Equipping Families in the Andes Region with Integrated Microfinance and Health Services
Technical Brief # 2: Health Practices and Outcomes

Marcia Metcalfe and Bobbi Gray
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Introduction

Millions of Microfinance Institution (MFI) clients throughout Latin America are challenged by the dual circumstances of poverty and poor health, and lack access to health information, appropriate services and the financial tools that help them afford needed care. Like other families struggling to raise themselves out of poverty, they pay a disproportionately high level of their meager income on health expenditures and health shocks, and too many are driven back into poverty as a result of preventable health events.

Meri, from Perú, is one such client. Meri sold grains for ten years and her income was just about the "safe" amount to cater to her family. She considered herself a successful businesswoman. She bought her grains from the market women in Huancayo who cultivated all types of grains from barley to quinoa to green peas. She would grind them to make into custard to sell in Lima for a good price. Maintaining her small-scale business demanded she travel monthly to Lima to sell and invest in new products. And for years she enjoyed the fruits of her labor, until an unprecedented health complication changed it all. After her fifth child, a vein in her abdominal area ruptured, she hemorrhaged internally and went to the hospital. Her health problem meant that she could no longer travel to Lima to sell her products and she became indebted to the hospital, multiple microfinance institutions and the municipality. Meri has no other income and the few soles her husband makes from shining shoes in the market is what they rely on now. She felt she was never prepared for major medical bills.

> *We have seen with our own eyes the difficulties that our clients face and decided it was important to offer health services that are integrated with our financial services.*
>
> *—ADRA Staff Member*

"Now I try to sell underwear and pantyhose," she says, "But most of the time I am not successful in selling, and we go hungry. I still have problems, but there is nothing I can do. A medical consultation costs 15 soles, and the ultrasound another 30 … it seems my stress settles in my stomach. And every day I feel pain, as if anxiety is taking over."

The costs add up. Research of clients similar to Meri indicates health costs can reach 10,000 soles, or US$3,000 for treating a heart attack. For a family living under the national poverty line of approximately $2.75 per day per capita in Perú, this can mean almost three years of wages. Financial

institutions that support the vulnerable poor and seek to improve their level of financial inclusion and resiliency to financial shocks are beginning to pay attention.

The microfinance markets in Perú and Ecuador are extremely competitive, with a diversity of institutions offering services to the poor. Many MFIs are looking for further diversification of their product mix to increase client loyalty as well as to reflect their commitment to meeting client needs. MFI leaders and staff report that illness is often a key factor in client problems with loan repayment and savings deposits, and that too often ill health causes clients to slip into poverty again—much like Meri did. An integrated program of microfinance and health-protection services is a means to deliver practical, powerful and coordinated tools to create lasting improvement in the economic and social welfare of MFI clients and their families.

Between 2011 and 2013, Freedom from Hunger, in partnership with Oikocredit and five microfinance institution (MFI) partners in Ecuador (Cooprogreso and FACES) and Perú (ADRA, FINCA Peru, Confianza/Caja Nuestra Gente), planned, developed and piloted health programs that link financial services with access to a range of health services. After market research and product design workshops, all but one of the MFIs listed above implemented health service packages that are described below in Table 1. Health education topics differed by program but included prevention of non-communicable diseases, planning ahead for health events and women's health. The education modules were complemented by linkages with health providers as well as a variety of health-financing mechanisms to pay for preventive or diagnostic care or health insurance. Table 1 below shows the total outreach at the end of the project period.

Table 1. MFI Partner Loan Clients and Outreach of Pilot Health Programs—June 2013

		Numbers of Clients for Different Types of Products					Total	
MFI Partners	Total MFI Loan Clients	Health Education	Health Days/ Brigades	Health Savings/ Prepaid Program	Health Loans*	Health Insurance	Clients Using Health Program	Percentage
Cooprogresso (Ecuador)	17,130	1,590	5,199		17,130	17,130	17,130	100%
FACES (Ecuador)	9,193	780					780	8.5
ADRA (Perú)	16,654	1,520		599			1,520	9
Confianza/Caja Nuestra Gente (Perú)[1]	95,852	X		X			X	--
FINCA Perú	16,134	3,263	804				3,263	20
TOTAL	154,963	7,153	6003	599	17,130	17,130	22,693	14.5%

* Access to health loans. No use of loans reported as of May 2013.

