FINANCING HEALTHIER LIVES

Empowering Women Through Integration of Microfinance and Health Education

MICROCREDIT SUMMIT CAMPAIGN

A Project of RESULTS Educational Fund

UNFPA

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This document is a joint publication of the United Nations Population Fund and the Microcredit Summit Campaign.


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Executive Summary

This year marks the halfway point since the United Nations Millennium Development Goals (MDGs) were set in 2000 with a 2015 target date. This juncture is the perfect time to take a close look at how much progress has been made towards meeting the goals and how organizations like the United Nations Population Fund (UNFPA) and the Microcredit Summit Campaign (MCS) can make a significant contribution to accomplishing these audacious goals. It is also appropriate to assess which strategies have been most effective in achieving the apparent gains over the last seven years. In July 2008, the Group of Eight (G-8) countries met and took stock of where the world stands with regards to the MDGs. In what was a vote of confidence in the results achieved so far, the countries renewed their endorsement of the goals. They particularly noted that the least progress has been made in improving maternal health (MDG 5), with close to 500,000 women still dying each year due to pregnancy-related causes. All G-8 countries particularly underscored a commitment to improving in this area.

Over the past seven years, the MDGs have shaped development priorities for governments, donors and practitioner agencies worldwide. There is no question that if the MDGs are achieved, it would represent enormous progress towards the UNFPA vision that every woman, man and child enjoy a life of health and equal opportunity. It would also reflect the enormous contribution of MCS and its members to the economic and social empowerment of women, especially those living in extreme poverty.

The *Millennium Development Goals Report* published in 2007 cautions, however, that although significant gains have been made, much remains to be done. If current trends continue, there is a chance that the goals will not be fulfilled. There is an urgent need for all institutions involved to break with "business as usual" and devise strategies to scale up efforts to meet the targets.

This document is an update of an earlier edition published in 2006 and primarily focuses attention on the strategy of integrating microfinance services with health education.[1] Highlighted within are MCS and UNFPA's joint global efforts to empower women using this strategy, employing methodology developed by and receiving training in its use by a key partner, Freedom from Hunger. Included is analysis from innovative work in Africa, Asia and Latin America. Of special note are the results from a pilot project in India that shows how local capacity can effectively be built to accelerate the large-scale global adoption of integration.

The document also serves as a call to action for development agencies, governments, microfinance institutions (MFIs), and donors to invest in this strategy that holds the promise of making many of the MDG targets truly achievable.

The final section offers eight concrete recommendations for action to realize the potential of the "combined services" approach of integrating microfinance services with health education. All eight actions rely on the development agencies, governments, MFIs and donors to promote integrated health education and microfinance while championing microfinance as one of the pillars for meeting the MDGs.

[1] See *From Microfinance to Macro-Change: Integrating Health Education with Microfinance to Empower Women and Reduce Poverty*. United Nations Population Fund, New York, NY, 2006.

The Millennium Development Goals

1. **Eradicate extreme hunger and poverty.** Halving the proportion of people living on less than $1 a day and the proportion of those who suffer from hunger.
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, and in all levels of education no later than 2015.
4. **Reduce child mortality.** Reducing by two-thirds the under-five mortality rate between 1990 and 2015.
5. **Improve maternal health.** Reducing the maternal mortality rate by three-quarters between 1990 and 2015.
6. **Combat HIV/AIDS, malaria and other diseases.** Halting and beginning to reverse the spread of HIV/AIDS, malaria and other diseases by 2015.
7. **Ensure environmental stability.** Cutting by one-half the proportion of people without sustainable access to safe drinking water and basic sanitation; integrating the principles of sustainable development into country policies and programs; and reversing the loss of environmental resources.
8. **Develop a global partnership for development.** Reforming aid and trade and financial systems with special treatment for the least developed countries and small island developing states.

Source: *The Millennium Development Goals Report*, United Nations, New York, NY, 2007.

