the problem is not with the accessibility of medical care, but rather with the lack of access [to] means to finance that health care.” Whatever form it took (savings, loans, insurance, or a combination of these), respondents needed ready access to capital to face health expenses – from those small monthly expenditures on medicines, to investment in an insecticide-treated mosquito net, and from a health insurance premium to hospital fees and medicines for major surgery.

**Health Products and Services.** Further, people needed improved access to health products and services in their communities. For instance, insecticide-treated mosquito nets and condoms were needed in rural African communities; oral rehydration solution and water treatment tablets were needed in rural India; pharmaceuticals were required in rural Bolivia and the Philippines. And everywhere there was a need for more affordable and/or higher quality health care.

This analysis of actual service gaps and needs on the basis of client information, official data, and field observation was an important ingredient for identifying and developing potential solutions.

**Client demands**

While assessing needs was one side of the equation, the market research and product innovation teams also carefully considered the demands expressed by the clients. During focus group discussions, respondents were encouraged to brainstorm and suggest ways in which the MFI might address their most pressing health-related problems.

All of the clients expressed a demand for greater availability of quality primary and specialty healthcare services and for more health education and training to help them protect and manage their own health. Women in each of the five countries wanted to be able to access “modern” healthcare services, but some also valued traditional medicines, healers, or prayer, either for certain diseases which they believed that modern medicine could not cure, or to supplement modern medical treatment. Many clients indicated a preference for services that would be directly provided by the MFI, while others suggested the MFI develop special arrangements with local, community providers. Clients also expressed various demands for products or mechanisms that would help them afford and pay for quality services. These included a variety of ideas, ranging from subsidies for some services, to health savings and loan products, to health insurance that would help reduce individual costs.

“Due to financial constraints, people take a chance on albularios [traditional practitioners] and some may actually be restored to health.”

—(CARD CLIENT, PHILIPPINES)
financial risk from the expense of serious illness.

### Table 4: Demand for Health Education, Services and Financing

<table>
<thead>
<tr>
<th>MFI Clients</th>
<th>Health Education</th>
<th>Health Products and Services</th>
<th>Health Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bandhan</strong></td>
<td>■ Reproductive health</td>
<td>■ Low-cost medicines</td>
<td>■ Emergency health loans at a lower rate than other loans</td>
</tr>
<tr>
<td><em>(India)</em></td>
<td></td>
<td></td>
<td>■ Voluntary weekly savings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>■ Health insurance for families</td>
</tr>
<tr>
<td><strong>CARD</strong></td>
<td>■ CARD Clinic with free or lower cost consultations, diagnostic services and medicines</td>
<td></td>
<td>■ Enrollment in PhilHealth (hospital insurance program)</td>
</tr>
<tr>
<td><em>(Philippines)</em></td>
<td>■ Pharmacy in community with free or low cost generic and brand medicines and vitamins</td>
<td></td>
<td>■ Discounts on medical services such as doctors, hospitals, medicines</td>
</tr>
<tr>
<td></td>
<td>■ Optometric services and affordable glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CRECER</strong></td>
<td>■ Prevention and management of most frequent illnesses</td>
<td>■ Health center or clinic located in CRECER branches</td>
<td>■ Provider agreements for discounted hospital care, specialists, surgery, medicines, and diagnostic care</td>
</tr>
<tr>
<td><em>(Bolivia)</em></td>
<td>■ Use of traditional and natural medicines</td>
<td>■ CRECER doctor</td>
<td>■ Health emergency loans with low interest and quick access</td>
</tr>
<tr>
<td></td>
<td>■ Women's health</td>
<td>■ Regular health checks</td>
<td>■ Health care savings arrangements</td>
</tr>
<tr>
<td></td>
<td>■ Training on health system and how to access services</td>
<td></td>
<td>■ Family health insurance with periodic payments and/or prepayment scheme for private clinics</td>
</tr>
<tr>
<td><strong>PADME</strong></td>
<td>■ Malaria</td>
<td>■ Affordable and easily available mosquito nets</td>
<td>■ Affordable health insurance</td>
</tr>
<tr>
<td><em>(Bénin)</em></td>
<td>■ Family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Low-risk pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Other infectious diseases, e.g. tuberculosis, cholera, typhoid fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RCPB</strong></td>
<td>■ Prevention and management for most prevalent diseases</td>
<td>■ Access to free or low-cost diagnostic services and medicines including vaccinations</td>
<td>■ Voluntary savings programs that can be quickly accessed</td>
</tr>
<tr>
<td><em>(Burkina Faso)</em></td>
<td></td>
<td>■ Advocacy to improve public services</td>
<td>■ Emergency loans</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>■ Health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>■ Solidarity fund for high-impact diseases</td>
</tr>
</tbody>
</table>
The specific demands and product attributes for health services and health financing products as identified by clients of each MFI are summarized in Table 4. While clients indicated a desire for more “free” or low cost services, on the one hand, they also indicated a willingness to pay for services. The demand for free services might be more accurately interpreted to mean that clients want to be able to access and pay for medical services when needed, whether or not cash is immediately available. In fact many of the clients expressed enthusiasm for the idea of setting aside health savings and having access to health loans at reasonable rates of interest that could be repaid slowly in installments. In every country, clients expressed interest in insurance or similar mechanisms to protect them from major medical expenses, and some even demonstrated a basic understanding of and openness to risk pooling.

