

Provision of health services to microfinance clients:

An analysis of evidence and future directions

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A Master's Paper submitted to the faculty of
the University of North Carolina at Chapel Hill
In partial fulfillment of the requirements for
the degree of Master of Public Health in
the Public Health Leadership Program.

Chapel Hill

2009

Advisor

Second Reader

Date: 13 April 2009

Abstract

Introduction

The growth of microfinance as an effective tool for poverty reduction provides a mechanism to extend health services to the poor and needy. Of the 3,552 reported microfinance institutions (MFI), 226 MFIs also provides health services to their clients in Latin America (53), Africa (43) and South Asia (130). There are limited systematic efforts to understand the sector, except for evaluation of individual programs. This paper attempts to develop a broader understanding of the microfinance and health sector by collecting views from senior MFI practitioners about their experiences in offering health services to clients.

Methods

Identification of microfinance institutions with self-reported health programs in Africa, Latin America and South Asia was done through exploring the Microfinance and Information Exchange (MIX) database. A self-administered questionnaire was designed to collect experiences from identified MFI practitioners with health programs. After an initial poor response from general emailing of the questionnaire to the MFIs, a selective approach was taken through approaching several intermediary organizations to encourage MFIs to participate in the survey.

Findings

Fourteen MFIs completed the survey to date with ongoing follow-up efforts underway. MFI health programs can be classified into four broad categories, according to their primary goals: raising client awareness of health-related issues, facilitating access to health services, provision of health services, and removing financial barriers. Hygiene and sanitation, childhood illnesses, maternal health, HIV/AIDS and water & sanitation dominate the health needs addressed by MFIs. Although preventive health programs dominate the agenda of MFIs, curative services are also offered through means such as referring to formal health care providers and financing health services through extending health micro insurance and providing health loans at the individual level.

Conclusions

This study is a first of its kind effort to document the experiences of microfinance practitioners with health programs through a survey. The study confronts the general belief that MFIs offer health services to protect their business interest because of clients falling sick and being unable to repay loans. The key conclusion of the study is that the MFIs appear to be motivated by the lack of client awareness about health issues. Also, MFIs struggle to design appropriate community sensitive health programs which can result in failures. Finally there is lack of evidence sharing in the sector, which calls for more systematic efforts to strengthen the evaluation and applied research capacity.

Glossary

BRAC:	Bangladesh Rural Advancement Committee
CARD:	Center for Agriculture and Rural Development
CHC:	Cambodia Health Center
GK:	Grameen Kalyan
ID:	Initiative for Development
ILO:	International Labor Organization
MFI:	Microfinance Institution
MDG:	Millennium Development Goals
MIX:	Microfinance and Information Exchange
NGO:	Non Government Organization
NHIS:	National Health Insurance Scheme
SEWA:	Self Employed Women's Association
STUP:	Specially Targeted Ultra Poor
UNFPA:	United Nations Fund for Population
USAID:	United States Agency for International Development

Introduction

Microfinance, the extension of small loans to groups of poor people for the purpose of investing in self-employment programs, pioneered by Muhammad Yunus in Bangladesh during 1970s, has proved to be an effective and powerful tool for poverty reduction. Evidence shows the positive impact of microfinance on poverty reduction as it relates to the first six out of eight Millennium Development Goals¹ (Morduch and Haley 2001). As of December 31, 2007, 3,552 microfinance institutions reported reaching 154,825,825 clients, 106,584,679 of whom were among the poorest when they took their first loan. Of these poorest clients, 83.4 percent, or 88,726,893, were women. Approximately 90.1 percent of the poorest clients reported were in Asia, a continent that is home to approximately 63.5 percent of the world's people living on less than US\$1 a day (Sam 2009). The microfinance industry is increasingly becoming part of the larger financial framework and microfinance institutions (MFIs) are emerging as social businesses within this framework, catering to an untapped market segment while creating value for their members, through access to low cost financial services. This assimilation into the routine financial infrastructure allows for greater innovation in financial instruments, delivery channels and business partnerships that overcome the legal and market-related constraints in reaching out to the poor. What once started as a purely philanthropic endeavor has now attracted attention of several mainstream corporate players. In 2007, JP Morgan launched a microfinance unit as part of its emerging markets strategy. Pierre Omidyar, founder of eBay, gave \$100 million to Tufts University in 2005 with the stipulation that the donation be

¹ The Millennium Development Goals (MDGs), adopted at the United Nations' Millennium Summit, September, 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor by the year 2015.

used to create a fund seeking its returns only through investments in microfinance. According to the Microcredit Summit Campaign report, by end of December 2007, the total cash turnover of these institutions worldwide is estimated at \$2.5 billion.

