Microfinance and Health:

A Case for Integrated Service Delivery

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ABSTRACT

World Bank sources indicate that more than 1 billion people live on less than a dollar a day worldwide. The Human Development Report 2003 states that out of 42 million people living with HIV/AIDS in the world, 39 million live in developing countries. The link between poverty and poor health is evident.

Poverty is a multidimensional problem requiring a comprehensive solution strategy. Microfinance institutions (MFIs) have emerged as an important strategy for poverty alleviation. Most MFIs focus on improving the poor people's incomes. By ignoring health and education as important needs of the poor, 'minimalist' MFIs (financial services only) provide an incomplete solution.

This paper identifies the value of MFIs focusing on fulfilling other basic needs of the poor by incorporating 'better health of clients' as a primary goal. By doing so, MFIs can have a greater impact on poverty alleviation. Though this presents a challenge for MFIs in terms of financial sustainability, MFIs cannot ignore their clients' health concerns. Health service provision strategies are outlined in the paper. MFIs must choose strategies appropriate to their internal and external context to balance social objectives and financial constraints. Poverty alleviation is successful only when all basic needs are fulfilled.

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I. Introduction

The Millennium Development Goals (MDGs), adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor by the year 2015. World Bank sources indicate that more than 1 billion people live on less than a dollar a day worldwide. The Human Development Report 2003 states that during the 1990s - though the percentage of poor worldwide declined from 30% to 23%, excluding China the number of poor has *increased* by 28 million.[1] And, more than 10 million children die every year from preventable diseases – nearly 30,000 *a day*. The link between poverty and poor health is well documented. Of 42 million people living with HIV/AIDS worldwide, 39 million are in developing countries.[2] National and international organizations recognize poverty is an urgent global problem, and focus attention to address this problem through many poverty alleviation strategies.

Microfinance institutions (MFIs) have documented success in poverty alleviation. Microfinance is financial intermediation through the distribution of small loans, acceptance of small savings and provision of other financial products and services to the poor.[3] Microfinance's contribution in poverty alleviation is reflected in the United Nations declaring 2005 as the 'International Year of Microcredit'. The Microcredit Summit Campaign, begun in 1997 with the goal of providing microfinance to a 100 million of the world's poorest families, states in its 2003 report that 41.6 million poorest clients have been gained access to financial services since 1997.[4]

Poverty is typically analyzed as an economic issue with level of income a common measure to determine individuals' well-being. The concept of poverty has now evolved to also include other deprivations such as lack of food, housing, clothing, education and healthcare. This paper explores poverty as a multi-dimensional problem with lack of income a significant, but not the only part of the problem. Poor people world-wide also lack adequate health care, education and civic participation.[5]

Given the multi-dimensional elements of poverty, solutions require multi-pronged efforts, with simultaneous action on multiple fronts.[6,7] Therefore, critics question the extent to which microfinance (with its emphasis on financial services for the poor) reduces poverty. This paper maintains though MFIs provide financial services to the poor, most address only part of the poverty problem. By ignoring health and education, 'minimalist' MFIs (financial services only) offer an incomplete solution. In many African countries, MFIs face a significant percentage of their clients infected with or at risk of HIV/AIDS.

[1] Human Development Report 2003. pg. 5
[2] Human Development Report 2003. pg. 8
[3] Joe Remenyi and Jr. Benjamin Quiñones (eds.), *Microfinance and Poverty Alleviation: Case Studies from Asia and the Pacific*. (New York, N.Y.: Pinter, 2000) pp. 7
[4] Daley-Harris, Sam. *State of the Microcredit Summit Campaign Report 2003*. pg. 3
[5] Dunford, Christopher. "Building better lives: Sustainable integration of microfinance with education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs." In Sam Daley-Harris(ed.) *Pathways Out of Poverty*. (Connecticut: Kumarian Press Ltd., 2002) pp. 78
[6] Sebstad, Jennefer and Monique Cohen. *Microfinance, Risk Management and Poverty*. Synthesis report generated under the AIMS (Assessing the Impact of Microenterprise Services) project at Management Systems International for USAID, March 2000. pp. 20
[7] Kazuo, Takahashi (ed.) *Globalization and the Challenges of Poverty Alleviation*. (Japan: The Foundation for Advanced Studies on International Development, 1998) pp. 83