“There are many CARD members who will put their money to CARD and whoever gets sick will use that money. Not all members will get sick at the same time.”

(CARD client, Philippines, describing her idea for a risk pooling product)

Where health microinsurance is or will be made available, very poor people may find themselves facing a difficult dilemma: paying the premium to insure against illnesses that are high impact but relatively unlikely, or paying for treatment of smaller, more frequent and more certain health problems. This is especially difficult since the latter, left untreated, have the potential to become high impact.

The overall feedback from clients with respect to willingness to pay is well summarized in the CRECER market research report: “There is not a demand for “free” service, but rather for receiving quality service, good treatment, personalized attention, complete information and to get problems solved. There is a clear willingness to pay a fair amount for the services received.”

Microfinance Institution Goals and Capacity

For each of the MFIs participating in MAHP, information from the market research provided further evidence of the important link between health and the ability of women to be successful microentrepreneurs and microfinance clients. Even beyond their critical social missions, MFIs have a direct business interest in the health of their clients. Clients who are healthy and have the means to pay for health care when needed are better able to maintain their membership in MFIs, repay and take new and larger loans, build assets and improve their household financial status.

Moreover, such additional services can provide competitive advantage to MFIs. Microfinance clients are well aware of the various products and benefits offered by competing MFIs. Clients at CRECER cited health services being provided by a large competing MFI in Bolivia. At PADME, which operates in a very competitive market, clients mentioned that they would like to have access to the health microinsurance product offered by one of PADME’s competitors. And at CARD, the provision of successful

“We can pay a fair amount for fair treatment…”
And “We can set aside savings at each meeting.”

—(CRECER CLIENTS, BOLIVIA)
life insurance and retirement savings programs are frequently cited as reasons that members continue to participate in the credit program. So for MFIs operating in an increasingly competitive market, health protection services can help to differentiate and enhance their product offerings for member attraction, retention, loyalty and growth.

Despite the apparent benefits, understanding and addressing the health protection needs of poor MFI clients is complex and challenging, requiring expertise and skills that are different from those needed to manage successful MFIs. Most MFIs approach the decision to add and integrate new products with appropriate caution. Experienced leaders are rightfully concerned about detracting focus from what they do well, and the risk of compromising their core products in the process.

MFIs operate with lean staffing and are unlikely to have personnel with health service delivery or health financing expertise. Operating on thin margins already, MFIs have legitimate questions about the additional administrative costs and long-term sustainability of health programs. Health insurance, with its serious financial risks, is of particular concern, since experience and knowledge about the successful development and operation of sustainable health microinsurance programs is very limited.

