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**From Microfinance
 to Macro Change:**
 Integrating Health Education
 and Microfinance to Empower
 Women and Reduce Poverty



“Microcredit is a critical anti-poverty tool and a wise investment in human capital. Now that the nations of the world have committed themselves to reduce by half by the year 2015 the number of people living on less than \$1 a day, we must look even more seriously at the pivotal role that sustainable microfinance can play and is playing in reaching this Millennium Development Goal.”

—Kofi Annan, United Nations Secretary General



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Executive Summary

Development priorities for governments, donors and practitioner agencies worldwide are guided by the Millennium Development Goals (MDGs)—a set of targets for reducing extreme poverty and extending universal rights by 2015. If the MDGs are achieved, it would represent enormous progress toward the United Nations Population Fund's (UNFPA's) vision that, worldwide, “every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.” As the *Human Development Report 2005* (HDR 2005) warns, however, the promise of the MDGs will not be fulfilled if current trends continue. In fact, UN Secretary General Kofi Annan has said, “The Millennium Development Goals can be met by 2015—but only if all involved break with business as usual and dramatically accelerate and scale up action now.”

The time has come for action. This document calls on development agencies, governments, microfinance institutions (MFIs), and donors to help realize the goal of health and equal opportunity for all by investing in strategies with proven impact on the problem of global poverty and poor health. It proposes one specific strategy that acknowledges the intimate relationship between poverty and poor health, and has proven impacts for very large numbers of the poor and very poor¹. This proposed strategy is the combination of microfinance and reproductive health education.

Dramatic findings are emerging on the macro level that support the importance of microfinance. A 14-year study by the World Bank of three MFIs in Bangladesh finds that 40 percent of the *entire* reduction of poverty in rural Bangladesh was directly attributable to microfinance². Juxtaposed with other countrywide data presented in the HDR 2005, this evidence is even more powerful. The HDR 2005 cites Bangladesh's successes in human development by comparing it to India, a country with much higher income and economic growth, but lesser progress toward human development goals. It declares that, “Had India matched Bangladesh's rate of reduction in child mortality

over the past decade, 732,000 fewer children would die this year.” The HDR 2005 presents four strategies directly contributing to Bangladesh's advances, including “*expanded opportunities for employment and access to Microcredit.*”

Despite the impressive impacts of microfinance services on poverty, health, and empowerment, the development community realizes other services and strategies—besides credit—must be made available to create a web of support to help families lift themselves out of poverty. Two organizations in Bolivia, CRECER and Pro Mujer, are already successfully combining microfinance services with reproductive health education, while also reaching large numbers of poor clients and achieving financial self-sufficiency. Summaries of case studies on both institutions appear in the third section of this document.

Many believe that microfinance could maximize its potential by integrating other complementary services within the infrastructure of the financial services. While others have taken the integration of microfinance and health education to profound levels within their own institutions, the U.S.-based non-governmental organization Freedom from Hunger has for years been leading the charge globally and, as a result, microfinance programs in many regions have successfully offered basic health information to clients along with financial services. **If reproductive health education were to be integrated on a massive scale with microfinance services for the very poor worldwide, then the true potential of microfinance to empower women and offer a dignified route out of poverty could be realized.**

The final section of this document offers eight concrete recommendations for action to realize the potential of combined services. Inherent in all eight actions is the crucial role that development agencies, governments, MFIs and donors can play in supporting integrated reproductive health education and microfinance services, while also championing microfinance as one of the pillars for meeting the Millennium Development Goals.

¹ In this document, “very poor” is defined as those who are in the bottom half of those living below their nation's poverty line, or any of the 1.2 billion who live on less than US\$1 a day adjusted for purchasing power parity (PPP).

² The four largest programs in Bangladesh have a combined total of more than 15 million clients affecting some 75 million family members, equal to more than half the population of Bangladesh.

Introduction

The microfinance movement is bringing hope, prosperity, and progress to many of the poorest people in the world.

—Amartya Sen, Lamont University Professor, Harvard University, Nobel Laureate in Economics (1998)

This document is a call to action for development agencies, governments, MFIs and donors that are committed to finding practical strategies to fulfill the shared vision for human development. Built upon the backbone of a poverty alleviation mechanism already reaching more than 66.6 million of the world's poorest families, **the proposed strategy calls for combining reproductive health education with microfinance services in developing countries.**

The first section of the document acknowledges and reviews the intimate link between poverty, poor health outcomes and inequality. The next section presents microfinance as an effective poverty reduction strategy and reviews the evidence for its impact on poverty as well as its broader impacts. The third section proposes microfinance as a vehicle for improving reproductive health outcomes, HIV prevention and women's empowerment by combining health education with microfinance programs. Summaries of case study institutions in Bolivia that are already employing this strategy are presented, along with evidence of the impact of combined microfinance and health education services. Finally, recommendations for action are made to development agencies, governments, MFIs and donors to promote and expand this essential strategy.

The Millennium Development Goals

- 1. Eradicate extreme hunger and poverty.** Halving the proportion of people living on less than \$1 a day and halving malnutrition.
- 2. Achieve universal primary education.** Ensuring that all children are able to complete primary education.
- 3. Promote gender equality and empower women.** Eliminating gender disparity in primary and secondary schooling, preferably by 2005 and no later than 2015.
- 4. Reduce child mortality.** Cutting the under-five death rate by two-thirds.
- 5. Improve maternal health.** Reducing the maternal mortality rate by three-quarters.
- 6. Combat HIV/AIDS, malaria and other diseases.** Halting and beginning to reverse HIV/AIDS and other diseases.
- 7. Ensure environmental stability.** Cutting by half the proportion of people without sustainable access to safe drinking water and sanitation.
- 8. Develop a global partnership for development.** Reforming aid and trade with special treatment for the poorest countries.

Poverty, Poor Health and Inequality

For every child who dies, millions more will fall sick or miss school, trapped in a vicious circle that links poor health in childhood to poverty in adulthood. Like the 500,000 women who die each year of pregnancy-related causes, more than 98% of children who die each year live in poor countries. They die because of where they are born.

—Human Development Report 2005

Poverty, poor health and inequality are so intimately connected that distinguishing between the causes of one and effects of another is virtually impossible. The more than one billion people on this planet who live in extreme poverty, especially the women, bear a hugely disproportionate burden of the world's sickness, poor health and inequality. Every minute, a woman dies from complications in pregnancy and childbirth, and 20 more suffer serious complications—the majority of these poor and living in developing countries.

A woman living in poverty is more likely to bear too many children too close together at too young an age; die during childbirth; bear an underweight baby; contract HIV; and witness the death of her young children. The lack of adequate financial resources limits the ability of poor families to handle these traumatic health events that often plunge them into an even worse economic situation from which, generations later, they still have not recovered.

