Freedom from Hunger

Findings from Microfinance Institutions Offering Health Services to Clients

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INTRODUCTION

Microfinance, the extension of small loans to groups of poor people for the purpose of investing in livelihood-generating activities, has proved to be an effective tool for increasing income with a positive impact on poverty reduction as it relates to the first six of the Millennium Development Goals.[1] Over 3,500 microfinance institutions (MFIs) provide microcredit and financial services to more than 155 million households worldwide, according to The Microfinance Information Exchange database (www.mixmarket.org).[2] Conservative estimates indicate that at least 34 million of these households are very poor by the Millennium Development Goals definition, representing 170 million people, often living in remote and hard-to-reach locales.[3]

While the potential for impact of microfinance has a growing body of evidence, it is also increasingly well understood that health problems may represent the greatest threat to the poor achieving and sustaining life improvements. Recognizing the vulnerability, a small but growing number of MFIs has integrated health-related services, such as education, clinical care, health-financing and linkages to public and private health providers as a complement to financial products.

Whether and how to integrate health services with microfinance is a matter of active debate. In the meantime, however, a growing number of MFIs are taking steps to consider health-related services. In order to better understand the current motivations and practices of MFIs, we designed and implemented a pilot survey of MFIs currently offering health-related programs. The results provide useful information to inform both the debate and the "real world" implementation of programs.

Study Methods

Design

The objective of the study is to understand practices of MFIs in Africa, Latin America and South Asia that have integrated health components into their MFI program. A self-administered questionnaire, available online in three languages as well as in document form (English, French, and Spanish), was designed to collect data on the following indicators:

- principal motivations for offering health services
- health needs targeted by MFIs
- types of health services provided
- client outreach with health programs
- duration and funding
- key performance indicators

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[1] Morduch, J. and B. Haley. (2001). "Analysis of the Effects of Microfinance on Poverty Reduction." *NYU Wagner Working Papers Series* prepared for the Canadian International Development Agency, November 2001.

[2] Microfinance Information Exchange (2009). Retrieved from: www.mixmarket.org.

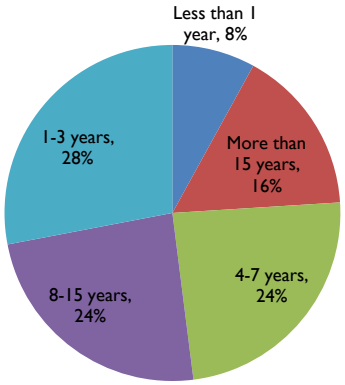
[3] Daley-Harris, S. *State of the Microcredit Summit Campaign Report 2009*. http://www.microcreditsummit.org/uploads/socrs/SOCR2009_English.pdf.

Participant Characteristics

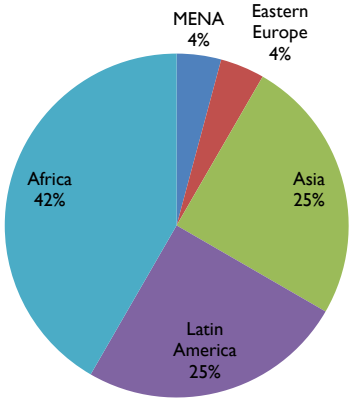
MFIs that participated in this study were identified through a combination of searching the Microfinance Information Exchange Market, an advertisement on the MicroLinks and Microfinance Gateway websites, and opportunistic solicitation of survey participation at regional conferences in Latin American and Africa. The survey was pre-tested among 14 MFIs. Of the total 46 MFIs that took the survey, 28 were included for analysis. Two reasons for exclusion were respondents' lack of a qualifying health program and non-completion of the survey.

Although a small sample, the 28 MFIs completing the survey together provide services to one million clients across three continents. Respondents were well dispersed, with 42 percent of the MFI responses from Africa, 25 percent each from Latin America and Asia, and a very small proportion of responses (4 percent each) from Eastern Europe and MENA (Middle East and North Africa).

Duration of Health Programs



Geographical Distribution



Limitations

Response to the survey was by self-selection and all data is self-reported without external validation. Participation in the survey was encouraged directly and by third-party advertisement by two intermediaries, Freedom from Hunger and MicroCredit Enterprises. These two organizations have intact and ongoing partner relationships with several MFIs around the world to provide technical assistance and funding opportunities. The survey responses likely represent a convenience sample of highly motivated MFIs who agreed to participate; hence, the results do not present the complete representative picture of MFIs with health programs.

