

Linking health to microfinance to reduce poverty

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Introduction

At the forefront of global health priorities are the achievement of the United Nations' Millennium Development Goals (MDGs) and the strengthening of health systems. The MDGs focus the worldwide development agenda on reducing extreme poverty as well as improving health, education and human rights by 2015. At the same time, the World Health Organization is emphasizing the need to build health-system capacity, a global challenge that is most elusive in rural and resource-poor environments. Meeting global health needs calls for more inter-sectoral approaches. One that holds real promise, though largely underutilized, is the linking of microfinance with appropriate health-related services.

Numerous impact evaluation studies support the effectiveness of microfinance and its impact on poverty. Research funded by The World Bank examined the impact of three microfinance institutions in Bangladesh over a seven-year period and found dramatic decreases in overall poverty, with the highest impact on those families in extreme poverty.¹ However, microfinance is not a silver bullet; legitimate issues exist, such as the ability to address the needs of extremely poor people, the level of debt burden for individuals, and the uneven performance of microfinance institutions worldwide.

Microfinance institutions and health

More than 3500 microfinance institutions around the world provide credit and other financial services to more than 155 million households in support of income generation and consumption. According to conservative estimates from United States Agency for International Development (USAID) studies, at least 34 million of these households are very poor, representing 170 million people, many of whom live in remote areas beyond the

reach of health agencies, both private and government.

Every day, thousands of microfinance workers travel to poor communities to provide microfinance services, often to groups of women convening on a regular basis over months and years to repay loans and deposit savings. Many microfinance institutions in Africa, Asia and Latin America already successfully offer services beyond microfinance, including training in business and financial management. An increasing number also offer health-related services, such as education, clinical care, health financing (loans, savings and health insurance) and establishing linkages to public and private health providers to facilitate access to health care. This is a vast, private-sector infrastructure of service delivery that is mostly self-financed by interest on loans.

Microfinance institutions offer a unique opportunity, admittedly with challenges, to employ this global infrastructure for delivery of health-related services to those most in need. The world's poorest people bear a hugely disproportionate share of disease and ill-health. The World Bank study, *Voices of the poor*,² gathered views from more than 60 000 poor people and reported that ill-health and inability to access medical care emerged as key factors inducing and resulting from poverty. In a subsequent publication, *Dying for change*,³ thousands of interviewees most

frequently identified illness – even ahead of losing a job – from among 15 causes of a downward slide into poverty.

Why would microfinance institutions expand their services to include health? There are two basic reasons: health services are a natural extension of their mission of financial security and social protection of the client, and healthier clients better serve the microfinance institutions' goals of growth and long-term viability. Clients are not the only beneficiary; when a family member is ill, this affects productivity. Thus access to health-related programmes and services generally includes the household, not just the client.

Evidence of impact

Studies of microfinance institutions delivering health-related services show increasing evidence of positive impact. Multiple studies show that adding health education alone, usually delivered during the routinely scheduled microfinance group meetings, improves knowledge that leads to behavioural change. These behaviours are associated with positive health outcomes in diverse areas that are critically important to achieving the MDGs, such as maternal and child health, and infectious disease (Box 1).

Microfinance institutions provide health programmes that have positive impact on leading causes of death due to undernutrition, which constitutes 53%

Box 1. Areas with positive outcomes from health education combined with microfinance

- Reproductive health
- Preventive and primary health care for children
- Child nutrition
- Breastfeeding
- Child diarrhoea
- HIV prevention
- Domestic abuse/gender-based violence
- Sexually transmitted disease
- Malaria

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(Submitted: 28 August 2009 – Revised version received: 2 November 2009 – Accepted: 5 November 2009)

of all childhood deaths, and diarrhoea, which is the most common cause of illness and the second leading cause of child deaths in the world. In the Dominican Republic, Dohn et al.⁴ found significant improvements in the treatment of diarrhoeal disease. A control group that received microcredit only showed no change in diarrhoea incidence but, in the group that received health education only, incidence decreased by 29% and, in the group that received both microcredit and education, incidence decreased by 43%. In the Plurinational State of Bolivia and Ghana, research shows that mothers' health and nutrition practices can be changed by an integrated programme of village banking and child-survival education, with resulting behaviour changes in breastfeeding and management of diarrhoea that lead to significant increased height-for-age and weight-for-age for children of participants.⁵

In South Africa, Pronyk et al.⁶ found a positive impact of a comprehensive training and education programme on microfinance group members, for whom the risk of physical or sexual abuse by intimate partners was reduced by more than half as compared to a control group of microcredit-only members and to the general community.

In Ghana, de la Cruz et al.⁷ found that microfinance institutions can effectively contribute to community and national malaria initiatives by increasing knowledge, leading to increased insecticide-treated bed net ownership

and use by vulnerable members of the household (children under the age of five and pregnant women).

In Uganda, Barnes et al.⁸ found that 32% of women receiving education about HIV/AIDS prevention through their microcredit groups tried at least one HIV/AIDS prevention practice, compared to 18% of non-clients.

Beyond the potential contributions to disease and mortality reduction, microfinance can strengthen health systems. This capacity-building ranges from national initiatives to targeted local strategies. Perhaps the best illustration of how microfinance and health programmes strengthen national capacity is in Bangladesh. There, institutions such as BRAC (Bangladesh Rural Advancement Committee) have launched integrated programmes over the past three decades to combat poverty by combining health, education and credit services, including partnering with the national government for large-scale tuberculosis- and malaria-control initiatives.

Demonstrating the possibilities for local capacity-building, two studies from Uganda examined a project in which a variety of private health providers were given micro-loans and business skills training with the tandem goals of increasing the capacity of small-scale private health-care practices and improving public health outcomes. These clinics showed increased patient attendance and a significant improvement in clients' perceptions of quality of care.⁹

Conclusion

Single solutions are not enough to solve the prevalent and persistent problems of infectious disease, high maternal and infant death rates, and the rising incidence of chronic illness. Poor populations need access to a coordinated set of financial and health services to have income security and better health.

Microfinance institutions have already shown themselves capable of contributing to improving health-care capacity and health outcomes by educating clients, facilitating access to public and private providers, making referrals to higher levels of skill and resources, providing health financing options (such as loans, savings and micro insurance) and even directly delivering clinical care.

Worldwide, health systems are proving to be inadequate at meeting population needs. The global health community could broaden its contribution to achievement of the MDGs and strengthening of health systems worldwide through intersectoral programming that utilizes a microfinance platform to reach poor and underserved populations. ■

Funding: Sheila Leatherman was supported by a Gillings Visiting Professorship award at the University of North Carolina.

Competing interests: None declared

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