The more than one billion poor people on this planet who live in extreme poverty, especially women, bear a hugely disproportionate burden of the world's sickness, poor health and inequality.

The Results of Poverty, Poor Health and Inequality

- One in five people in the world—more than one billion people—still survive on less than \$1 a day, a level of poverty so abject that it threatens survival. Another 1.5 billion people live on \$1–\$2 a day. More than 40% of the world's population constitute, in effect, a global underclass, faced daily with the reality or the threat of extreme poverty.

- In 2004 an estimated three million people died from [HIV], and another five million became infected. Almost all of these deaths were in the developing world, with 70% of them in Africa.
- An estimated 530,000 women die each year in pregnancy or childbirth....At least 8 million women a year suffer severe complications in pregnancy or childbirth, with grave risks to their health....the vast majority of these deaths occur in developing countries.

Source: Human Development Report 2005

Conversely, poor families with access to even modest increases in financial resources can better manage the health problems that occur. Money generated from a small business, for example, contributes to household income, which can improve the family's food security and support the children's education. A family with even small amounts of savings can use them to more quickly manage and recover from traumatic events, such as the death or illness of a wage earner.

Increases in household income are not the whole story for reducing poverty and poor health outcomes—neither can be achieved without gender equality and empowerment of women. Research has shown that inequalities in gender and women's lack of empowerment inhibit economic growth and development. A World Bank report on gender equality states, “In no region of the developing world are women equal to men in legal, social, and economic rights. Gender gaps are widespread in access to and control of resources, in economic opportunities, in power and political voice. Women and girls bear the

“We know that poverty is not just about lack of money; it is also about lack of choice. This is particularly true for women. Today, many women cannot make their own choices about pregnancy and childbearing; they cannot make their own choices about seeking medical care. These choices are made for them and, in the worst cases, there simply are no choices.”

—Thoraya Ahmed Obaid,
Executive Director, UNFPA

largest and most direct costs of these inequalities—but the costs cut more broadly across society, ultimately harming everyone.”³ The MDGs recognize the importance of empowerment and gender equality to eliminating poverty by including it as the third of the eight goals: “Promote gender equality and empower women.”

Improved reproductive health is also a key factor to reduce poverty, improve health outcomes and promote gender equality. On a global scale, promoting access to reproductive health information and resources for poor families will yield positive results on multiple development fronts. The UNFPA document, *Beijing at Ten: UNFPA's Commitment to the Platform for Action*, succinctly makes this point when it states:

The ability of women to control their own fertility is absolutely fundamental to women's empowerment and equality. When a woman can plan her family, she can plan the rest of her life. When she is healthy, she can be more productive. And when her reproductive rights are promoted and protected, she has freedom to participate more fully and equally in society.

Progress toward many of the worldwide development goals mentioned previously can be achieved when the increased economic status of poor families is coupled with improvements in the area of reproductive health. A family with fewer children that is free from sickness and disease is better equipped to utilize, invest and grow its scarce financial resources.

³“Engendering development through gender equality in rights, resources, and voices.” Report summary. <http://www.worldbank.org/gender/prt/engendersummary.pdf>

Microfinance:

An Effective Strategy to Reduce Global Poverty

Microfinance stands as one of the most promising and cost-effective tools in the fight against global poverty...First, there is clear evidence that microfinance can work for the very poor. Many among the very poor actively seek better ways to borrow, save, and purchase insurance—but find themselves too often rebuffed by state banks or traditional commercial institutions. Not all would make reliable customers, but microfinance practitioners have demonstrated that it is possible to serve large numbers of the very poor.

—Jonathan Morduch, Chair, United Nations Expert Group on Poverty Statistics, September 20, 2005

What Is Microfinance?

Microcredit means offering very small loans to poor people, usually women, to help grow their small-scale businesses or start new ones. After microcredit institutions realized in the 1990s that the poor need a variety of financial products (not just credit), microcredit became “microfinance,” expanding to include savings and other financial products, such as insurance.

The most common mechanism used by microfinance institutions to offer their services to clients is group-based lending. Borrowers form groups to mutually guarantee one another's loans. The groups meet weekly or biweekly to make loan repayments and to deposit savings. Loan cycles and repayment schedules for microcredit are short, usually four to six months, to account for the nature of most microbusinesses—enterprises with cash turnover on a daily and weekly basis. The interest charged on loans is always significantly lower than the rate charged by other credit sources for poor women, such as loan sharks and moneylenders.

A specified amount of savings is usually required in order for a group to receive a loan. For most women members,

their savings represents the first-ever opportunity to accumulate money for purchasing assets or emergency use. Field staff that support the microfinance groups are a critical component. They are usually the “face” of any microfinance program, as they attend all group meetings and train groups on how to elect leaders, decide on loan amounts and manage their own finances. Of course, each microfinance program is slightly different, but this basic methodology forms the foundation of most programs worldwide.

Why Are Microfinance Services Offered Primarily to Women?

- Women are a better credit risk than men.
- Women benefit from creation of a social network and increased level of empowerment, in addition to economic benefits.
- The group structure offers a source of mutual support and collective courage otherwise nonexistent for most women accessing microfinance services.
- Income directly and positively affects the health of family members when controlled by women and earned in small and regular amounts.

Microfinance Today

After three decades, the growth and expansion of microfinance services continues on an amazing upward trajectory. The Microcredit Summit Campaign reports more than 3,100 institutions of various types offering microfinance services to more than 92 million clients, over 80 percent of whom are women. The key priorities for microfinance practitioners in the coming decade are:

- to achieve large-scale outreach,
- to attain financial self-sufficiency,
- to reach a significant percentage of each nation's poor with microfinance services, and
- to play a significant role in reducing poverty

The Story of Sufia

Sufia Begum, from the district of Feni in Bangladesh, married Bachhu Mia before she was 13 years old. They had three children, but her husband married again and abandoned her and the children, whom Sufia had great difficulty feeding. Many times they had to starve along with her. The children didn't attend school and the family slept on the ground.

With no other way to survive, Sufia Begum resorted to begging. “There's nothing in my stomach,” she would tell a passerby. “For God's sake, would you please give me some food?” One day Sufia met Monwara, president of Basanti Landless Women's Group, members of ASA Bangladesh (an organization providing microfinance services). Monwara told Sufia about the loan program for the poor. Sufia worried that she would not be able to pay back a loan. Monwara encouraged her and Sufia took a loan of about \$40, which she used to purchase dry fish, biscuits, nuts, chocolate, and other foods. From her town in the Feni district, Sufia traveled to small, rural villages to sell her goods.

Instead of begging, Sufia began to say, “Do you need churi, shanka, dry fish, or chocolate?” Gradually the villagers began to see her as a regular trader and became routine customers. Sufia carried the food in a basket that rested atop her head.