Included in the pilot programs were pre- and post-test surveys to understand key health needs as well as track progress over time. This technical brief covers the health knowledge, attitudes, practices and outcomes that were documented during these monitoring and evaluation efforts. The purpose of sharing this data is to provide a better understanding of the needs and demands for health products and services as well as the role MFIs are playing in improving the health of their clients.

Methods

All five of the MFIs listed above participated in quantitative pre-test surveys that covered topics such as key knowledge, attitude, behavior, and outcomes through questions regarding preventive health care; direct and indirect costs of illness and seeking care; attitudes towards saving and preparing for health events; reported illnesses; women's health; children's health; financial behaviors

[1] Confianza went through a merger during the pilot period. They had ambitious plans to provide health education, a voluntary health savings product, and linkages to discounted services with health providers.

such as whether they saved money specifically for health and emergencies; chronic illnesses; and use and knowledge of insurance.

The surveys were collected using Lot Quality Assurance Sampling[2] (LQAS, a random sampling tool for collecting 19 surveys in each of five program areas for a total of 95 surveys). Approximately 450 surveys were completed in total with the five partners across Ecuador and Perú. During the project period, only two partners were able to complete a post-test—ADRA and FINCA Perú. While multiple indicators were collected with each partner, we will focus on the indicators that were collected across all the partners and the few that were most important for understanding the potential future benefit of the proposed health benefits packages at each partner. Most of the analysis provided here focuses on the pre-test data since we were unable to collect post-test data with all partners. While post-test data is presented here for two of the partners, we will not be making pre- and post-test comparisons and will instead, be describing trends and similarities among partners to paint a picture of general health outcomes and status of clients.

Results

The results below (Tables 2 and 3) are presented in a dashboard as a way to make easy comparisons of the data. The data primarily focuses on reported illnesses in the last six months, estimated costs incurred when there was illness in the household, whether they set money aside for health, whether they have used their business loans for health expenses and whether they have had a general medical exam in the last 12 months. Thematic learnings that arise from all five partners are highlighted following the tables.

Table 2. Andes Integrated Health and Microfinance Dashboard— Ecuador

Partner	Cooprogreso	FACES
Baseline Evaluation Findings (summary)	***Baseline (n=89)*** • 62% had an illness in the family in the last six months • Estimated average of $91 for the reported incidence of illness • 26% have set money aside for health • 36% have used part of their business loans for health • 60% have some sort of health insurance • 16% have used their health insurance in the last six months • 23% have been diagnosed with a chronic illness • 12% have had a general exam in the last year • 46% have had a Pap Smear in the last year	***Baseline (n=95)*** • 32% had an illness in the family in the last six months • Estimated average of $63 for the reported incidence of illness • 5% have set money aside for health • 5% have used part of their business loans for health • 28% have some sort of health insurance • 0% have used their health insurance in the last six months • 9% could name three of the five exams they should have each year • 7% have been diagnosed with a chronic illness • 6% have had a general exam in the past year. • 3% have had a Pap Smear in the last year

[2] Valadez, J., W. Weiss, C. Leburg & R. Davis. (2003). *Assessing community programs: A trainer's guide. Using LQAS for baseline surveys and regular monitoring*. St. Albans, UK: Teaching-aids At Low Cost (TALC).

Table 3. Andes Integrated Health and Microfinance Dashboard— Perú (continued)

Partner	ADRA	CONFIANZA	FINCA Perú
Baseline Evaluation Findings (summary)	***Baseline (n=95)*** • 62% had an illness in the family in the last six months • Estimated average of $426 for the reported incidence of illness • 47% have set money aside for health • 41% have used part of their business loans for health • 7% could name 3 of the 5 exams they should have each year • 36% were diagnosed with a chronic illness • 13% have had a general medical exam in the past year • 16% have had a Pap smear in the past year	***Baseline (n=95)*** • 63% had an illness in the family in the last six months • 16% had gone to a medical clinic for treatment • Estimated an average of $94 for the reported illness • 46% have set money aside for health • 12% have used part of their business loans for health • 23% could name 3 of the 5 exams they should have each year • 11% have been diagnosed with a chronic illness • 28% have had a general medical exam in the past year • 40% have had a Pap Smear in the past year	***Baseline (n=95)*** • 49% had an illness in the family in the last six months • Estimated average of $351 for the reported illness. • 54% have set money aside for health • 29% have used part of their business loans for health • 39% have been diagnosed with a chronic illness • 27% have had a general exam in the past year. • 39% have had a Pap smear in the past year • 5% have had new symptoms related to an illness in the female reproductive system
Endline Evaluation Findings (summary)	***Endline (n=95)*** • 51% have set money aside for health • 27% have used part of their business loans for health • 22% could name 3 of the 5 exams they should have each year • 45% were diagnosed with a chronic illness • 32% have had a general medical exam in the past year • 33% have had a Pap smear in the past year • 81% could name at least 1 medical service provided in ADRA's health program • 64% had used at least 1 health service as provided in ADRA's health program	Not applicable (no health program launched during project period).	***Endline (n=95)*** • 45% had an illness in the family in the last six months • Estimated average $547 on reported incident of illness • 43% have set money aside for health • 27% have used part of their business loans for health • 31% have had a general exam in the past year • 19% have had new symptoms related to an illness in the female reproductive system • 94% had heard of a FINCA health campaign • 15% received services at a FINCA campaign