Ignoring clients' health not only negates the ultimate poverty alleviation goal of the MFI but also threatens the institution's viability, as increasing number of clients are unable to pay back their loans.[8]

This paper highlights the necessity of incorporating health as a primary goal for MFIs and makes recommendations to take advantage of the MFI service model to provide comprehensive solutions to the problem of poverty. The recommendations are potentially transferable to education services, although further research is required.

The paper's first section provides a brief description of microfinance and highlights the positive impacts on client, their families and the community at large. It then presents the case for focusing on the positive externalities (specifically health), including them in institutions' primary goals. The second section offers strategies to accomplish better health and education. An example of a program incorporating health and credit services is provided. The analysis in this paper is meant to provide MFIs better understanding of client needs and how to (re)structure programs to increase impact addressing such needs.

II. Microfinance & the case for targeting health

Microfinance is financial intermediation through the distribution of small loans, acceptance of small savings and provision of other financial products and services to the poor.[9] MFIs are generally categorized by the scope of their products and services: a 'minimalist' approach (providing financial services only) or an 'integrated' approach (financial services and additional services are offered). MFIs share the common goal of poverty alleviation primarily achieved through increasing and diversifying income opportunities for the poor.

Microfinance focuses on providing poor people with access to credit, so they can engage in income-generating activities. Increased incomes are used to increase assets, including permanent houses or savings accounts, that offer recourse during hard times, and consumption, especially in food, nutrition, and education. Empirical data supports this.[10] Since many MFIs target women as potential clients, numerous studies have documented additional positive effects for women: increased empowerment and self-worth, improved gender relations within households, and decreased domestic violence.[11,12] Edmark and Ericson's study on the impact of microcredit on children's schooling provides specific examples of positive impacts from increased household income.[13]

Despite documented positive impacts like female empowerment, children's schooling, and better health, poverty persists, and critics contend these benefits are limited in both size and scope. In order to accomplish all encompassing poverty alleviation, including better health and education, these issues require specific program targeting. Successful intervention is not possible only through increasing incomes. As Streeten aptly expressed, "The choice is between precision bombing and devastation

[8] Parker, Joan, Ira Singh, and Kelly Hattel. *The Role of Microfinance in the Fight Against HIV/AIDS*. A report to the Joint United Nations Program on HIV/AIDS developed by Development Alternatives, Inc., 2000.
[9] Remenyi and Quiñones (eds.), 2000, pp. 7
[10] Sebstad and Cohen, 2000, pp. 50
[11] Sebstad and Cohen, 2000, pp. 59
[12] Mizan, Ainon Nahar. *In Quest of Empowerment: The Grameen Bank Impact in Women's Power and Status*. (Bangladesh, Dhaka: The University Press Limited, 1994).
[13] Edmark, Karin and Erica Ercison. "Impact of Microcredit on Children's primary and secondary schooling" in *Grameen Dialogue* published by Grameen Trust, April 2002.

bombing."[14] MFIs with scarce resources can apply them more efficiently to yield greater impact on poverty alleviation.

One strategy to increase the impact of the microfinance on poverty alleviation is by focusing on 'better health' as an important goal for the MFI. Three reasons for MFIs to incorporate better client and family health as a primary goal are:

1. ***To provide a more comprehensive poverty solution***: For MFIs to better achieve poverty alleviation, they need to recognize clients' non-financial needs and facilitate satisfaction of such needs. Poor people will not break out of the circle of poverty without significant health and education improvements.[15] Though MFIs have been effective raising incomes, income change alone is insufficient to mitigate health problems. A study commissioned by the Microcredit Summit Campaign states: "public health researchers have long appreciated that increasing income and assets alone is a relatively slow and insufficient strategy for combating many serious ills, such as child malnutrition, the spread of HIV/AIDS and women's lack of choice in determining the number and timing of pregnancies." Better health is not only a necessary component of poverty alleviation; it can also be a *complementary* strategy. WHO's Commission on Macroeconomics and Health (CMH) indicates health is also, "a means to achieving other development goals relating to poverty reduction." Better health increases people's productivity, thereby adding significant value to income-generation. A person works harder when healthy, and avoid expenses by not having medical bills.[16] Therefore, health programs are valuable complementary strategies.