By June of 2004, Sufia had repaid her loan and took another loan of about \$80, so that she could expand her business. With the profits she generated, Sufia bought a cot for her children to sleep on and put a tin roof on her family's house.

The Story of Ana

Before receiving a \$100 microloan to expand her tortilla business, Ana Ruiz of Nicaragua lived in a scrap-wood shack with her eight children. She had no furniture except for her worktable and her children never had shoes or attended school. After her second loan she was able to send her four oldest to school and buy eight plastic chairs so the children wouldn't have to sit in the dirt. Before her microloan, her children were malnourished. "The little ones run around now," she says. "They go to sleep early because they are tired from playing around, not because they are weak."

Several microfinance institutions, in countries such as Bangladesh, Bolivia and Uganda, have achieved the first two goals and substantially contribute toward the third and fourth goals. These institutions are proving that large numbers of the poor can be reached while also achieving financial self-sufficiency.

The 3,164 institutions that report to the Microcredit Summit Campaign estimate that 72 percent of their clients were among the poorest when they took their first loan. *The State of the Microcredit Summit Campaign Report 2005* asserts that, "Assuming five persons per family, the 66.6 million poorest clients reached by the end of 2004 affected some 333 million family members." What is most revolutionary about microfinance as a development strategy is the revolving nature of loan funds, its clear focus on reaching the very poor, and its success in doing so.

The Evidence for Microfinance's Impacts on Poverty

Microfinance clients manage their cash flows and apply them to whatever household priority they judge most important for their own welfare. Thus microfinance is an especially participatory and non-paternalistic development input. Access to flexible, convenient, and affordable financial services empowers and equips the poor to make their own choices and build their way out of poverty in a sustained and self-determined way.

—Is Microfinance an Effective Strategy to Reach the Millennium Development Goals? CGAP Focus Note No. 24 by Elizabeth Littlefield, Jonathan Morduch, and Syed Hashemi

The body of evidence for microfinance's impact on poverty has grown to such a level that the answer to the question, "Does microfinance really work as a poverty alleviation mechanism for the poor?" is a definitive "Yes," provided the services target the poor and the institution is well-run. While neutral and even negative findings can be teased out of any individual study, the totality of evidence identifies microfinance as a critical strategy for poverty reduction. Some of the most notable evidence for microfinance's impact on poverty includes the following findings:

- After a two-year period, participants in three Ugandan microfinance programs showed an increase in both assets and savings compared to a non-participant group, and reported greater profits from their microbusinesses (Barnes 2001).
- An evaluation in India discovered that three-fourths of members who participated for longer periods experienced marked improvements in their economic status (Todd 2001).
- A study of Grameen Bank clients in Bangladesh found that after eight to ten years in the program, 57.5 percent of participant households were no longer poor (Todd 1996).
- Another study in Bangladesh revealed that the funds lent to women produced a 20 percent return to income from borrowing in the form of household expenditures (Khandker 2005).

- Comparing poverty rates over a seven-year period, the same study found that poverty declined by 18 percentage points in program villages and 13 percentage points in non-program areas. Also, it estimated more than half the reduction in poverty among program participants to be directly attributable to microfinance (Khandker 2005).

Broader Impacts of Microfinance

Although sometimes more challenging to measure, evidence is clear that microfinance offers impacts for poor women and families well beyond changes in income and poverty level. Researchers have examined the effects of microfinance on women's empowerment and nutrition, among other areas, and have discovered effects in all spheres.

Direct observation of microfinance clients tells us that increased self-confidence, especially among the poorest women, is one of the first changes to take place. The ability to borrow and repay a loan and build savings is no doubt an empowering experience for poor women. Coupled with the mutual support and collective courage offered through the group dynamic, women are empowered to participate in family and community decisions, and are more able to overcome obstacles of inequality.

Most studies examining women's empowerment focus on women's decision-making power in various realms of their lives as a reflection of levels of empowerment. A study in Bangladesh found that Grameen Bank members were 7.5 times more likely than the comparison group to be empowered, and BRAC members were 4.5 times more likely to be empowered—and the level of empowerment increased with the duration of membership (Hashemi 1996). In Nepal, an evaluation found that 68 percent of microfinance participants in the Women's Empowerment

Program experienced an increase in their decision-making roles in areas traditionally dominated by men (Cheston and Kuhn 2002). In Ghana, microfinance participants demonstrated increased empowerment when they began to give advice to others, and participants in Bolivia became more involved in local political life after joining the microfinance program (MkNelly and Dunford 1998 and 1999).

"We're happy whenever we meet at the [village bank group] and get to talk about our progress."

—Focus group participant and member of CARD in the Philippines

Attempts to measure the effects of microfinance on health have shown that families accessing microfinance have better health practices and better nutrition and are less sick than comparison families. Increased incomes lead to better and more food for the family, improved living conditions, and consumption of health services, including preventive health care. When microfinance is coupled with health education, a strategy discussed further in the next section of this paper, these impacts are greatly enhanced.

Freedom from Hunger's evaluation in Ghana and Bolivia found that in both countries program participants had better health knowledge and practices in the areas of breastfeeding, diarrhea treatment, and immunization as a result of education on these topics provided by the microfinance program (MkNelly and Dunford 1998 and 1999). And, in Ghana, participants' children had better nutritional status than non-participants' children. After receiving health education, clients of FOCCAS in Uganda had better health care practices than non-clients, and 32 percent of clients had tried at least one HIV/AIDS prevention practice, compared to 18 percent of non-clients (Barnes 2001).

Attempts to measure the effects of microfinance on health have shown that families accessing microfinance have better health practices and better nutrition and are less sick than comparison families.

The Story of Hermelil

Through her microfinance program in the Philippines, Hermelil attends education sessions on health, nutrition and business development. With the loan she received, Hermelil started a small store. She sleeps on the floor of the store and her mother and children sleep in a shack nearby.

"Before joining my Credit Association, I always stayed in my house. I never socialized. I thought that because my background was poor, the other women wouldn't accept me. But they did.

"I know how to separate what I spend on my inventory from what I make in earnings. That way I can determine my profit. I even separate the cost of types of products so that I know which ones make the most money. I use my profits to pay the children's school fees."

Microfinance as a Strategy to Alleviate Global Poverty

The studies just described make an impressive case for the power of microfinance to reduce poverty among program participants. But, what about microfinance's effects at a national level? Can microfinance have real impact on the problem of global poverty? Recent evidence demonstrates that it can. Through Shahidur Khandker's analysis in 2005, he found that 40 percent of the *entire* reduction of poverty in rural Bangladesh was directly attributable to microfinance. Juxtaposed with other countrywide data presented in the HDR 2005, this evidence is even more powerful. The HDR 2005 cites Bangladesh as an example of a country making extraordinary advances in human development indicators without the economic growth experienced by other countries.