Many of the gaps revealed through the market research related to the national health structure and funding, or availability of affordable health products and medicines. These would appear to be out of the scope of MFIs’ control or domains of expertise. Rather than attempt these directly, the MFIs and Freedom from Hunger looked for innovative ways to capitalize on the expertise and influence of the MFIs to develop solutions – such as strategic linkages, entrepreneurial opportunities for their clients, and acting as a collective voice for their clients.

Clearly, MFIs need to carefully match the needs and demands of their clients with their own institutional goals and capacity to find a solution that adds as much value as possible to clients by drawing on and even enhancing institutional strengths.

All of the packages...incorporate revenue-generation elements intended to ensure long-term sustainability, and efficiency of operations is continually being refined to enable scale-up.

Microfinance and Health Protection Packages
The five MAHP partner MFIs each developed a unique, context-specific “package” of health

“There are many CARD members who will put their money to CARD and whoever gets sick will use that money. Not all members will get sick at the same time.”

—(CARD CLIENT, PHILIPPINES)
protection services to address the needs and demands of their clients. All of the packages address in some way all three of the main areas of need revealed through the market research: health education, health financing and access to health products and/or services. They all incorporate revenue-generation elements intended to ensure long-term sustainability, and efficiency of operations is continually being refined to enable scale-up.

- **Plan for Better Health** guides participants to consider their health-related financial risks, share their coping strategies, and evaluate how various financial products (such as health savings or loans offered by the MFI) can address their health-related needs.

- **Using Health Care Services** empowers participants to improve their health-seeking behavior by increasing their knowledge about how and when to access available health services, internationally accepted healthcare standards that citizens can expect their providers to follow, and how to negotiate for fair treatment.

- **Healthy Habits** explores facts about chronic diseases such as high blood pressure, diabetes and cancer; the behaviors that put participants’ families at risk; and alternative practices that are both realistic and relevant to their context.

**Health Education Components**

On the health education side, Freedom from Hunger worked with several of the partner MFIs to develop three new education modules in response to the market research findings, and these were integrated into the MAHP packages to build on and complement nonformal education on preventing and treating common diseases.

- **Health savings** accounts that enable people to set aside and protect funds so that money is available immediately and year-round when the inevitable, common and relatively low-impact diseases occur.

- **Health loans** for more significant health expenses or emergencies, to give clients an alternative to raiding business capital or turning to moneylenders.

- **Loans for health insurance premiums** to spread this expense over smaller, regular payments throughout the course of the year and ensure continuity of insurance coverage.

- **Health microinsurance** – one example of a partner-agent model in conjunction with a government program, and several examples of MFIs taking more gradual steps to explore options and viability with the goal of eventually offering some form of health insurance.

- **Mobile doctors** providing health education, preventive and diagnostic services in rural areas.

- **Preferred-provider program** with discounted primary care for rural microfinance clients.

- **Door-to-door visits by village entrepreneurs** who reinforce health education, sell health products and medicines, and provide referrals to local healthcare services.

- **Sales of health products** such as insecticide-treated nets, family planning products, oral rehydration solution, and safe water systems by MFI field agents, to complement health education.

- **Microfranchise distribution** of affordable essential drugs in rural areas.
Health Financing Components
Several different financing mechanisms contribute to the various packages, including:

Health Products and Services Components
Each of the MFIs is also experimenting with health provider linkages and/or extending access to vital

<table>
<thead>
<tr>
<th>Five Microfinance and Health Protection Packages</th>
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<tbody>
<tr>
<td>Under Experimentation through Freedom from Hunger’s</td>
</tr>
<tr>
<td>Microfinance and Health Protection Initiative (2006-2009)</td>
</tr>
</tbody>
</table>

**Bandhan: Health Education, Access to Health Products and Health Loans**
Bandhan is providing its clients in India with health education on preventing common illnesses, prenatal and neonatal care, and planning ahead to face health expenses. This education is accompanied by access to affordable, high-quality health products such as oral rehydration solution, paracetamol, and water disinfectant solution. Both the education and health products are delivered by health community organizers and village-level volunteers selected and trained by Bandhan. Health loans to cover major medical expenses have also been developed to complement the preventive services.