2. ***For MFI sustainability and performance***: Loan default and customer attrition are major problems confronting MFIs, directly impacting their operations and even survival. By addressing clients' health needs, MFIs can reduce loan defaults and increase income.

   Grameen Bank reports that, among its clients, illness and related expenditures are the leading cause for micro-business failures and loan default.[17] The negative impacts of poor client health on MFIs include:[18]

   - Delayed loan repayment
   - Inability to repay loans, resulting in default
   - Poor attendance at MFI group meetings
   - Decrease in client business performance, due to neglect and redirection of capital
   - Undermining MFI client group solidarity

   A microcredit impact study showed that medical expenses are a determining factor in endangering household budgets.[19] People identify illness and death as the most frequent and devastating economic shocks.[20] Sick people cannot work as well or engage in income generating activities.

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[14] Streeten, Paul. *Development Perspectives*. (London: The MacMillan Press Ltd., 1981) pp. 337

[15] Economic and Social Commission for Asia and the Pacific. *Showing the Way: Methodologies for Successful Rural Poverty Alleviation Projects*. United Nations Publication, 1996. pp. 36

[16] Kazuo, pp. 152

[17] *Grameen Health Centers Serve Thousands* in Grameen Connections, Vol 3(4), Fall 2000. Available at http://www.gfusa.org/newsletter/fall00/health.shtml

[18] Noble, Dr Gerry, Managing Director, Microcare Ltd. *Healthy Wealthy and Wise: An Introduction to Microfinance based Group Health Schemes.* Available at http://microinsurancecentre.org/index.cfm?fuseaction=resources.detaildoc&showcontributorID=36

[19] *Experimenting with a micro-health insurance system in Cambodia: the EMT example*. Available at http://www.microfinancegateway.org/viewpoint_microhealthins.htm

Chronic illnesses, particularly HIV/AIDS, pose serious threats to MFIs' activities. It is not a co-incidence that HIV/AIDS is emerging as major problem in precisely the geographic locations that MFIs work in – poverty is the common factor in both cases. There is significant overlap between the target population for microfinance and populations affected by this disease – people who are 25-40 years olds, poor, uneducated and lack access to health services. In countries with high incidence of HIV/AIDS, approaching 30% in parts of Africa, MFIs are struggling to operate successfully.

MFI client targeting to women exacerbates this issue, as women are usually more susceptible to health problems. In case of sick family members, women nurse and care for them. Poor women face increased health risks due to overwork and susceptibility to gynecological child-bearing related problems. Thus, the weak health of MFI female clients and their families adversely affects their engagement in economic activity and loan repayment. Such client problems directly impact MFI loan recovery and threaten financially self-sustainable organizations.

3. ***MFIs have unique capabilities to facilitate health services***: There are extensive challenges to deliver health services to poor people. MFIs have unique characteristics well suited to address some of these difficulties.

   MFIs can play an instrumental role in bringing health services to their clients. Effective outreach is a major problem when targeting poor people. MFIs provide regular access to the poor, applicable for health service delivery. Many MFIs have group-based delivery mechanisms where clients form groups that meet at regular intervals for loan administration. This group-based forum is an appropriate venue for health education services.[21] Additional MFI program delivery systems include branch locations in poor areas, client relationships, and home site visits. These channels are also effectively in providing health services. For example, studies document women increase healthcare service access when available locally.[22]

   Increased health services availability is an insufficient poverty alleviation mechanism without complementary efforts to improve incomes and education. By itself, health intervention impact is minimal and not cost-effective.[23] For example, individual health programs providing information on better nutrition are incomplete without methods to increase income to purchase food. MFIs providing opportunities to increase income and social support group development help overcome the socio-economic hurdles, maximized in conjunction with increased access to health facilities.