The HDR 2005 compares Bangladesh's successes in human development to India, a country with much higher income and economic growth than Bangladesh, but lesser progress toward human development goals. It declares that, "Had India matched Bangladesh's rate of reduction in child mortality over the past decade, 732,000 fewer children would die this year." The HDR presents four strategies directly

contributing to Bangladesh's advances, specifically naming BRAC (an organization providing microfinance services, among other services) as one of the non-governmental organizations "improving access to basic services through innovative programs." Another of the four strategies, called "virtuous cycles and female agency" by the HDR, centers on the idea that:

Improved access to health and education for women, allied with expanded opportunities for employment and access to microcredit, has expanded choice and empowered women. While gender disparities still exist, women have become increasingly powerful catalysts for development, demanding greater control over fertility and birth spacing, education for their daughters and access to services.

In other words, because of the availability of programs such as microfinance, along with increased empowerment and access to reproductive health services for women, Bangladesh was able to improve development of its people

"Had India matched Bangladesh's rate of reduction in child mortality over the past decade, 732,000 fewer children would die this year."

despite lagging behind India's stunning economic growth. The data on Bangladesh is supported by a powerful anecdote found in Professor Jeffrey Sachs' book, *The End of Poverty*, which offers a glimpse of microfinance's effects in clients' lives. In the book, he describes a visit with BRAC microcredit clients and learns that the women all had, or planned to have, no more than two children each.

Perhaps more amazing than the stories of how microfinance was fueling small-scale businesses, were the women's attitudes to child rearing....Here was a group where the average number of children for these mothers was between one and two childrenThis social norm was new, a demonstration of a change of outlook and possibility so dramatic that Dr. Rosenfield [the Dean of the Columbia University School of Public Health] dwelt on it throughout the rest of his visit....he remembered vividly the days when Bangladeshi rural women would typically have had six or seven children.⁴

Considering Bangladesh as an example of microfinance's potential on a national scale, it is not such a stretch to imagine its potential impact on global poverty. Recognition of the intimate link between poverty, poor health and inequality along with the evidence of microfinance's broader impacts in these areas demands the expansion of microfinance services to the poor as a primary strategy for meeting the MDGs.

⁴Sachs, Jeffrey (2005):*The End of Poverty*. The Penguin Press, pp. 13-14.

Maximizing Potential:

Microfinance as a Vehicle for Improving Reproductive Health, Preventing HIV and Increasing Women's Empowerment

Microcredit institutions increasingly recognize their dependence on the health of their clients and their clients' families. Many acknowledge the challenging circumstances for clients playing the triple roles of wife, mother and business-woman. Local public health officials confirm that much of the risk to clients and microcredit institutions alike could be greatly reduced with the use of effective family planning methods. In some countries, the HIV/AIDS epidemic is so severe that it threatens microcredit institutions through reduced loan portfolio growth, decreased client retention, increased portfolio delinquency and increased draw-down from savings deposits, as well as death of experienced staff or the burdens on them of caring for dying relatives.

—Pathways Out of Poverty, 2002

The integration of reproductive health education and microfinance services takes into consideration that the poor, especially the poorest, are unlikely to access reproductive health education and services without the incentive of immediate benefit, which the offer of affordable credit can provide. The prospect of getting a loan can draw people to a program that offers them additional services. Certain features of group-based microfinance programs make them ideal for integration of reproductive health education:

1) Group-based microfinance brings poor women together on a regular basis over periods of months and years to repay loans and deposit savings. These meetings are also opportunities to provide reproductive health education (and other health topics) over extended periods. Services can be provided to mothers and also younger and older women who would not normally be reached by reproductive health education.

- 2) Increased income and assets due to microfinance should enable women clients to put what they learn from reproductive health education into practice, and to increase their consumption of primary health services and contraceptives.
- 3) Microfinance services empower women, enhance their roles as decision-makers within the family, and pave the way for behavior change.
- 4) Microfinance programs often achieve financial self-sufficiency through interest paid on loans. They can generate sufficient income to sustain not only the financial services but also additional reproductive health education services offered by the same staff. Much of the cost of education is in bringing sufficient numbers of people together with an educator at set times and places, which is already achieved by the microfinance operations.

The Impact of Combined Reproductive Health Education and Microfinance Services

In light of the impacts of microfinance previously presented, it is safe to assume those impacts would only be further enhanced by the addition of health education services, specifically reproductive health education. There is a limited amount of research focused specifically on the impacts of combined programs on reproductive health outcomes. However, the research that does exist allows one to make educated assumptions about the impacts such programs have had.

Several studies have specifically examined contraceptive use by their clients as a result of participation in microfinance programs. Some of these programs were offering additional education services and others were not. Regardless, most found an increase in contraceptive use among program

The Story of Saraswathi

"When my children cried at night from hunger, I felt like killing myself," recalled Saraswathi Krishnan, who lives in India. Saraswathi's husband, an unskilled wage laborer, earned very little and often squandered what little he made on alcohol. Eventually, when the roof of their tiny hut was about to collapse, having no jewelry or other assets to pledge for a loan to repair it, Saraswathi sold her seven-year-old daughter into bonded labor to a local merchant for 2,000 Indian rupees (about US\$40).

"My little girl complained to me daily that the merchant abused her. His family would eat food in front of her and give her none," she remembered. Five years later Saraswathi joined Working Women's Forum, a women's self-help and microcredit program based in Madras, India. With her first loan she paid off her debt to the merchant, freeing her daughter, who now attends school, and began a small vegetable-selling business.

Now Saraswathi's vegetable business is thriving, thanks to her hard work and the training she has received from the program. She is glad to be able to give her children opportunities. With the family's new sources of income, Saraswathi has a sense of pride and security she never before experienced. "I will never mortgage my children again; they will be educated. Now I see to it that my husband is good and does not beat me anymore."

The Story of Janet

Janet Mwima is 50 years old and participates in an integrated health education and microfinance program in Uganda.

“My major source of income is from the charcoal business. I have some land where I plant maize, beans and bananas. My family consumes what I grow.

“The education from [the microfinance organization] has benefited me in terms of health care and I can take care of my family. Since I have stopped giving birth, I pass along the family planning information I learn from [the program] to others who are of childbearing age—especially the information about child spacing and breastfeeding.”

participants. BRAC in Bangladesh, which offers a variety of social and financial services to clients, found that members who had participated for more than four years had higher rates of contraceptive use (Khandker 1998). Another study in Bangladesh of a new microfinance program found participants, after a year or more, were 1.8 times more likely to use contraceptives than the control group (Steele et al. 1998).