**CARD: Health Education, Health Microinsurance, Health Loans and Linkages**
CARD is offering two health protection service packages in the Philippines. In more urban areas, CARD offers health loans to pay the premium for PhilHealth, a national health insurance program that provides hospital coverage to CARD clients through a partner-agent model. In a rural area, CARD has created linkages with health care providers who offer discounts to CARD clients for primary care. CARD is also exploring a franchise network for distribution of affordable essential drugs. Health education on health microinsurance, financial planning for health, rational use of available health services, and on preventing and treating dengue fever complement the services offered in both pilot areas.

**CRECER: Health Education, Health Loans and Linkages to Health Care Providers**
CRECER is providing its clients in rural Bolivia with linkages to health care providers who regularly visit communities to conduct “health days” when primary care and basic diagnostic services are made available. Group health loans help clients pay for these high-quality community-based services. Individual health loans are also available to cover substantial healthcare expenses, such as treatment of a disease revealed by a health day diagnosis. New health education sessions focus on prevention and treatment of common infectious and chronic illnesses, effective health-seeking behavior and managing health-related financial risks.

**PADME: Health Education, Access to Health Products and Prepaid Health Plan**
PADME has launched Credit with Education with a particular focus on health in rural Bénin. Behavior-change education is being delivered on malaria (a high economic burden in the area), common but deadly childhood illnesses and HIV/AIDS. To complement the health education, PADME is providing access to health products, such as insecticide-treated mosquito nets, oral rehydration solution and condoms. PADME will also conduct a feasibility study on establishing a health microinsurance mechanism whereby healthcare services would be provided to enrolled clients for a flat annual fee.

**RCPB: Health Education, Health Savings, Health Loans and Solidarity Fund**
RCPB’s innovation package in Burkina Faso includes three complementary financial products: health savings to cover primary care and medicine for common illnesses; health loans to cover treatment that exceeds clients’ health savings; and a health solidarity fund for communities to invest as they wish toward the improvement of local health services and issues. RCPB is also offering health education on planning ahead to pay for health expenses and advocating for better health services. RCPB is promoting quality care for its clients by forming alliances with rural health centers.
health products, through the following mechanisms:

**Cohesive and Holistic Packages**

Each MFI combined several of these components to achieve a cohesive, holistic package of services that work together in an integrated way to meet the requirements of the local population. Summaries of the specific health protection innovation packages offered by each MFI are provided in the inset.

**Sharing Successful Models**

Launched by the MFIs in 2007, experimentation, refinement, scale-up and research on the sustainability and impact of these products and services will continue through 2009. In the meantime, more detailed documentation of the product specifics and lessons learned is being carried out by Freedom from Hunger with the intention of disseminating practical information and training on successful models in the future, so that other MFIs can replicate or adapt such services in their unique contexts.

**CONCLUSION**

The market research conducted in 2006 by Freedom from Hunger and the five MFIs participating in the Microfinance and Health Protection initiative confirmed the overwhelming burden of ill health on very poor people and provided a more nuanced understanding of health issues and financing in Bénin, Bolivia, Burkina Faso, India and the Philippines. The research showed that – like people everywhere – microfinance clients around the world demand quality and affordable health care that they can access reliably when needed. Poor people are willing to pay for good quality health services and products, but they require mechanisms that enable them to do so over time. Microfinance clients also value education on health and health financing, and repeatedly expressed a demand for such training.