Mission and Vision

"…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 with 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

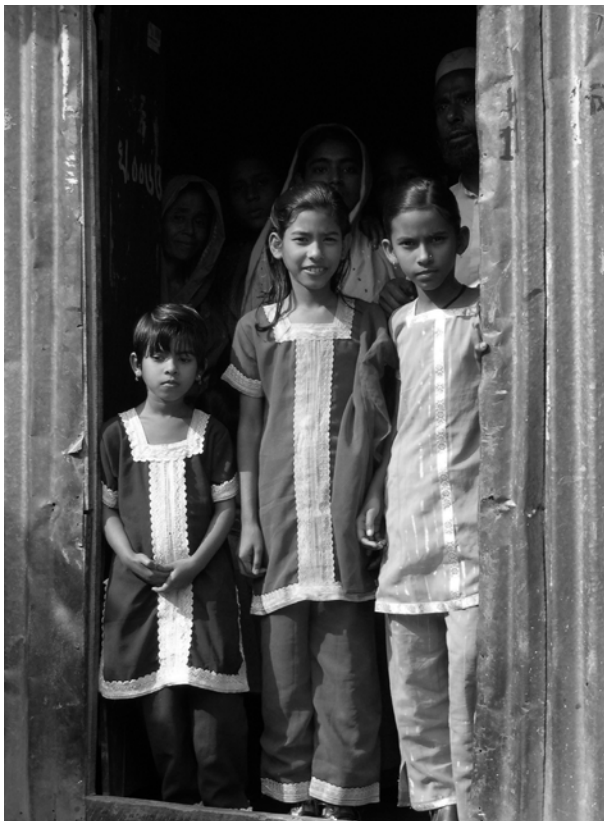
UNFPA is committed to ensuring that "every pregnancy is wanted, every birth is safe, every young person is free of HIV and AIDS, and every girl and woman is treated with dignity and respect." UNFPA's work is driven by the 1994 International Conference on Population and Development (ICPD) Programme of Action as well as the MDGs. The ICPD Programme of Action serves as a blueprint for the population programs of all U.N. agencies and member states though the year 2015. It should be noted that the ICPD mandate is often considered a turning point in the world's approach to population issues. For the first time, 179 countries formally acknowledged that population, poverty, patterns of production and consumption, and the environment are so closely intertwined that none can be considered in isolation. They also agreed on a road map for progress with the following goals:

- Universal access to reproductive health services by 2015
- Universal primary education and closing the gender gap in education by 2015
- Reduced maternal mortality by 75 percent by 2015
- Reduced infant mortality
- Increased life expectancy
- Reduced HIV infection rates

At the 2005 World Summit, world leaders reaffirmed the need to keep gender equality, HIV and AIDS and reproductive health at the top of the development agenda. Subsequently, additional targets, including universal access to reproductive health by 2015, and related indicators were added to the MDGs.

Reflective of the ICPD theme, UNFPA recognizes that to effectively improve the health and well-being of women, it is critical to develop a strategy that also provides them with a vehicle for economic self-reliance. To this end, UNFPA has partnered with MCS to increase the capacity of microfinance institutions (MFIs) to integrate health education into their operations.

MCS, the largest network of MFIs, donor agencies and other stakeholders, is dedicated to transforming the lives of the poor by designing, implementing and managing innovative projects that focus on poverty alleviation through microfinance. Like UNFPA, MCS recognizes that financial services, when integrated with health education, can dramatically enhance movement out of poverty and enhance economic and social empowerment. Over the past several years, the MCS-UNFPA partnership has served as a basis of support for the MCS membership to mainstream such integration. Key to this partnership has been the development of the methodology used, and the training and technical assistance to employ integrated microfinance services, by Freedom from Hunger, a pioneer in the design and dissemination of integrated financial services and lifeskills training and related products and services that equip the rural poor to escape poverty and achieve household food security. Freedom from Hunger's experience and expertise extend across multiple sectors that address the causes of chronic hunger and poverty, including microfinance, livelihood development, health and nutrition, household food security, and empowerment of women.