For this document, the Microcredit Summit commissioned its own qualitative research in late 2005, using focus groups on three continents to assess the reproductive health impacts of integrated services. A summary of those results are found in this section.

Focus Group Discussions

The Microcredit Summit Campaign conducted focus groups to inform this document, and to better understand what clients perceive as the effects of their participation in combined microfinance and health education programs, particularly in the area of empowerment, reproductive health and HIV/AIDS. The focus group discussions took place in three countries, Bolivia, Ghana and the Philippines, with clients of organizations offering integrated services and, in some cases, with their family members.

In each country, focus group discussions were held with a mix of individuals, including client-only groups and groups with a mix of clients and their family members. During the focus group discussions, members were asked how their lives were affected in a number of areas by their participation in the programs, specifically business skills, changes in workload, decision-making in the family, pre- and post-natal care, family planning practices, and HIV/AIDS knowledge and practices.

Across the three countries, women overwhelmingly expressed positive feelings and effects in many of these areas as a result of participation in the integrated programs. In all three countries, (a) the clients indicated learning valuable skills and information to help manage their businesses, such as separating business and personal expenses, budgeting, and diversifying products and (b) women reported that they participated in decision-making, along with their husbands, on how money is spent.

In Ghana, where focus groups were held with clients of the Upper Manya Kro Rural Bank, participants all enthusiastically agreed that their workloads had significantly decreased since gaining access to the microfinance and education program. The women, when probed on this topic,

explained that they no longer needed to borrow from other sources or buy goods on credit, which used to cause money shortages and stress and tension within the household. One focus group participant described this effect by saying, “Previously, there used to be quarrels at home at the slightest provocation, owing to the heavy work that had to be done by each family member just to enable the family to meet its basic needs.

Now, there is peace because we don't have to overwork ourselves.”

In the area of reproductive health services, the majority of women reported using pre- and post-natal care from local health clinics despite, in some cases, the difficulty of accessing these services. Also across the three countries, most women gave birth at home attended by a midwife or health worker from the clinic. Others, most of whom had difficult pregnancies or some kind of illness, gave birth in the hospital or clinic.

Results of the focus group discussions emphasized the great need for services, products and education in the area of child spacing and contraceptives. Women in the three countries reported receiving information and support from the field staff of the program regarding family planning, availability of health services and HIV/AIDS. They talked about the program as a resource in these matters, and a venue for receiving advice and information on reproductive health and HIV/AIDS. In Bolivia, all but two focus group participants from the four groups gave advice about family planning and/or HIV to family and friends. Advice-giving seems to be a strong effect of the educational services received through their participation in CRECER's program.

In the Philippines, with clients of CARD, discussion participants pointed out, often emotionally, that they consider their group a source of support and their participation in it has increased their self-confidence. The focus group moderator reported one participant describing her feelings on this subject by relating the following:

We have learned [about HIV] with CRECER. Sometimes we do not have the opportunity to talk with our husbands, but here [in our group] we can talk with others.

—Focus group participant in Bolivia

She thinks that CARD is a big responsibility, but it gives her a good feeling—it makes her prouder and gives her a sense of fulfillment of being a woman and wife. Her membership with CARD, and the business she started, has encouraged her husband to work better. It has inspired him to live his life better; his cock-fighting activities and other vices are now a thing of the past. She is also happy that she is able to help and provide employment to others. Thus, there's no such feeling of a heavy workload, but rather fulfillment.

Summary of Results from Workshop Evaluations

We have also drawn from evaluations of the Microcredit Summit's trainings in Africa and Asia on the combination of health education and microfinance. With technical assistance from Freedom from Hunger beginning in late 2004 until September 2005, the Microcredit Summit Campaign—with financial support from UNFPA, the UN Foundation, and Johnson & Johnson—implemented a series of three- and five- day workshops on the integration of health education with microfinance services. The trainings were carried out in eight countries across Asia and Africa, with representatives from more than 160 institutions attending one or both of the workshops. Independent evaluators were hired to follow up with the institutions and examine the progress toward implementation of integrated services.

The information yielded so far by evaluations from seven countries offers an indication of the level of interest on the part of local organizations for offering integrated services, and the potential for outreach of these services. Of the 164 institutions that attended the trainings in seven of the eight countries, 46 have begun integrating health education services with their existing microfinance programs. Most are doing so through pilot projects, in anywhere from 3 to 70 percent of their existing village banks. Once these 46 institutions extend the combined services to all their clients, they will reach more than 463,000 program participants, affecting some 2.3 million family members. Another 38 institutions have not yet begun to integrate health education but have plans to do so in the future, and these organizations represent an additional 270,000 microfinance clients.

Two Cases from Bolivia:

Successful Integration of Health Education and Microfinance Services

The evaluators made field visits to a sampling of the institutions that had begun offering health education in two topical areas—HIV prevention and care, and integrated management of childhood illnesses. During the same field visits, evaluators asked the organizations what kinds of support they would need to sustain and expand combined services. Unanimously, they responded with a need for more funding to support the start-up costs, such as training and materials, of integrating the health education. **Many spoke about their desire to “mainstream health education” into the microfinance services, and the need for donor support and recognition to accomplish this.** Microfinance institutions also expressed the need for technical support in the area of monitoring and evaluation of the integrated services to better understand impacts of the health education.

Evaluators used pre- and post-surveys to understand the level of client knowledge before and after the education sessions and what actions they planned to take as a result:

What clients already knew	What clients learned	What actions they will take as a result
<p>HIV/AIDS:</p> <ul style="list-style-type: none"> • AIDS has no cure • HIV is transmitted through sex and sharing sharp instruments • Abstinence and condoms control the spread of HIV • Prostitutes and people with promiscuous lifestyles are more vulnerable <p>Childhood Illnesses:</p> <ul style="list-style-type: none"> • Children who are vomiting, have blood in their stool and who are convulsing need to go to a hospital • Not all cases of diarrhea in children need medical attention • Medications need to be given to children right away 	<p>HIV/AIDS:</p> <ul style="list-style-type: none"> • HIV can be contracted through sex and sharp instruments, through birth and breastfeeding, and through blood transfusions • It is important to know your own HIV status • Using condoms and fresh syringes can prevent HIV • Blood tests can tell you whether you have HIV <p>Childhood Illnesses:</p> <ul style="list-style-type: none"> • The danger signs in children that indicate immediate medical attention is needed • Sick children need more frequent feedings 	<p>HIV/AIDS:</p> <ul style="list-style-type: none"> • Educate family, friends and neighbors • Prevent HIV through vigilant use of shared materials • Counsel people in high-risk groups on testing and risk reduction • Remain faithful to their spouse • Avoid casual sex • Get an HIV test <p>Childhood Illnesses:</p> <ul style="list-style-type: none"> • Tell doctor about all the health problems their child is experiencing • Take children to a hospital immediately if they exhibit danger signs • Ensure doctors complete the appropriate checks of their children • Practice home care for common illnesses in children

The evaluations of the Microcredit Summit Campaign’s integration workshops demonstrate a clear interest and will on the part of many microfinance institutions to offer health education along with their financial services. And, the potential outreach is significant—considering the first series of workshops alone demonstrate a possible reach of over half a million clients, affecting several million family members.