Analysis of local health-related needs, client demands, and MFI capacity led to the design of five innovative and cohesive health protection packages intended to provide relevant and valuable health solutions for poor people, while also being practical, sustainable, scalable and replicable for MFIs. Health financing products such as health savings, loans and microinsurance programs for microfinance clients and their families are combined with readier access to high-quality, affordable health products (such as insecticide-treated mosquito nets and essential medicines), while education on health financing, healthcare services and prevention of common diseases promotes and reinforces the MFI’s health protection package. The coming years of ongoing demonstration, testing and research through the Microfinance and Health Protection initiative will reveal the ultimate viability and success of these innovations. Freedom from Hunger is committed to sharing recommended approaches and lessons learned, and to inspiring other organizations not only to explore their own solutions to this challenge, but also to share their experiences.
The link between poverty and ill health is longstanding, and the heroic efforts of the microfinance and public health sectors to address these issues are not new. But we are now on the cusp of combining the important incremental contributions of both sectors in an efficient, sustainable and holistic manner. And the leap ahead for very poor people, as a result of integrated microfinance and health services, is likely to be exponential.

**Annex 1: Basic Information on Participating MFIs and Specific Areas of Market Research**

<table>
<thead>
<tr>
<th>MFI (Country)</th>
<th>Members/Active Borrowers¹</th>
<th>Outstanding Loan Portfolio ($)</th>
<th>Areas of Market Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bandhan (India)</td>
<td>761,565</td>
<td>$65,580,321</td>
<td>Baruipur town (45 km outside Kolkata)</td>
</tr>
<tr>
<td>CARD (Philippines)</td>
<td>456,737</td>
<td>$39,952,675</td>
<td>Atimonan and Pagbilao, Quezon Province</td>
</tr>
<tr>
<td>CRECER (Bolivia)</td>
<td>98,202</td>
<td>$26,902,257</td>
<td>Urban and rural municipalities in CRECER’s La Paz regional office. Includes municipalities in provinces of Aroma, Ingavi, Inquisivi, Los Andes, Murillo, and Omasuyos</td>
</tr>
<tr>
<td>PADME (Bénin)</td>
<td>55,105</td>
<td>$31,995,085</td>
<td>Communes in the Plateau region including: Ifangnin, Pobè, Kétou, Adjouère, and Saké</td>
</tr>
<tr>
<td>RCPB (Burkina Faso)</td>
<td>147,872</td>
<td>$61,258,282</td>
<td>North region, Yatenga Province</td>
</tr>
</tbody>
</table>

Total combined members/active borrowers: 1,519,481

¹ All data is self-reported as of December 2007 for Bandhan, CARD, CRECER and PADME, and October 2007 for RCPB.
<table>
<thead>
<tr>
<th>Country (MFI)</th>
<th>Most Common Routine (Low Impact Illnesses)</th>
<th>Most Common Serious (High Impact Illnesses)</th>
<th>Diseases with Most Impact on Women and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>India</strong> (Bandhan)</td>
<td>Cold, cough and fever, skin diseases, diarrhea, gastric (hyper-acidity)</td>
<td>Cancer, stroke, cardiac disease, appendicitis, kidney problems, gynecological problems, childbirth complications, gastric ulcers, gall bladder, asthma, typhoid fever, jaundice (liver disease), tuberculosis</td>
<td>Women: Gynecological problems, childbirth complications Children: Appendicitis, jaundice</td>
</tr>
<tr>
<td><strong>Philippines</strong> (CARD)</td>
<td>Cough, cold, fever and flu, diarrhea, amoebiasis, UTI, hypertension, skin diseases, rheumatism (arthritis)</td>
<td>Cancer, diabetes, stroke, lung problems, asthma, typhoid fever, tuberculosis</td>
<td>Women: Female cancers Children: Amoebiasis, typhoid fever, diarrhea</td>
</tr>
<tr>
<td><strong>Bolivia</strong> (CRECER)</td>
<td>Cough, colds, fever, skin diseases (scabies), diarrhea, UTI, gastric ulcers, dental problems, anemia, infectious childhood diseases (measles, chicken pox, etc.), rheumatism</td>
<td>Pneumonia, gall bladder disease, kidney problems, female cancers (breast, cervix, ovarian), accidents/trauma, rabies, appendicitis, gastric ulcers</td>
<td>Women: Anemia, gall bladder problems, cancer, complications of pregnancy and childbirth, vaginal infections Children: Pneumonia, developmental problems (teenagers), skin problems (scabies), anemia</td>
</tr>
<tr>
<td><strong>Bénin</strong> (PADME)</td>
<td>Malaria, anemia, coughs, diarrhea/vomiting high blood pressure, glaucoma, gastric ulcers, measles</td>
<td>Malaria, anemia, cholera, HIV/AIDS, complications from childbirth, typhoid fever, glaucoma, gastric ulcers</td>
<td>Women: complications from pregnancy and childbirth, anemia Children: Malaria, stomach illnesses, anemia, measles</td>
</tr>
<tr>
<td><strong>Burkina Faso</strong> (RCPB)</td>
<td>Malaria, coughs and whooping cough, high blood pressure, stomach pain, diarrhea, eye pain, skin diseases, dental problems, typhoid fever</td>
<td>Malaria, HIV/AIDS, meningitis</td>
<td>Children: malaria, meningitis, coughs, stomach pains, eye pain</td>
</tr>
</tbody>
</table>
**ANNEX 3: MICROFINANCE CLIENTS’ CURRENT SOURCES OF AND DEMANDS FOR HEALTH INFORMATION**