The above discussion highlights the various reasons why MFIs need to include 'better health' as a primary goal and provide products and services to fulfill the same. There are mission related and market focused incentives. Institutions may also have additional motivations to apply non-financial services to their programming. In competitive markets, value added services, like health offerings, differentiates the MFI and may provide competitive advantage.

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[20] Sebstad and Cohen, 2000, pp. 45

[21] Dunford, Christopher. "Building better lives: Sustainable integration of microfinance with education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs." In Sam Daley-Harris(ed.) *Pathways Out of Poverty.* (Connecticut: Kumarian Press Ltd., 2002) pp. 82

[22] Mizan, 1994, pp. 153

[23] Mosley and Chen, 1984, pp.4

III. Strategies to align Microfinance & Health

In the microfinance industry, despite the identified importance to address client health and increasing recognition to address non-credit client needs,[24] there is no industry consensus how to target this need. The biggest concern is MFI sustainability. Although clients may benefit from non-financial services, they may not be willing (or able) to pay enough to cover the costs of service provision. Therefore, offering such products and services adds to MFIs' costs but may not lead to a corresponding revenue increase.

> "Microfinance practitioners are often motivated to provide nonfinancial services to their clients, because they recognize the need and hear the demand. However, the legitimate concern for sustainability, interpreted as the financial viability of the microfinance service as a business, has made practitioners very cautious about nonfinancial add-ons. They believe that add-ons can only be a drag on the drive for sustainability."[25]

While a valid operational concern for the MFI, the sector cannot ignore client health concerns. Microfinance balances the 'double bottom line', of financial and social objectives.[26] Once an MFI incorporates 'better health' as a primary poverty alleviation goal, the challenge is to identify affordable and sustainable strategies to achieve this goal.

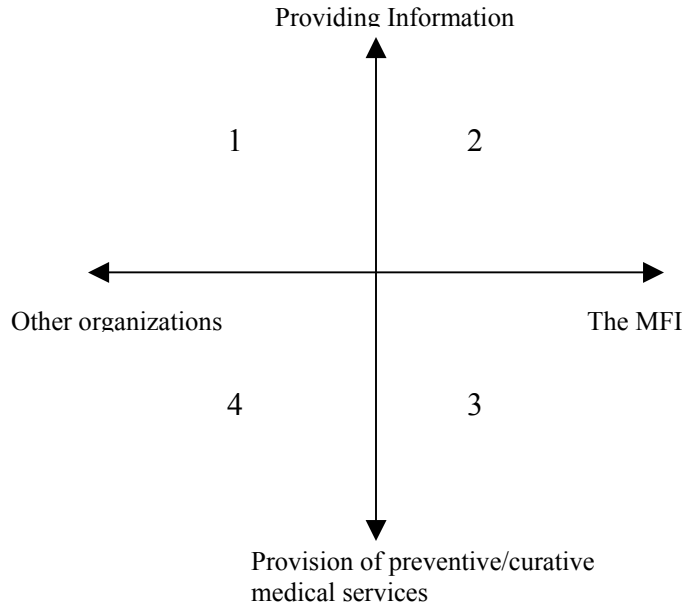
The following figure displays potential strategies for MFIs in health delivery in related context. The appropriate strategies, or combination of strategies, depends on many factors, including the MFI's organizational structure and capacity, as well as the socio-economic, cultural and political context in which they operate

[24] Sebstad and Cohen, 2000, pp. 47

[25] Dunford, Christopher. "Building better lives: Sustainable integration of microfinance with education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs." In Sam Daley-Harris(ed.) *Pathways Out of Poverty.* (Connecticut: Kumarian Press Ltd., 2002) pp. 62.