Once these 46 institutions extend the combined services to all their clients, they will reach more than 463,000 program participants, affecting some 2.3 million family members.

“The credit allows me to buy vegetables in larger quantities so I have more to sell. This increases my profit. I can then buy milk for my son. My income also allows me to save. Now I have a reserve to meet an emergency and to help my family through hard times. Before, I didn’t. We’ve learned about feeding practices for infants and children. We’ve also learned about the importance of good hygiene to prevent sickness such as diarrhea. I value this education very much. Many women in our village lost their children when they became sick. I know how to protect my son and I share that knowledge with others in my community—even the older women.”

—Rosemary Flores, a 20-year-old mother of a two-year-old son and Credit with Education member of CRECER in Bolivia.

Examples abound of microfinance institutions that have successfully integrated microfinance with non-financial services without compromising the impacts for clients or the financial strength of the institution. The most promising approach to an integrated microfinance and reproductive health education service is one that combines the services at all levels of the institution. The approach has field staff offering both the microfinance and the education at the same point of service: the group meeting. This provides cost efficiencies to the institution because separate administrative and program structures are not necessary to sustain both services, allowing the marginal costs of the education to be covered with revenue generated from the microfinance.

Two institutions in Bolivia—CRECER and Pro Mujer—illustrate the successful integration of health education, including reproductive health and HIV/AIDS prevention, with microfinance services. Both orient their services to poor women and both recognize and embrace the need

for a variety of services to improve the status of poor families. The following are summaries of case studies of these two institutions.

A Summary of the Case of CRECER⁵

Background

Crédito con Educación Rural (CRECER) is the largest group-based lender in Bolivia, widely recognized in recent years for its success in reaching financial self-sufficiency without compromising its commitment to health education services, nor to reaching poor clients. CRECER’s mission is to offer substantive and supportive integrated financial and education services to poor women and their families in rural and marginal urban areas of Bolivia to support their autonomous actions for the betterment of the families’ health, nutrition and economic status.

Methodology

CRECER’s methodology is based on village banking, with banks (or communal associations) consisting of 15 to 20 members. The members of each bank elect a five-person board of directors to lead the group. Loans from CRECER are made to the group, and then divided among the members. Individual loan sizes average US \$150, repaid over 16 or 24 weeks. To receive a loan, at least 10 percent of the value of the loan must be on deposit as savings.

CRECER’s village banks all meet on a weekly or biweekly basis in the program communities. Local CRECER staff (or promoters) attend the meetings during which the members make loan repayments and deposit savings. Not only do the promoters train the new village banks and new members in how to manage the group’s finances, but they also offer education sessions on a variety of topics to improve maternal and child health, reproductive health, self-esteem and management of their businesses. A field staff of 124

⁵ Full text of the case study of CRECER can be found at <http://www.microcreditsummit.org>.

promoters are employed by CRECER to administer the integrated services. CRECER sees the integration of health education with its financial services as its competitive advantage in the vibrant Bolivian microfinance marketplace.

CRECER works to enhance the health education provided during the weekly meetings. In some regions, CRECER established relationships with health service providers—such as rural clinics—to offer referrals to clinic services. Clinic staff will also visit village bank meetings to assess health care needs, and CRECER promotes health campaigns, such as vaccination and PAP smear services, through its village bank meetings.

Health Education Topics offered by CRECER:

- Family planning
- Women's health
- Breastfeeding
- Integrated management of childhood illnesses
- Infant and child feeding
- Immunization
- Diarrhea prevention and treatment
- Self-esteem

Additionally, CRECER created an innovative network within its Credit with Education program that offers family planning education and contraceptives to village bank clients. The program, called the Community-Based Distribution System, identifies one member of the village bank to become the Community-Based Distributor (CBD). The 330 CBDs receive special training about the use of various family planning methods and then receive a supply of contraceptives at cost.⁶ A CBD's stock is replenished by the promoter, but limited by government health regulations to condoms and Cycle Beads. However, the CBD is trained to offer advice on a range of family planning options and is linked to local family planning service providers.

⁶ CRECER buys the contraceptives at subsidized prices from local providers.

⁷ In other words, 133% of the program's total costs are covered by income from the program.

Outreach and Financial Self-Sufficiency

As of September 2005, CRECER was serving 68,748 clients, mostly women, in eight of Bolivia's nine departments. Despite offering education in addition to financial services, and reaching mostly poor clients, CRECER's financial performance is impressive, with an operational self-sufficiency ratio of 133 percent.⁷ Progress in the areas of growth, efficiency and financial self-sufficiency has been steady over the past few years for CRECER, even while offering the additional health education service—the costs of which are now fully covered by income from the financial services.

CRECER sees the integration of health education with its financial services as its competitive advantage in the vibrant Bolivian microfinance marketplace.

For example, as of December 2001, CRECER was serving 30,989 clients, had an outstanding loan portfolio of almost US \$4 million, had a staff productivity ratio of 223 clients per field staff, and an operational self-sufficiency ratio of 102 percent. Four years later, the number of clients has more than doubled as has the number of clients served per field staff. The portfolio has grown by more than 30 percent and operational self-sufficiency stands at 133 percent.

CRECER by the numbers:

Number of Village Banks	4,306
Number of Members	68,748
Amount of Outstanding Loans	US \$12,462,959
Amount of Savings	US \$3,237,807
Average Loan Size per Borrower	US \$150
Portfolio at Risk	0.17%
Operational Self-Sufficiency	133%

To understand the profile of its clientele and whether its services were reaching the intended population, CRECER contracted with the Ohio State University Rural Finance Program and AGRODATA to do assessment of the poverty level of CRECER's clients. The following summarizes results of the studies:

- Approximately three-fourths (73 percent) of CRECER client households fell below the national poverty line. More specifically, approximately one-fourth (23 percent) of the CRECER clientele were classified as “poorest,” one-half (50 percent) “moderately poor,” one-fifth (21 percent) were at the threshold, and only a few (6 percent) “non-poor” (Gonzalez-Vega, 2001).⁸
- In early 2002, the CGAP Poverty Assessment tool was applied to a sample of new CRECER clients and non-clients. CRECER's services were found to have a pro-poor bias, with 39 percent of the clients categorized in the poorest tercile, another 40 percent in the middle tercile and only 22 percent in the better-off tercile (Jimenez, 2002).⁹

CRECER is realizing its goal of achieving financial self-sufficiency while also reaching large numbers of poor clients, and it is doing so while covering the marginal cost of offering health and business education services to clients. CRECER is gaining widespread recognition in the microfinance community for this accomplishment and was one of two institutions featured in a paper commissioned by the Microcredit Summit Campaign as a model for reaching the goals of financial self-sufficiency and poverty outreach.