Poverty, Women's Empowerment and Reproductive Health

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

The more than 850 million people on this planet who live in extreme poverty (on less than $1 a day), especially the women, bear a hugely disproportionate burden of the world's sickness, poor health and inequality.

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 850 million people on this planet who live in extreme poverty (on less than $1 a day), especially the women, bear a hugely disproportionate burden of the world's sickness, poor health and inequality. Every minute, a woman dies from complications during pregnancy and childbirth, and 20 more suffer serious complications—the majority of these are 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.

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.

A number of studies underscore these findings and show that an increase in a woman's income has a positive impact on, among other things, the educational and nutritional status of her children (Rogers and Youssef, 1988; Consultative Group to Assist the Poor – CGAP, 2004).

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,

[i]n 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 largest and most direct costs of these inequalities—but the costs cut more broadly across society, ultimately harming everyone.[2]

The MDGs recognize the importance of empowerment and gender equality to eliminating poverty by including it as the third of the eight goals: "[p]romote gender equality and empower women."

[2] World Bank. 2001. *Engendering Development: Through Gender Equality in Rights, Resources, and Voice*. Oxford University Press, p4.

The Results of Poverty, Poor Health and Inequality

- One in eight people in the world—more than 850 million people—still survive on less than US$1 a day, a level of poverty so abject that it threatens survival. In effect, a global underclass, faced daily with the reality of extreme poverty.
- In 2006, an estimated 2.9 million people died from [HIV], and another four million became infected. Almost all of these deaths were in the developing world, with 80% of them in Sub-Saharan Africa.
- More than 500,000 women die each year from complications during pregnancy or childbirth. Almost all of them are in Sub-Saharan Africa and Asia.

Sources: *The Millennium Development Goals Report*, United Nations, New York, NY, 2007; *State of World Population*, UNFPA, New York, NY, 2007.

Empowerment Framework

A project on Assessing the Impact of Microenterprise Services (AIMS) was launched by the United States Agency for International Development (USAID) in 1995. In line with the overall goal of assessing the impact of microfinance institutions (MFIs) on their clients, a key objective of AIMS was to develop guidelines for assessing the impact of microenterprise services at the individual level. The AIMS team published a guide that consolidates three analytical frameworks of empowerment previously used in the microfinance context into a single comprehensive framework (Chen, 1997).

According to the AIMS framework, four important types of change must be analyzed in order to evaluate empowerment of women:

- **Material change** in the women's lives, such as increased income and access to resources.
- **Cognitive change** in the women's lives in the form of increased knowledge and improved skills.
- **Perceptual change** in the women's lives leading to enhanced self-esteem and a more positive vision of the future.
- **Relational change** in the women's lives illustrated through their increased role in decision-making, increased bargaining power and reduced dependence on others for access to markets and public institutions.

Source: *A Guide for Assessing the Impact of Microenterprise Services at the Individual Level.* M. A. Chen, USAID Office of Microenterprise Development. AIMS Project, Washington, DC.

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 free from sickness and disease is better equipped to utilize, invest and grow its scarce financial resources.

"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

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?

Microfinance is the provision of very small loans and other financial and business services to poor people, usually women, to help grow their small-scale enterprises or start new ones. The most common mechanism used by microfinance institutions to offer their services to clients is group-based lending. Borrowers form groups to mutually guarantee each other'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.

A specified amount of savings is usually required 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 for emergency use. Field staff supporting the microfinance groups are a critical component for success. 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 has some variances, but this basic methodology forms the foundation of most programs worldwide.

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 3,300 institutions of various types offering microfinance services to more than 133 million clients, some 70 percent of whom were living in absolute poverty when they received their first loan. Of these poorest clients, more than 85 percent are women. The key priorities for microfinance practitioners in the coming decade are to

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

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 *State of the Microcredit Summit Campaign Report 2007* asserts that, "Assuming five persons per family, the 92.9 million poorest clients reached by the end of 2006 affected some 464,612,870 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.