However, provision of credit alone cannot mitigate poverty. A poor woman who generates income through microfinance but who does not have adequate access to health care for herself and her family, and who lacks essential information about health and nutrition is still living in poverty. There is a greater reduction in poverty when microfinance programs are combined with increased access to basic social services than when the programs focus on credit alone (Nigam and Mohiuddin 2008). The unmet demands as well as the social and business rationale for microfinance institutions (MFI) to diversify into provision of health services are discussed in the following sections. The aim is to highlight the growing interest among microfinance institutions to offer health services as products to protect poor clients from health related morbidity. The paper is organized in nine sections. The first two sections discuss broadly the microfinance sector and scope for integrating health services into microfinance; the third section discusses the types of health services. The remaining sections (four through nine) describe a study that was undertaken to collect information directly from MFIs that have health programs. The fourth section discusses the study design and methods. The fifth section discusses the characteristics of survey respondents. The sixth section discusses the limitations of the study. Findings are discussed in the seventh section, followed by a discussion section and a section presenting conclusions drawn from the study.

Integrating Health Services into Microfinance Program

There are multiple arguments for integrating microfinance and health services. At a macro level, Microfinance is poised to become an effective tool to address the growing public health concerns for developing economies with 3 out of 8 Millennium Development Goals directly relating to health;

- i. Reduce child mortality: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
- ii. Improve maternal health: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
- iii. Combat HIV/AIDS, Malaria and other diseases: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

From the business perspective, a number of studies have demonstrated the effectiveness of combining microfinance and other development tools in increasing client outreach (i.e. the more clients it serves) and maximizing benefits to the clients of MFI (Oxfam GB 1999, Smith and Jain 1999, Johnson and Ben 1997, Marcus and Harper 1999, Wright 2000). A 15 month microfinance and health integration pilot project in southern India by Freedom from Hunger in partnership with the Microcredit Summit Campaign and with financial support from Johnson & Johnson, demonstrated that MFIs were willing and able to pay for health education training that expanded client services and improved clients' health (Sam 2009). There is a strong business rationale for integrating health services into microfinance program. Among Grameen Bank clients, illness and related expenditures are the leading cause for micro-business failures and loan default (Ohri 2004). A study among self help groups in two districts of Kerala, India

found that out of 2338 loans taken during 2005- 2006, 11% were taken for health care purpose (Gopalan 2007).

Other benefits of integrating health services into microfinance include economic empowerment, social empowerment, and reduced gender based violence. In one of the rare randomized control trials in the area, Kim et. al. (2006) demonstrated the impact of microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa.

Types of health services by MFI

Microfinance organizations have experimented with different types of health programs depending on their client needs and institutional strategic interests. Programs range from preventive to curative services. Prevention includes promoting health awareness, education and advocacy to provision of health insurance; health loans, and savings. Curative services include home based health services as well as formalizing linkages with public and private healthcare providers. Different models of health provision exist. While in some cases MFIs have formally contracted with healthcare providers to provide services to their clients (Mamun 2007, Siegel et al. 2001, Hauck 1997) in other cases they have set up a specialized agency within their own structure to directly deliver health services (CIDEF 1998). Multilateral and bilateral agencies as well as philanthropists like UNFPA, USAID, ILO, Bill & Melinda Gates Foundation supported MFIs to diversify, adding health to their portfolios (Sam 2009, Siegel et al. 2001). Technical support agencies like Freedom from Hunger have implemented projects to demonstrate the effectiveness of providing health services in conjunction with microfinance

programs (Sam 2009, Dunford et al 2006). With this background in mind, a study was undertaken to collect more detailed information about MFIs which have health programs.

Study Objective, Design & Methods

The objective of the study is to understand practices of MFI practitioners, in Africa, Latin America and South Asia, who have integrated health component into their MFI program. These three regions represent two-third of MFIs registered globally.

This study has two parts:

- I. Identifying MFIs which have health programs
- II. Surveying a sample of such MFIs to understand their practices

The study was conducted as part of a master's thesis in the Gillings School of Global Public Health, University of North Carolina at Chapel Hill. This study is part of a larger effort entitled "Integrating Microcredit with Global Public Health", which is supported through a Gillings Award at the UNC Gillings School of Global Public Health. Specific objectives were to understand the health program of each respondent MFI; program goals, design, customer practices, program implementation processes, and success factors.