A Summary of the Case of Pro Mujer Bolivia¹⁰

Background

Pro Mujer is a non-regulated institution in Bolivia whose mission is to “support women living in socioeconomic exclusion through integrated participatory services to achieve personal, family and community sustainability” Pro Mujer Bolivia was the first of the Pro Mujer network members, which include Peru, Nicaragua, and Mexico. Pro Mujer Bolivia currently has offices in 41 locations in the regions of El Alto, La Paz, Cochabamba, Sucre, Tarija, Potosí, Santa Cruz, Oruro and Beni.

⁸ Gonzalez-Vega, Claudio (2001): “Profile of the Clients of CRECER and Their Households in Bolivia.” Preliminary results by Rural Finance Program. The Ohio State University, Columbus, OH.

⁹ Jimenez, Miguel (2002): “A Poverty Assessment of Micro-finance CRECER, Bolivia” on behalf of the Consultative Group to Assist the Poor.

¹⁰ Full text of the case of Pro Mujer Bolivia can be found at <http://www.microcreditsummit.org>

¹¹ Pro Mujer Bolivia Annual Report 2005

Methodology

Pro Mujer Bolivia's integrated microfinance and health services are offered to women grouped into Communal Associations. The institution focuses its services on poor, illiterate women living in peri-urban and urban areas, and believes that “this population segment needs a comprehensive intervention from the institution, including human development services that respond to their social and personal needs and reinforce the credit's positive effects.”¹¹ The Communal Associations have an average of 25 members. To become a Communal Association, groups must receive training (about ten hours in total) from Pro Mujer staff in management and administration of their groups, and in women's empowerment.

Loans are offered to groups for three- to seven-month cycles and then divided up to individual members. Amounts of loans range from US \$100 to US \$1,000 and clients make payments of principal and interest during weekly meetings. In order to receive a loan, each client is also required to deposit a specified amount of savings, based on the client's loan cycle and the requested amount.

The nonfinancial, or human development, services provided by Pro Mujer Bolivia are of two types: business development and health. The business development service is offered with the objective of improving business management skills of women clients. The health services offered by Pro Mujer strive toward the following goals:

- Awareness-raising and orientation of women in family health topics so they can prevent the most common diseases affecting them and their families.
- Orientation in sexual and reproductive health so women will learn the importance of birth spacing and the possibilities for controlling their reproductive life.
- The provision of basic assistance and orientation for solving first-level health problems and in case of more complex problems, referral to health care centers.

A Study by Pro Mujer of Perceptions Regarding the Access of Reproductive Health Services

Pro Mujer Bolivia conducted a study in 1996 and 1997 in El Alto and Sucre, to understand the perceptions of users and non users of reproductive health services as well as perceptions of providers of these services. The results provided insight into the attitudes of potential clientele and of the health service providers for that clientele. Pro Mujer was interested to find that the main reasons both users and non-users of reproductive health services did not access health services were the lack of economic resources and because of feelings of fear, shame and embarrassment. Study participants suggested that to improve access to health services, friendly and well-trained staff should be available at all points of service, and the services should be delivered rapidly, in confidence and in their own languages.¹²

The health care services for Pro Mujer clients are provided in consulting rooms at the Pro Mujer offices, or Focal Centers, with a special focus on services for sexual and reproductive health, newborn health and family health. The health education includes reproductive health topics as well as topics related to maternal and child health. As of June 2005, more than 45,000 members had accessed sexual and/or reproductive health consultations from the Focal Centers, over 5,700 received prenatal consultations, and greater than 9,000 health education sessions were delivered.

The Communal Associations meet weekly at the locations established by Pro Mujer. These Focal Centers are able to house staff and offer all its services. The 41 Focal Centers are in geographically strategic locations so that most clients do not have to travel more than a half hour to arrive at the Center. The Health and Business Development staff are housed in the Focal Center so that clients can access these services directly on meeting days.

¹² De la Quintana, Claudia, Gretzel Jové and Carmen Velasco (1998): *Salud Reproductiva en Población Migrante: estudio comparativo El Alto – Sucre*. Pro Mujer & Family Health International. Bolivia.

¹³ Berry, John (2005): "Healthy Women, Healthy Business: A Comparative Study of Pro Mujer's Integration of Microfinance and Health Services." Case study summary. SEEP Network Practitioner Learning Program.

Reproductive Health Topics offered by Pro Mujer:

- Responsibilities of mothers and fathers
- Family planning methods
- Pregnancy and birth
- Abortion
- Sexually transmitted infections
- Uterine and breast cancer

The key difference in service delivery between Pro Mujer and CRECER is that CRECER's staff go to the clients and provide both the financial services and the health education in the communities, whereas Pro Mujer's clients come to the Focal Center where different staff offer the different services.

Outreach and Financial Self-Sufficiency

As of September 2005, Pro Mujer was offering its integrated microfinance, health and business development services to more than 68,000 clients, most of whom are women. The operating self-sufficiency of the organization's microfinance services was 107 percent, but this does not include the costs for the nonfinancial services. Pro Mujer Bolivia has been steadily expanding its program outreach by more than 20 percent per year over the past three years. The total loan portfolio has grown at an even greater rate.

Progress is being made in covering the costs of the non-financial services with revenue generated from the program. Earlier this year, the entire network of Pro Mujer institutions participated in a study for the SEEP (Small Enterprise Education and Promotion) Network's Practitioner Learning Program. In that study, Pro Mujer participated in a cost-allocation exercise to examine the true costs of both its financial and health services. The study found that, "Interestingly, sustainability levels in financial service delivery improved by an average of 20 percent after cost allocation, while even after allocation health services covered up to 142 percent of their costs with earned income and donations and up to 70 percent with earned income alone."¹³

The study also calculated that Pro Mujer Bolivia's services—both financial and educational—cost the institution US \$5.60 per client per year. Pro Mujer views the financial self-sufficiency of nonfinancial services as an institutional priority, and believes it improves the financial services' performance.

Pro Mujer by the numbers:

Number of Village Banks	3,329
Number of Members	68,883
Number of Savers	14,477
Amount of Outstanding Loans	US \$8,416,345
Amount of Client Savings	US \$4,092,107
Average Loan Size per Borrower	US \$183
Portfolio at Risk	0.5%
Operational Self-Sufficiency	107%

Pro Mujer monitors the profiles of new clients to ensure that their target population—poor, marginalized women—are those actually accessing the services. They find that new Communal Association members are almost solely marginalized women of low socioeconomic status and most are without a microbusiness. Most incoming Pro Mujer clients have limited access to credit, low family income and very little formal education. More than half of the families of new clients have experienced a food crisis in the past year.