[26] Simanowitz, Anton, and Alice Walter. "Ensuring Impact: Reaching the Poorest While Building Financially Self-Sufficient Institutions, and Showing Improvements in the Lives of the Poorest Women and Their Families." In Sam Daley-Harris(ed.) *Pathways Out of Poverty.* (Connecticut: Kumarian Press Ltd., 2002) pp. 62.

Figure 1: Mapping Strategies for Integrated Health and Credit Services



In the figure above, the x-axis signifies the service provider; ranging from the MFI to other organizations, including non-governmental organizations (NGOs) or government programs. In between the ends are partnerships, collaborations, and other hybrids. The y-axis denotes the range of health services provided; from information/education, for example about healthy living habits, to full health service provision (i.e., preventive and curative).

Quadrants 1 and 4 involve strategies where MFIs link with other organizations. These strategies have been widely applied in the context of HIV/AIDS where MFIs have partnered with other NGOs and/or government programs that provide informational sessions, workshops and treatment options for HIV-affected clients and family members. Strategies that lie in Quadrant 2 are most common and usually the least expensive for MFIs. These can be as basic as incorporating Grameen Bank's 'Sixteen Decisions'. Strategies in Quadrant 3 are most seen by larger MFIs with organizational capacity to add new services themselves.

Detailing specific strategies highlights MFI options. The Microcredit Summit Campaign report also explores health service strategies by differentiating between linked, parallel, and unified delivery: [27]

- ***Linked*** **service delivery by two or more independent organizations operating in the same area.** *In this channel, financial services are offered by a specialist microfinance institution at the same time as nonfinancial services (health, education and others) are offered by one or more independent specialist or generalist organizations—to the same people in need.*

[27] Dunford, Christopher. "Building Better Lives: Sustainable Integration of Microfinance with Education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs". In Sam Daley-Harris(ed.) *Pathways Out of Poverty.* (Connecticut: Kumarian Press Ltd., 2002) pp. 80.

The linked service delivery model is well represented in the industry. Some MFIs have developed 'innovative' linkages. For example, SEWA (Self-Employed Women's Association) in India has an exchange program with a medical college where students require rural internship training. Student interns provide curative care and preventative health education to SEWA clients.[28] There are also HIV/AIDS linked service delivery model examples. FINCA and Opportunity International are partnering with other community service organizations to provide informational workshops on HIV/AIDS prevention and care as part of the African Microenterprise AIDS Initiative.[29]

- ***Parallel*** **service delivery by two or more programs of the same organization operating in the same area.** *A generalist or multi-purpose organization (often a grant-mobilizing local, national or international private development organization) offers microfinance services through a specialist microcredit program staff at the same time as offering other sector services through different program staff of the same organization—to the same people in need.*

The Grameen family of companies may be seen as an umbrella organization that serves to fulfill different needs. Grameen Bank is the microcredit providing institution. Grameen Kalyan is the rural healthcare provider. Though these organizations work individually in their specific sector areas, there is considerable overlap in populations served.[30] Grameen Kalyan Centers are located close to the Bank branches; borrowers have ready access to both. Products and services are designed to complement each other.

- ***Unified*** **service delivery by one organization, one program, and one staff.** *The same staff of the same organization offers both microcredit and other sector services—to the same people in need.*

This model is usually applicable when services are provided in remote, sparsely populated areas, which do not justify the existence of two separate service providers. Here staff training is important to ensure successful multiple client services.