Findings

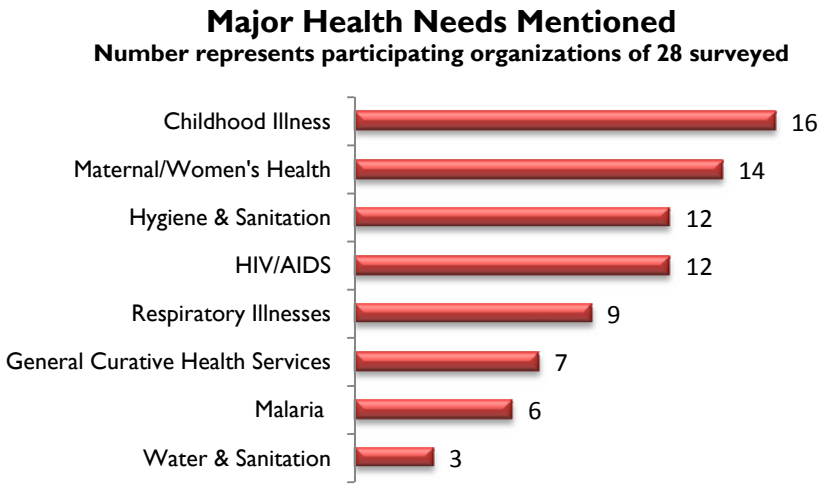
The survey reveals that responding MFIs offer an extensive variety of health products and services to address a range of client-health needs. Most of the survey participants appear to offer these programs out of concern about the lack of client knowledge to prevent and manage common health problems. Additionally, the responding MFIs implement programs on a pilot basis before establishing a formal ongoing set of programs, perhaps reflecting the need for and lack of evidence to effectively tailor-make health programs according to the need of clients. This piloting requires each MFI to learn on its own rather than be able to adopt and adapt "tried and true" approaches.

Motivation

The principal motivations for offering health services were found to be the MFIs' recognition of the health-related knowledge deficits of the clients (86%), difficulty of clients in receiving preventive care (79%), inability to pay for care when sick (64%), difficulty in receiving care when sick (61%) and inability to pay for essential medicines (57%). Although not ranked as a top motivation, concern about loan repayment is mentioned by 13 of the responding MFIs, or 46 percent.

Health Needs

The participating MFIs offer health programs that commonly address multiple needs of clients through a variety of interventions. In this sample, childhood illness (57%) and women's health (50%) dominate as the top health needs addressed. Others include hygiene/sanitation (43%), HIV/AIDS (43%), respiratory illnesses (32%), general curative health services (25%), malaria (21%) and water and sanitation (11%). The following topics were also mentioned in smaller numbers: family planning, diarrhea, ophthalmology, diabetes, breastfeeding, nutrition, heart disease, tertiary care and medicinal plants.



Health Programs

The type of program most commonly offered to meet health needs is group-based health education sessions (86%). Other health-related programs offered by MFIs include contracts with individual public/private healthcare providers (36%), health promotion events (32%), direct delivery of health services and counseling (25%), micro-insurance (18%) and facilitated referral to healthcare facilities (18%). Additional interventions mentioned include health loans at individual level, community pharmacies or dispensaries, access to affordable medicines, support for community water and sanitation, training for community health workers, health vouchers, health savings and provision of health products through distribution by clients as a form of microenterprise. While some program goals are meant to address a single health need, such as treatment of tuberculosis or improving health insurance coverage, other programs are meant to address broader goals by providing a bundle of services.

CONCLUSIONS

The survey data underscore the interest and potential for MFIs to implement a wide range of innovative health interventions across the globe. A growing body of literature studies shows that beyond poverty alleviation, microfinance institutions are capable of contributing to health improvement through increasing knowledge. This leads to behavioral changes and enhances access to health services through addressing financial, geographic and other barriers. Positive health outcomes have been demonstrated in diverse areas, such as nutrition, infectious disease, maternal and child health, domestic violence and malaria.[4] Given the increasingly compelling evidence that extending health services to the poor through microfinance institutions is associated with improved health awareness, behaviors and health outcomes, it is critically important to support and nurture the growing interest and willingness of MFIs to add health programs to their financial services.

[4] Dunford, C. and B. MkNelly. (2002) "Using Microfinance to Improve Health and Nutrition Security." *Global Health Link* (November-December No. 118: 9, 22.) http://www.globalhealth.org/publications/article.php3?id=878. | Mohindra, K.S., S. Haddad and D. Narayana. (2008). "Can Microcredit Help Improve the Health of Poor Women? Some Findings from a Cross-Sectional Study in Kerala, India." *International Journal for Equity in Health*, 7:2.

The results show that MFIs that offer health programs are committed to meeting client needs; however, most do so with some concerns about sustainability. It is important to continue learning more about the current status and experiences of a greater number of MFIs that are implementing health programs, particularly the cost and benefits. Collecting and analyzing these data to share with the community of MFI practitioners will contribute to ongoing efforts to build effective technical capacity in program design and implementation as well as optimize impact and reduce the risk of program failure.

With its ability to reach the poor in large numbers worldwide, sometimes in remote and hard-to-reach geographical areas, the microfinance sector has the potential to play a key role in extending health-related services to the poor, often with only a modest additional investment in capacity.