1. Identification of MFIs with health programs

We identified the existence of health programs in microfinance institutions in Africa, Latin America and South Asia, through exploring the Microfinance and Information Exchange (MIX) database. The MIX MARKET™ is a global, web-based, microfinance information platform. It

provides broad information about the microfinance industry/sector; microfinance institutions (MFIs) worldwide, public and private funds that invest in microfinance, MFI networks, raters/external evaluators, advisory firms, and governmental and regulatory agencies. The MIX MARKET currently provides data on 1374 MFIs, 104 investors and 182 partners (MIX Market 2009). The following search terms were used: health, health services, health loan, health insurance, health program. Forty Three MFIs in Africa, 53 MFIs in Latin America, and 130 MFIs in South Asia have been identified through this process as having health programs. These 226 programs vary widely from small scale health awareness programs to large and complex health programs delivering complex clinical services.

2. Questionnaire Survey

A brief self-administered questionnaire was developed and forwarded to the 226 MFIs identified through the above process. A copy of the questionnaire is provided in Appendix 1. The questionnaire was designed in three languages: English, French, and Spanish. The questionnaire was designed to measure: health needs addressed by the health program, health interventions, principal motivations for offering health services, goals of the discrete offered health programs, design and duration of health program, clients outreach, and key performance indicators. The questionnaire included objective questions, multiple choice questions with provision for additional response, and open ended questions. In conclusion, the respondents were asked if they have done an evaluation of their health programs, and their willingness to share such materials. Those MFIs which have consented to participate in a case study may be evaluated for a second stage in-depth case study, which would be carried out at a

later period. Both offline (MS Word) and online (Qualtrics software) questionnaires were used for collecting responses from participants with questionnaire emailed to MFIs. A total of 27 MFIs (11%) showed interest in the survey of which 14 completed the survey. Analysis presented in the following sections is based on responses from 14 MFIs who completed the survey. A list of MFIs completing the survey is given in appendix 2.

Limitations

The methods discussed above have three major limitations:

1. The MIX market database does not explicitly list health services of MFI. However, this is chosen as the primary search tool because it enlists 1374 of the 3552 reported MFIs. There is no known database, to the author, which reports MFIs by health program. To validate our search and to have additional information about MFIs offering health services, personal communications were made with recognized leaders in the microfinance and health sector, like Freedom from Hunger, and Microcredit Enterprise.
2. Being a self-reported questionnaire, primarily shared through email among the MFI community, the initial response rate predictably was low at around 6%, even after two reminders. In the language of social exchange theory, the costs of responding are perceived to be much higher than any anticipated rewards for doing so. Hence, organizations with good presence and working relations with the MFI community were approached to encourage MFIs to participate in the survey. Freedom from Hunger and Microcredit Enterprise facilitated the survey response collection through forwarding and encouraging their partners to participate in the survey. This had a positive effect on response rate and is

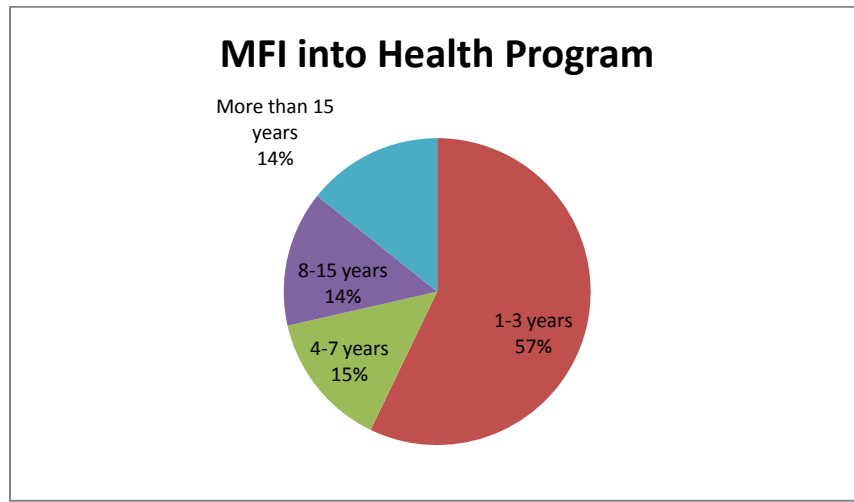
expected to increase the response rate further through ongoing follow-up. This limitation underlies the importance of intermediaries in seeking participation from senior managers of MFIs.

3. The 14 survey responses represent a convenience sample of highly motivated MFIs who agreed to participate. Hence the results do not present the complete representative picture of MFIs having health programs. However, characteristic of the respondents, as discussed in the sample characteristics section, do indicate that the limited sample does have some representation geographically, and represent views of MFIs reaching out to a total of half a million population with health services.