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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."

Source: Pro Mujer International.

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 the three Ugandan microfinance programs showed an increase in both assets and savings compared to a nonparticipant 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 one-half the reduction in poverty among program participants to be directly attributable to microfinance (Khandker, 2005).

Microfinance as a Strategy to Alleviate Global Poverty

The described studies 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 United Nations Development Programme's *Human Development Report 2005* (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, "[h]ad 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 nongovernmental 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.*

Kishwar's Story

Kishwar lives with her family in a slum near the railway station in Lahore, Pakistan. Health and sanitation conditions are extremely poor, causing disease and infections to run rampant. Kishwar's husband and sons together run their shoe-making and -selling business—selling from the shop and also taking orders from wholesalers. In 2001, their business suffered huge losses and they nearly went bankrupt. The family took a loan from a moneylender to rejuvenate their business. Unfortunately, the exorbitant interest rates, coupled with harsh penalties for late repayments, caused the family's debt to spiral out of control. Desperate for a way out, Kishwar discovered Kashf Foundation through a friend. Kishwar was wary of taking another loan, but her husband encouraged her to have faith.

The first loan of 5,000 Rs (US$83) was used to purchase leather, rexine, ready-made soles, thread and other materials for their shoe shop. As production increased, sales also picked up. Slowly, Kishwar and her husband were able to repay the moneylender. Savings in the first year of the Kashf loan were nominal because of this, but now their weekly profits are between 1,000 and 2,000 Rs. ($16–$30). Kishwar plans to take the next loan and increase their product range.

Recently, one of Kishwar's daughters had to submit the equivalent of $16 as a fee for her college entrance exam. Unable to come up with such a large amount of money on short notice, Kishwar applied for and received a consumption loan from Kashf to cover the expense. Though illiterate, Kishwar understands the value of education. She has chosen to use the family's meager resources to educate her two daughters, rather than her five sons, because she believes her daughters are more serious about their education. In a society where male children are given first priority in everything, particularly schooling, Kishwar has bravely broken with tradition and set an example for her entire community.

Kishwar has aspirations for sending both her daughters to college and also helping her sons establish individual, reliable and profitable enterprises. In two years, with Kashf's sustained assistance, she sees her family's business thriving like never before with ten employees and a telephone installed at the shop.

Kashf's impact on Kishwar's life has been more than just financial. She is now a center manager (five groups of five clients each form one center) and says that she can confidently address and advise her center members on different issues, whereas earlier she was too timid to say more than a few words to anybody. With this new sense of self-esteem and confidence, Kishwar mentors other women in her community, encouraging them to take advantage of the opportunity provided by Kashf to take control of their economic situations and make better lives for themselves and their families.

Source: Kashf Foundation.

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 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 children . . . . This 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.*[3]

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.

[3] Sachs, Jeffrey. 2005. *The End of Poverty*. The Penguin Press, pp. 13–14.

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

—Human Development Report 2005

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> *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 businesswoman. 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*

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

Flora's Story

Flora Callisaya is a 38-year-old single mother of three boys ages 12, 14 and 18. Living with her parents, Flora struggled to make a living and to support her sons. Barely able to sustain her family with her earnings, Flora went to Pro Mujer to inquire about a loan. Appreciating Pro Mujer's mandatory savings program, she decided to join.

Flora used her first loan to buy materials for her printing business. After her initial investment in her business, Flora's income increased, allowing her to expand her business and explore new enterprises such as her photography studio and selling dishware and gifts at weekly markets. When she first joined Pro Mujer, her first loan was only US$17; now her loan is $1,122.