A comprehensive impact evaluation of Pro Mujer Bolivia was performed in 2003 by FINRURAL. The study analyzed the effect of the integrated services on the poverty level of clients with more than two years of membership, compared to a similar group without exposure to Pro Mujer's services. The conclusion was that the services decreased the level of poverty, as 20 percent of program participant households were considered poor, while 40 percent of non-participant households were considered poor.¹⁴

¹⁴ FINRURAL (2003): *Evaluación de Impactos de Programas para La Mujer (Pro Mujer) Bolivia*. Final Report.

Conclusion and Recommendations

This document has shown that microfinance is a viable poverty alleviation strategy at the local, national and global levels, and that microfinance presents the perfect vehicle for offering reproductive health education to large groups of poor and very poor women. Institutions such as CRECER and Pro Mujer in Bolivia and BRAC and Grameen Bank in Bangladesh are successfully doing so and dozens of others have expressed great interest in combining health education with microfinance services. **But, what can be done to ensure that combined reproductive health education and microfinance reaches its full potential?**

Integrating microfinance and reproductive health education can be a critical tool for achieving the Millennium Development Goals by 2015, especially when implemented by well-run microfinance institutions that reach the very poor.

Microfinance is one of the practical development strategies and approaches that should be implemented and supported to attain the bold ambition of reducing world poverty by half.

—Investing in Development, UN Millennium Project

microfinance services must be brought to a large enough scale that its impacts on health outcomes are felt on the national and global levels.

During the World Summit, held in New York in September 2005, 151 heads of state from all over the world gathered to review progress in reaching the MDGs. Microfinance was recognized in the *2005 World Summit Outcome Document*, which notes, “We recognize the need for access to financial services, in particular for the poor, including microfinance and microcredit.”

These sentiments are echoed by other international bodies—such as the G8 Declarations of 2004 and 2005, the Commission on Private Sector Development, the UN Millennium Project, and the Africa Commission Report—

where, in their own declarations, microfinance is recognized as a key strategy for reducing poverty. Despite the call from world leaders and other international agencies to put microfinance at the front and center of poverty alleviation strategies, the true commitment to microfinance in terms of dollars is meager. The World Bank, whose mission is to, “help developing countries and their people reach the [MDGs] by working with our partners to alleviate poverty,”¹⁵ spends less than one percent of its annual budget on microfinance. Governments and other development bodies have yet to convert the rhetoric into action.

“I like that I have learned about family planning, especially because I am young. I’ve learned how to protect myself by using condoms.”

—Sarah Wanyenze, member of FOCCAS, an integrated microfinance program in Uganda

Development agencies, governments, MFIs and donors can broaden and deepen their contributions to realization of the Millennium Development Goals by supporting the integration of reproductive health education, including HIV/AIDS prevention and care, with sustainable, poverty-focused microfinance services for groups of poor and very poor women. Based on the most recent data of the Microcredit Summit Campaign, the number of clients reached with microfinance services is growing rapidly each year. Microfinance increases economic capacity and reduces families’ vulnerability to traumatic events. Many microfinance organizations are eager to integrate reproductive health-related education and referrals to quality reproductive health services with microfinance. When these organizations provide caring and culturally sensitive support to groups of poor and very poor women, they can further increase self-confidence and decision-making power in the family and community—both essential factors for progress of all women, but particularly the poor.

¹⁵ World Bank web site: <http://www.worldbank.org/>

The Story of Rajamma

Rajamma lives in Karnataka, India. Before she received her first loan from The Bridge Foundation (TBF), she was doing housework in “upper-caste” homes so she could feed her daughters the leftover scraps of food. She became so desperate that she borrowed money from a rich landowner. Unable to repay him, she was forced to send her daughters to work in his home—as virtual slaves. Rajamma joined TBF’s local Self Help Group and took out a loan of Rs 7,000 (US \$196) to purchase a milk cow. Within 10 months, she cleared the loan and released her daughters from their bond. She earns over Rs 1,200 (US \$34) each month. With her savings she bought half an acre of land and has taken another loan to irrigate it for groundnut cultivation. Rajamma’s eldest daughter is learning tailoring, while the younger girls are in school. With visible pride, Rajamma says that TBF has helped her regain her dignity and self-worth. She is one of the most active members in the group and is accepted as an equal in her village.

Recommended Action for Development Agencies, Governments and Donors

Development agencies, governments and donors can focus on eight actions to enhance their contributions toward the MDGs through integrating reproductive health education with microfinance programs:

- Direct significant financial resources to microfinance organizations—those whose work revolves around outreach to the poor and poorest, a focus on women, and achievement of financial self-sufficiency—explicitly for the integration of reproductive health education, along with other health topics.
- Promote combining reproductive health education and microfinance to other development bodies, governments and donors by disseminating this document, hosting briefings, and creating other advocacy tools.
- Support sustainable microfinance for the very poor as a primary strategy for achieving the MDGs through declarations, presentations and publications.
- Advocate for and fund evaluation efforts to assess the impact of integrated reproductive health education and microfinance services on reproductive health outcomes for poor families.
- Identify, collaborate with and support institutions—both practitioners and international technical assistance providers—that offer experience and competencies for the combination of reproductive health education with microfinance.
- Organize donor symposiums on the topic featuring leaders from a variety of institutions, such as BRAC, Grameen Bank, Pro Mujer, CRECER and Freedom from Hunger.

- Capitalize on the existing momentum created by the Microcredit Summit Campaign's integration workshops by promoting and supporting the continuation of workshops and other mechanisms for disseminating integration strategies.
- Sponsor trips for donor agencies, journalists, and parliamentarians to visit leading microfinance institutions that integrate sustainable microfinance for the very poor with reproductive and other health education.

Explicit and vocal support of combined reproductive health education and microfinance services, along with the promotion of microfinance as a key mechanism for poverty reduction, are crucial to realizing our shared human development goals. Putting these eight recommendations into practice will mark the change from rhetoric to action. This document concludes with a quote from the Human Development Report 2005:

If solemn promises, ambitious pledges, earnest commitments and high-level conferences lifted people out of poverty, put children in school and cut child deaths, the MDGs would have been achieved long ago. The currency of pledges from the international community is by now so severely debased by non-delivery that it is widely perceived as worthless. Restoring that currency is vital not just to the success of the MDGs but also to the creation of confidence in multilateralism and international cooperation—the twin foundations for strengthened international peace and security.

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