Characteristics of Respondents

Duration of health program

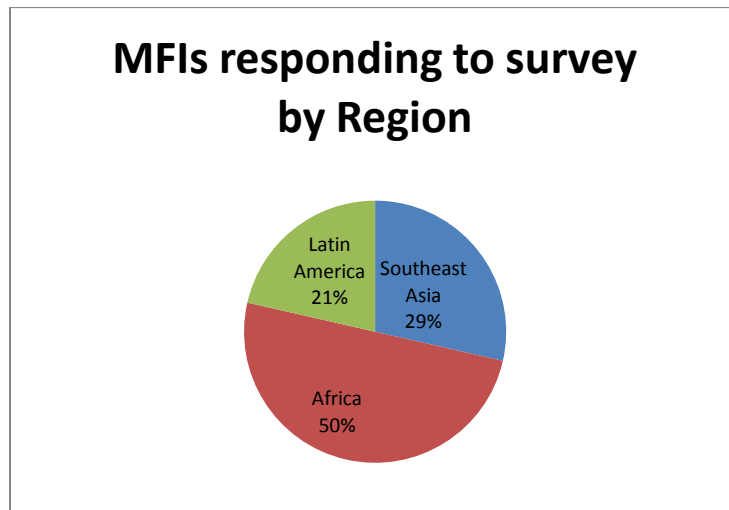
Fifty seven per cent of MFIs have health programs which are 1-3 years old, suggesting health is a recent program addition for more than half of sampled microfinance community. However, 14% of the MFIs have programs which are more than 15 years old. This suggests that while the majority of MFIs are new in health services, there are some with a long history of offering health services.

Figure 1: Years of health program in MFI

Client outreach

Together the 14 MFIs, completing the survey reach out to 464,164 clients with health services.

Figure 2 shows the distribution of MFIs, responding to survey by region. Half of the MFI response came from African region, with the rest shared between Latin America (21%) and Southeast Asia (29%). Although the geographical distribution of the respondents varies from the actual distribution of MFIs in the above region, this distribution shows adequate representation of MFIs from the three regions under study.

Figure 2: MFI responding to the survey by Region

Findings

Health program goals

Program goals vary widely across MFIs. While some health program goals are meant to address a single health need, such a reduction of tuberculosis or improving health insurance coverage, other programs were meant to address broader goals accompanied by provision of a bundle of services. The following illustrates the variability of goals;

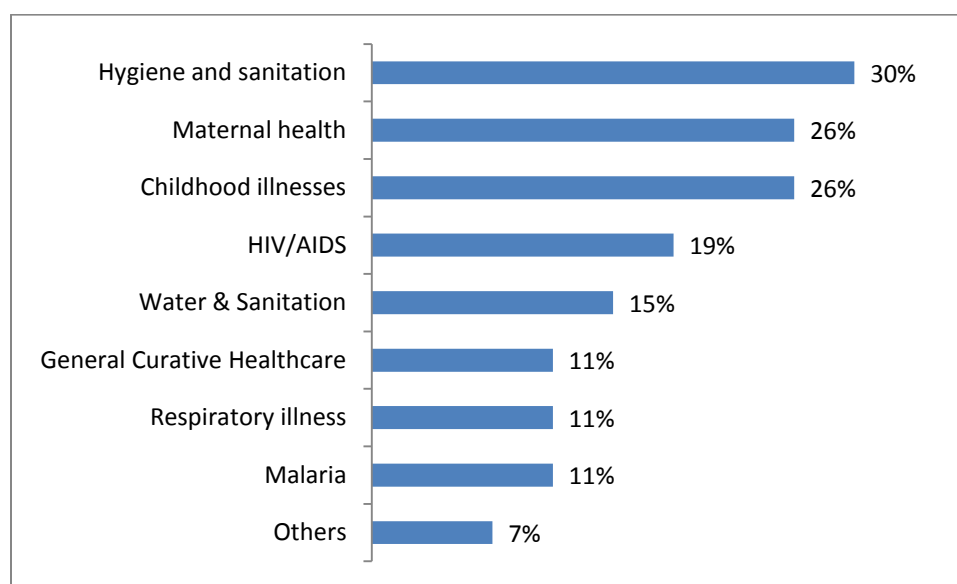
- *To have a maximum of our beneficiaries (borrowers and savers) registered with Ghana's National Health Insurance Scheme (NHIS) either through us or by themselves – ID, Ghana*
- *To reduce TB prevalence by reducing poverty – CHC Limited*
- *To furnish to the members of the timeliness of apprenticeship in the health domains, nutrition and family Planning in order to reinforce the techniques of family planning – Nyesigiso, Mali*