Flora insists, "I have invested my savings in good things." The impact of Pro Mujer has reached beyond her business; with her mandatory savings from Pro Mujer, Flora has bought her own land and a house. Encouraged by Pro Mujer's health workshops, Flora gets regular PAP smears as well as physical exams and vaccinations for her and her children. Flora says she appreciates what she has learned from Pro Mujer and urges her children to take advantage of Pro Mujer's nonfinancial services such as computer classes. In addition to the workshops, Flora has taken a leadership role as president of her communal bank for over 3 cycles.

"Pro Mujer is like school for us; here we can see each other, have fun, relax and learn. For us, Pro Mujer is a place we can be together," Flora says.

Source: Pro Mujer International.

Bolivia became more involved in local political life after joining the microfinance program (MkNelly and Dunford, 1998 and 1999).

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 evaluations 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 nonparticipants' children. After receiving health education, clients of FOCCAS in Uganda had better healthcare practices than nonclients, and 32 percent of clients had tried at least one HIV and AIDS prevention practice, compared to 18 percent of non-clients (Barnes, 2001).

The Impact of Combined Reproductive Health Education and Microfinance Services

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 education) over extended periods. Services can be provided to mothers and to 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.

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.

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.

Microfinance and Reduced Violence Against Women

The findings of a 2005 study bear highlighting here because of their groundbreaking implications. The study, conducted in South Africa, is among the most rigorous in terms of research methodology. The main purpose of the study was to determine whether the involvement of women in a microfinance program would ultimately reduce their vulnerability to intimate partner violence. The study also aimed to assess whether microfinance activities could result in raised levels of communication and collective action on HIV and gender issues within communities and reduce the vulnerability of 14- to 35-year-old household and village residents to HIV infection.

The microfinance services were provided by the Small Enterprise Foundation. A 12- to 15-module training curriculum called "Sisters for Life" was implemented during the loan center meetings and delivered by a team of trainers working in all villages.

One of the major findings was that 72 percent of the women with an intimate partner in the 12 months prior to being interviewed reported a substantial reduction in intimate partner violence. The levels of intimate partner violence were shown to reduce by 55 percent among clients.

The findings also showed evidence of positive material change in the form of additional income and expanded asset ownership of the clients; 95 percent of the clients experienced increased economic well-being. Evidence of relational change was detected through the fact that all of the 10 percent of total clients who attended a week of leadership training went on to play a central role in community mobilization.

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 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 Campaign commissioned its own qualitative research in late 2005 and continued research in 2008, 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.

Mary's Story

Mary, a member of one of the self-help groups supported through the McLevy Institute for Development Services, became a widow when her husband committed suicide after learning that he was HIV-positive. Soon after her husband's death, Mary began to exhibit HIV symptoms and was convinced by alert group members to get tested for the virus. When Mary learned that she, too, was HIV-positive, she also contemplated suicide, but thanks to the lessons on HIV and AIDS, group members supported her and decided to donate 1 percent of their income to Mary so that she could purchase nutritious food and medicine. Prior to receiving the lessons, many of these same group members would have shunned Mary and other individuals whom they suspected of being HIV-positive. Today, Mary has a thriving business and is able to continue supporting her children on her own.

Source: McLevy Institute for Development Services.

Focus-Group Discussions

Between 2005 and 2008, the Microcredit Summit Campaign conducted focus-group discussions 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 and AIDS. The focus-group discussions took place in four countries: Bolivia, Ghana, the Philippines and India, 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 and AIDS knowledge and practices.

Across the four countries, women overwhelmingly expressed positive feelings and effects in many of these areas as a result of participating 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 with their husbands on how money is spent.

In Ghana, where focus-group discussions 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 and 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 and 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 participation in CRECER's program.

In the Philippines, with clients of CARD, discussion participants often emotionally pointed out that they

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).

Joy's Story

After Joy's husband died of malaria, she found herself alone, taking care of six children in the Kabale District of Uganda near the Rwanda border. Instead of giving up in despair, she started a brick-making business.