Reported Illness

Between 32 and 63 percent of clients across all five organizations in Ecuador and Peru at baseline reported having an illness in their household in the last 6 months, with most reporting closer to 63 percent and an average of 54 percent.

Chronic Illness

On average, 23 percent have been diagnosed with a chronic illness, with a range of 7 percent to 39 percent. Clients reported being diagnosed with diabetes, osteoporosis, gastritis, cancer, heart disease, arthritis, high cholesterol, kidney disease, and high blood pressure.

Estimated Health Costs

The range of health costs was wide, from an average of $63 to $426. Those reporting on the lower end most frequently mentioned the cause of illness to be a childhood illness, such as influenza and

cough. Those reporting on the higher end report chronic illnesses or major health events such as surgery for gastritis or a hernia. However, some clients at Cooprogreso, for example, reported high costs for seeking treatment for relatively simple illnesses (up to $600 for influenza). On average, they spent up to $83 on these illnesses. Overall, they lost an average of $91 due to illness in the household in the past six months and approximately seven days of work. Clients at FACES lost up to 5 days of work due to illnesses and clients at FINCA Peru lost up to 27 days of work due to illnesses in their household. This data demonstrates the significant impact illness can have on a family in terms of direct and indirect costs.

Saving for Health

Five to 54 percent of microfinance clients across Peru and Ecuador reported setting money aside for health. Five percent was reported among FACES clients, and the remaining report closer to half. At FACES, about a quarter also reported having access to health insurance, which may have explained the lower propensity to save; however, a larger percentage of clients at Cooprogreso also report having health insurance (60 percent), so access to health insurance would not fully explain the low reported savings for future health expenditures at FACES. The finding that almost half of all these clients are saving money for future health expenses demonstrates the need for mechanisms to protect these health savings and the need for financial protection tools related to ongoing health needs and health crises.

Use of Business Loan for Health

On average, 30 percent of clients reported using part of their business loan for health expenses. The range was 5 percent to 41 percent. Research conducted under Freedom from Hunger's original Microfinance and Health Protection Initiative[3] with 5 MFIs found a similar range between 11 and 43 percent of clients reporting using a percentage of their microenterprise loans for health expenses.

Access to and Use of Health Insurance

Only the two partners in Ecuador collected data on knowledge, access and use of health insurance. Between 28 and 60 percent of clients reporting having health insurance, but a much smaller subset, between 0 and 16 percent had actually used their health insurance. Clients at Cooprogreso mentioned having access to and using Cooprogreso's health insurance product along with "Seguro Campesino" which is a national level insurance scheme for the rural poor. Most of the clients at FACES mentioned having Seguro Campesino however none of them had used it. There was very low knowledge about insurance policies at Cooprogreso, although attitudes toward health insurance appear positive: 94 percent agreed that health insurance could help reduce health expenses and 93 percent felt that insurance could bring peace of mind. Therefore, education and marketing were clear needs to increase usage of existing insurance as well as to promote and inform clients about new insurance products on offer.

[3] Between 2006 and 2010, with support from The Bill & Melinda Gates Foundation, Freedom from Hunger launched its Microfinance and Health Protection (MAHP) initiative. Five partners participated in this initiative: CARD (Philippines), CRECER (Bolivia), Bandhan (India), RCPB (Burkina Faso), and PADME (Benin).