<table>
<thead>
<tr>
<th>Country (MFI)</th>
<th>Source of Information (prevention, health behavior change education)</th>
<th>Topics/Information Provided</th>
<th>Client-Identified Demand for Additional Health Education or Information</th>
</tr>
</thead>
</table>
| **India (Bandhan)** | ■ Health workers from local health centers  
  ■ Healthcare providers (doctors, hospitals, pharmacists)  
  ■ Families  
  ■ Peer groups  
  ■ Media | ■ Care of children/immunizations  
  ■ General health and hygiene  
  ■ Nutrition  
  ■ Water and sanitation  
  ■ Malaria prevention  
  ■ Herbal remedies and self-care | ■ Reproductive health  
  ■ Preventive health care  
  ■ Self-care for minor ailments |
| **Philippines (CARD)** | ■ CARD Credit with Education  
  ■ Barangay Health Center midwives and workers  
  ■ Government programs/seminars  
  ■ Families, neighbors, peer groups  
  ■ Media - Television | ■ Breastfeeding  
  ■ Family planning  
  ■ Nutrition  
  ■ General preventive health  
  ■ Use of herbal remedies  
  ■ Care of children and child nutrition  
  ■ Information on medicines and vitamins | ■ More frequent classes  
  ■ Prevention and management of specific health problems and diseases |
| **Bolivia (CRECER)** | ■ CRECER Credit with Education  
  ■ Other MFI (Pro Mujer)  
  ■ Family, neighbors, friends | ■ Breastfeeding (and other topics delivered through CWE)  
  ■ Sexually transmitted diseases  
  ■ Care of children  
  ■ Preparing and using home remedies | ■ Greater understanding of traditional medicine  
  ■ Women’s health  
  ■ How to better access the health system  
  ■ Prevention and management of most common diseases |
| **Bénin (PADME)** | ■ Families  
  ■ Peer groups | ■ Herbal remedies, self-care | ■ Malaria prevention  
  ■ Family planning  
  ■ HIV/AIDS  
  ■ Low-risk pregnancy  
  ■ Tuberculosis and cough  
  ■ Cholera  
  ■ Typhoid fever  
  ■ Prevention of heart disease |
| **Burkina Faso (RCPB)** | ■ RCPB Credit with Education  
  ■ Public facilities  
  ■ Hospitals  
  ■ Families, peer groups  
  (No specific information reported in market research study; the following are inferred from reports of client health seeking behavior) | ■ AIDS prevention and treatment  
  ■ Self-care  
  ■ Malaria prevention  
  ■ Child health care  
  ■ Hygiene to avoid food-borne illness  
  (No specific information reported in market research study) | ■ prevention and management of most common illnesses |