With a small loan of US$150 and some savings, she was able to purchase a small piece of land and employ eight people to make bricks. In just four months, she sold $150 worth of bricks with an inventory worth $400 available for sale.

Since 2003, she has received several additional loans to enlarge her brick-making business. She also has expanded into growing potatoes and operating a small store. The profits from her business allow her to provide for her children's education and to hire 13 employees who can now also support their families.

Source: Five Talents International.

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:

> *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 from 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 cockfighting 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.*

Workshop Evaluations Summary

This document has also drawn from evaluations of the Microcredit Summit Campaign'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 by evaluations done in seven countries offers a great indication of the high 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.

The evaluators made field visits to a sampling of the institutions that had begun offering health education in two topics—HIV prevention and care, and integrated management of childhood illnesses. Evaluators used pre- and post-surveys to understand the level of client knowledge before and after the education sessions and the actions they planned to take as a result. The findings from these surveys were extremely encouraging. The vast majority of participating clients showed an increased knowledge of how best to prevent the spread of HIV and AIDS and respond to common childhood illnesses. They also reported sharing their newly acquired knowledge with family, friends and neighbors.

During the same field visits, evaluators asked the participating organizations about the 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.

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 demonstrates a possible reach of over half-a-million clients, affecting several million family members.

One major factor that will influence the achievement of this level of outreach is the ability of MFIs to build the capacity to mainstream these services beyond small samples of their client base. The goal of the MCS-UNFPA initiative is to ensure that a majority of MFIs are able to cost-effectively provide integrated services to all of their clients. It is critical that local capacity be built within individual countries in order to facilitate this process.

Building Local Capacity: The Microcredit Summit Campaign India Pilot Project

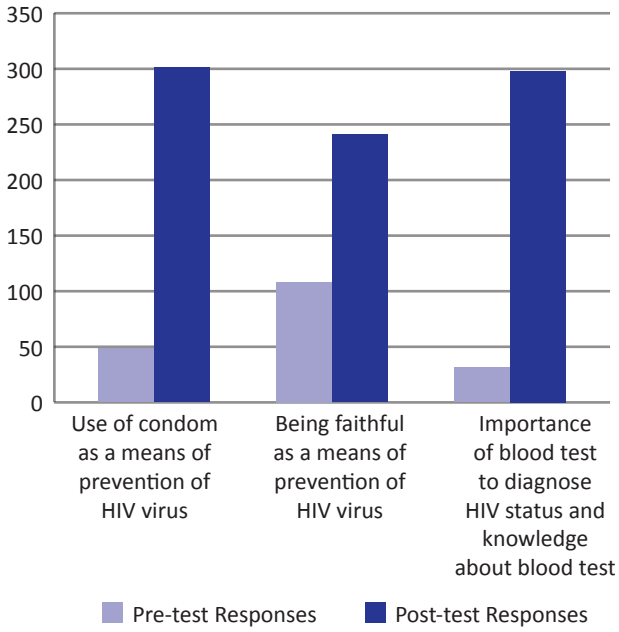
In early 2007, in response to the need to build local capacity in targeted countries, MCS launched a 15-month training-of-trainers project in partnership with three Indian MFIs. The training-of-trainers project has produced further evidence and data on how MFIs can even more efficiently adopt an effective health-integration strategy. There has been much discussion about the cost-effectiveness of integration and the ability of MFIs to absorb the additional costs. This project has shown that MFIs have recognized that the many benefits of having healthy clients who can be successful in their enterprises far outweigh the fairly nominal costs of integrating the health education into their operations.

In addition to the three MFIs in India, MCS worked with four in-country trainers to provide health education to the MFI clients. The institutions are based in two states of India: Tamil Nadu and Andhra Pradesh.