Annual Medical Exams

Knowledge on the five basic exams a woman should have on an annual basis was relatively low across all clients. Between 7 and 23 percent of clients could name at least three of the following: general medical exam, blood pressure test, breast exam, blood test for diabetes, and a Pap smear. When asked whether they had had a Pap smear (average of 29 percent, range of 3 to 46 percent) or general exam (average of 15 percent) in the last year, more reported having a Pap Smear than a general exam. At FACES, where we see the lowest report of going for any time of annual exam, most reported having gone for blood work for diabetes—27 percent of clients had had this exam.

Changes in health knowledge, attitudes, and behaviors

The comparison of the pre- and post-test results with ADRA and FINCA Peru show an overall improvement in knowledge, health-seeking behaviors and positive financial choices. While the sample sizes are small, and this necessarily indicates that the average incorporates a + or – 10 percentage-point confidence interval, there are movements in a positive direction for several indicators.

At ADRA (Peru), for example, more clients knew at least three preventive medical exams a person should have each year, with most reporting knowledge of a general medical exam and Pap smears. While similar numbers of clients at pre- and post-tests (approximately 50 percent), indicated they had estimated their health costs in the past six months, they estimated having greater health costs (from 3,800 soles at pre-test to 5,800 soles at the post test; a 1,900 difference) at the post-test. This may be a sign of greater understanding of total costs (direct and indirect) or that that they were paying more attention to the actual costs.

Fewer at the post-test reported saving money for health (from 40 percent at pre-test to 22 percent at the post-test), and those who were saving reported saving less. This is likely a timing issue as a result of the post-test being administered after clients had already completed the ADRA prepaid/savings program for the clinic. It may also be related to a change in savings behavior because many of the clients still had unused health credit at the clinic from the prepayment program, reducing the need to save at this point in time, enabling them to direct savings to other financial needs. A related and positive finding is that fewer clients reported using part of their business loans for health costs at the post-test (from 41 percent at pre-test to 27 percent at post-test). Those who indicated they didn't use part of a business loan were asked about the sources of money they used to cover health costs. The most frequently cited source was savings, "guarded money" or health savings at ADRA. The remaining most frequently cited sources were money from the sale of assets or from their businesses.

At FINCA, the most important finding is an overall improvement in certain areas of health knowledge. More clients at the post-test could identify a service every woman should have an on annual basis (Pap smear, from 76% to 92%); more could name at least three exams every adult should have on an annual basis, and more clients could name at least one way to overcome menopause symptoms (from 7% to 39%). There were also high levels of knowledge about FINCA's health fairs and the types of services offered (in the 94% range), although at the time of the survey,

only 15 percent of clients reported having participated in the health fairs. Those who had participated were satisfied with the price of the health fair as well as the service they received.

Attitudes regarding confidence levels for covering future health expenses, addressing future health needs as well as steps they could take to avoid a chronic illness remained low (in the 25 percent range) and relatively unchanged between the pre- and t post-tests.

Overall, there were relatively low levels of behavior change, which could be expected given a very short evaluation period of 6 months to a year maximum. There was very little change in the number of clients that sought out such preventive care screenings as Pap smears, breast exams, blood pressure exams and blood tests. However, it is necessary to note that at both times, clients were asked about whether they had had these exams during the past year, but the evaluation period was only about six to seven months long. Therefore, given that health fairs are held approximately every six months, we may have simply captured the same people reporting preventive care behaviors at both points in time. Nevertheless, there appears to be opportunities to enable women to act on their improved knowledge in order to receive essential preventive services.

Conclusion

In 2006, when Freedom from Hunger launched its Microfinance and Health Protection (MAHP) initiative with 5 MFIs across Bolivia, Benin, Burkina Faso, India, and the Philippines, it set out to demonstrate that MFIs could add health services to their financial services for the good of their clients and their organizations. In 2010, Freedom from Hunger partnered with OikoCredit to replicate tested health services, such as health savings, health fairs and brigades, and linkages to health providers in the Andes. The pre-test results highlight the need for educating clients about the life-saving health exams they need to do every year, the need to help facilitate low-cost health exams for clients and linkages to health providers to address common as well as chronic illnesses faced by families and the need for health financing mechanisms.

While the microfinance and health sectors individually often work in earnest towards goals of improving the well-being of the poor, this work demonstrates how organizations in each sector can make joint and incremental contributions to improving lives. Neither sector is a substitute for the other—but they can find ways to combine services that are efficient, sustainable, and meet the needs of the poor in a holistic way.