MFIs can apply a strategy or strategies best suited by considering internal institutional qualities and market factors. For example, SEWA realized the importance of health services for women and began a maternal protection scheme. The organization linked women to prenatal services for a nominal fee (linked delivery) and conducted training courses for local midwives (unified service delivery).[31]

There are numerous methods for MFIs to address client health issues and design cost-efficient program delivery to achieve these objectives. Methods to provide 'integrated' services to the poor, include:[32]

- Common service areas: defining the same geographic boundary for all services in an area
- Co-Location: Placing a number of services "under one roof"
- Joint Core Services: share services outreach, intake, diagnosis and evaluation, referral, follow-up, and transportation chores
- Case Planning: a number of specialists design a program to meet multiple client needs
- Case Management: a single service worker is assigned to address client service needs
- Joint Management Services: use specialized staff, shared equipment and consultative service
- Common eligibility and/or common application forms and shared client data

[28] Rose, Kalima. *Where Women are Leaders: The SEWA Movement in India*. (New Delhi: Vistaar Publications, 1992) pp. 254
[29] Parker et. al, 2000.
[30] *Grameen Health Centers Serve Thousands* in Grameen Connections, Vol 3(4), Fall 2000. Available at http://www.gfusa.org/newsletter/fall00/health.shtml
[31] Rose, 1992, pp. 27.
[32] Paiva, J.F.X. and Ledivina V. Cariño, (eds.) *Increasing Social Access to Basic Services*. For United Nations Children's Fund and Asian and Pacific Development Center. (Kuala Lumpur: Polygraphic Press, 1983). pp. 34

MFIs have numerous options to provide non-financial client services. Though MFIs need to take the initiative in providing 'integrated' services to their clients, donors and policy-makers also play a critical role in promoting partnerships between service providers. A strategic approach that builds linkages between social service providers is needed for effective and coordinated poverty alleviation interventions.

IV. Credit with Education: A Success Story

There are an increasing number of microfinance and health delivery examples. Many are quite new, so quantitative data is limited. Best practices are beginning to emerge, with increased industry attention. Associations like SEEP, the Small Enterprise Education Program, now holds panels on the subject at its annual meeting.[33] Program designs vary greatly with different goals, and not all emphasize the 'double bottom line' maximizing financial success and social benefits.

The Credit with Education Program implemented by Freedom From Hunger[34] is considered one of the most successful double bottom line programs incorporating health education with credit services. Credit with Education follows a *unified delivery service model.* A field officer fulfills dual responsibilities of administering loans and leading education sessions. By having the field officer also conduct the health education sessions as part of regular group meeting, the costs of the added service are low.

Controlled, multi-year research studies have documented Credit with Education programs produce comparable impacts on income and asset generation as standalone microfinance programs. Incorporating additional services like health education does NOT diminish credit service impact. More interestingly, Freedom From Hunger research documented significant improvements in children's nutritional status and intake of calories for Credit for Education program clients. MFIs providing integrated services have also been able to achieve financial self-sufficiency. The Credit with Education programs offer one example of how MFIs can better serve the needs of their clients without compromising the service quality or financial viability.

V. Conclusion

A billion people live on less than a dollar a day. The United Nations aspires to halve this number by 2015 led by its Millennium Development Goals. Poverty is a multidimensional problem requiring a comprehensive approach.

Microfinance is now established as an important poverty alleviation tool, although most MFIs exclusively focus on income generation for poor people. This is only a partial solution. MFIs need to target other 'basic needs' of the poor, including health and education. Though this adds challenges for MFIs, particularly for financial sustainability, MFIs cannot ignore clients' health concerns. There are multiple strategies to connect health interventions to financial services. Institutions must choose options based upon their specific characteristics like size, population served, and socio-economic and political context. There are increasing examples of successful credit and health programs. Freedom From Hunger, with its Credit with Education model, has best documented this area, the health impacts provided, and the continued financial success of partner MFIs. Microfinance client economic and physical well-being is vital towards a better tomorrow. Poverty alleviation is successful only when all basic needs of poor people are fulfilled.

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[33] SEEP Network Annual Conference, www.seepnetwork.org

[34] Dunford, Christopher. "Building Better Lives: Sustainable Integration of Microfinance with Education in Child Survival, Reproductive Health, and HIV/AIDS Prevention for the Poorest Entrepreneurs". In Sam Daley-Harris(ed.) *Pathways Out of Poverty.* (Connecticut: Kumarian Press Ltd., 2002)

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