Microfinance Institution	State	No. of Clients Reached
People's Multipurpose Development Society (PMDS)	Tamil Nadu	3,122
McLevy Institute of Development Services (MIDS)	Tamil Nadu	3,255
Star MicroFin Service Society (SMSS)	Andhra Pradesh	6,415

A total of 80 MFI field workers were trained and have delivered lessons to the targeted 12,792 clients on the topics of HIV and AIDS prevention, integrated management of childhood illnesses (IMCI), and women's reproductive health. The lessons have been well received and analysis of the evaluation reveals that, in Tamil Nadu State, all women report having shared the knowledge they gained with at least four members of their family or household. In addition, as with the earlier evaluations in 2005, the clients demonstrated a significant increase in knowledge about the lesson topics. It is interesting that the clients initially felt that they knew everything about HIV, thanks to a media campaign launched by the Indian State Government. However, on completion of the 12 lessons on this topic, they realized how much more there was to learn. Figure 1 illustrates the significant increase in knowledge as indicated in the pre- and post-tests that were administered.

Figure 1: *Knowledge about HIV virus*



Source: *Integration of Microfinance and Health Education: Findings of the Pilot Project Implemented in South India*, Microcredit Summit Campaign, 2008.Washington, DC.

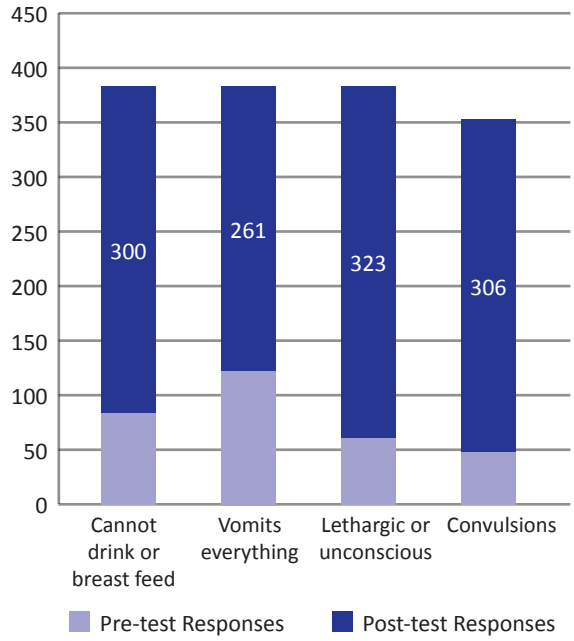
Similar results were found with the training module on IMCI. Many of the clients had no prior knowledge of the four critical danger signs for fever, cough and diarrhea in children. The results from the pre- and post-tests on this topic are displayed in Figure 2.

This pilot project established that by setting up a pool of local trainers, MCS can successfully scale up its outreach efforts. The in-country trainers in India have already set up a strategy to expand these capacity-building efforts to other regions of the country and MCS has plans to expand this work to 17 additional countries worldwide.

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.

Figure 2: *Knowledge about critical danger signs in children*



Source: *Integration of Microfinance and Health Education: Findings of the Pilot Project Implemented in South India*, Microcredit Summit Campaign, 2008.Washington, DC.

Recommended Actions 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 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 health education, along with other health topics.
- Promote combining 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 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 health education with microfinance.
- Organize donor symposiums on the topic featuring leaders from a variety of institutions.
- Capitalize on the existing momentum created by the Microcredit Summit Campaign's capacity-building work by promoting and supporting the continuation of training 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 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.

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Microcredit Summit Campaign

The Microcredit Summit Campaign (MCS), a project of RESULTS Educational Fund, is the world's largest global network of microcredit stakeholders. MCS has set the following two goals for 2015: 1) Ensure that 175 million of the world's poorest families, especially the women of those families, are receiving credit for self employment and other financial and business services. 2)Ensure that 100 million families rise above the US $1 a day threshold, adjusted for purchasing power parity (PPP), between 1990 and 2015.

United Nations Population Fund

The United Nations Population Fund (UNFPA), is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that 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. UNFPA supports programmes in some 150 countries through its Country Technical Services Teams and country offices.

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