- *To contribute the prevention of childhood illness and of the woman of the groups that we work – Prisma, Peru*
- *To provide groups of women financial services combined with informal education sessions about health (HIV/AIDS, Diarrhea, malaria, breastfeeding) – Kondo Jigima, Mali*
- *To provide preventive health care in the form of education and access to primary healthcare at clinics, free medical screening camps and hospital OPDs. Insulate the poor from financial "health shocks". Ensure high quality service delivery by all healthcare service providers. – Ujjivan, India*
- *To provide health protection services to clients and their families to achieve healthy microfinance clients. – CARD, Philippines*
- *To contribute to the improvement in the life conditions of women from rural and semi-urban communities utilizing two simultaneous products: to provide credit and savings services and to provide education to members in the area of health, nutrition, and micro-business management. – FUCEC, Togo*
- *To offer members health trainings that are dialogue-based in groups of clients. These trainings have the goal of protecting clients from illnesses such as malaria, HIV/AIDS and childhood illnesses as well as the change in attitude, behavior and beliefs of the members. – Kondo Jigima, Mali*
- *To provide preventive health education and ambulatory services to our clients. – Fundacion Espoir*

Health needs

MFIs were asked to identify the specific health needs of their clients that they seek to address through the health program. Hygiene and sanitation (30%) dominates the health needs addressed by the MFIs. Other major health needs include childhood illnesses (26%), maternal health (26%), HIV/AIDS (19%), and water & sanitation (15%) (Figure 4). Tertiary care of patients, herbal medicine plants, tuberculosis, malaria, family planning, and sexually transmitted infection are health needs MFIs mentioned under category of “others”. MFIs often address more than one health need.

Figure 4: Health Needs addressed by MFI

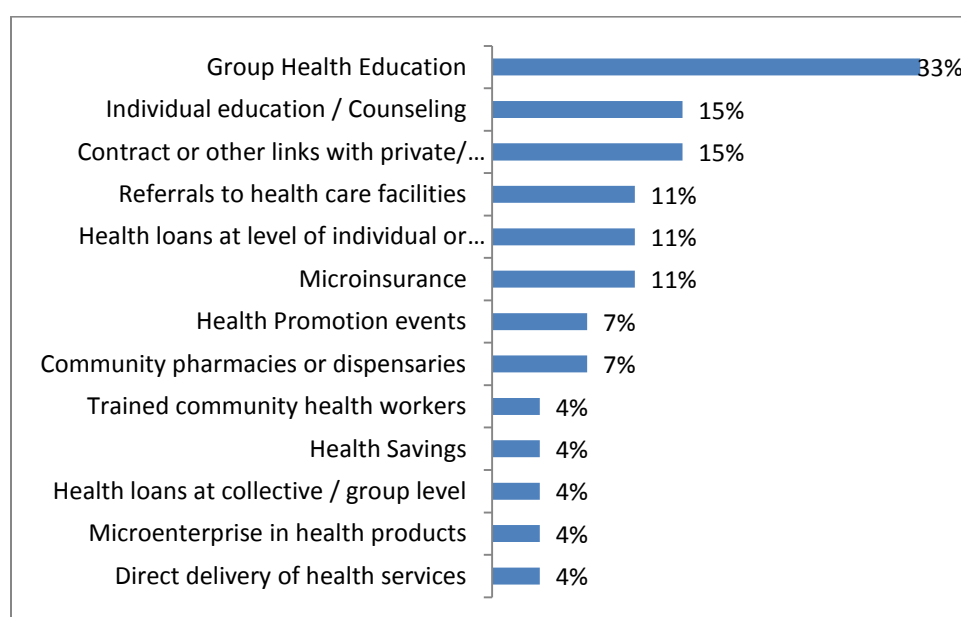


Health Program Delivery

Awareness and health education is an important program goal for MFIs to generate client awareness. One-third of all MFIs responding to the survey used group based health education session to spread health awareness among its clients, followed by individual counseling

sessions (15%). Fifteen per cent MFIs facilitate provision of health services through contracting with public/private health care providers, while 11% facilitate referral to health facilities. A fifth of MFIs who responded to the survey offer financial services in the form of health loans (11%), and micro insurance (11%). Other health programs include conducting health promotion events, community pharmacy or dispensary services; training community health workers, financial products like health savings and health loans at group level, provision of health services through direct delivery and microenterprise through health product distribution by clients.. MFIs often implement combinations of programs to address the health needs (Figure 5).

Figure 5: Health Program Delivery

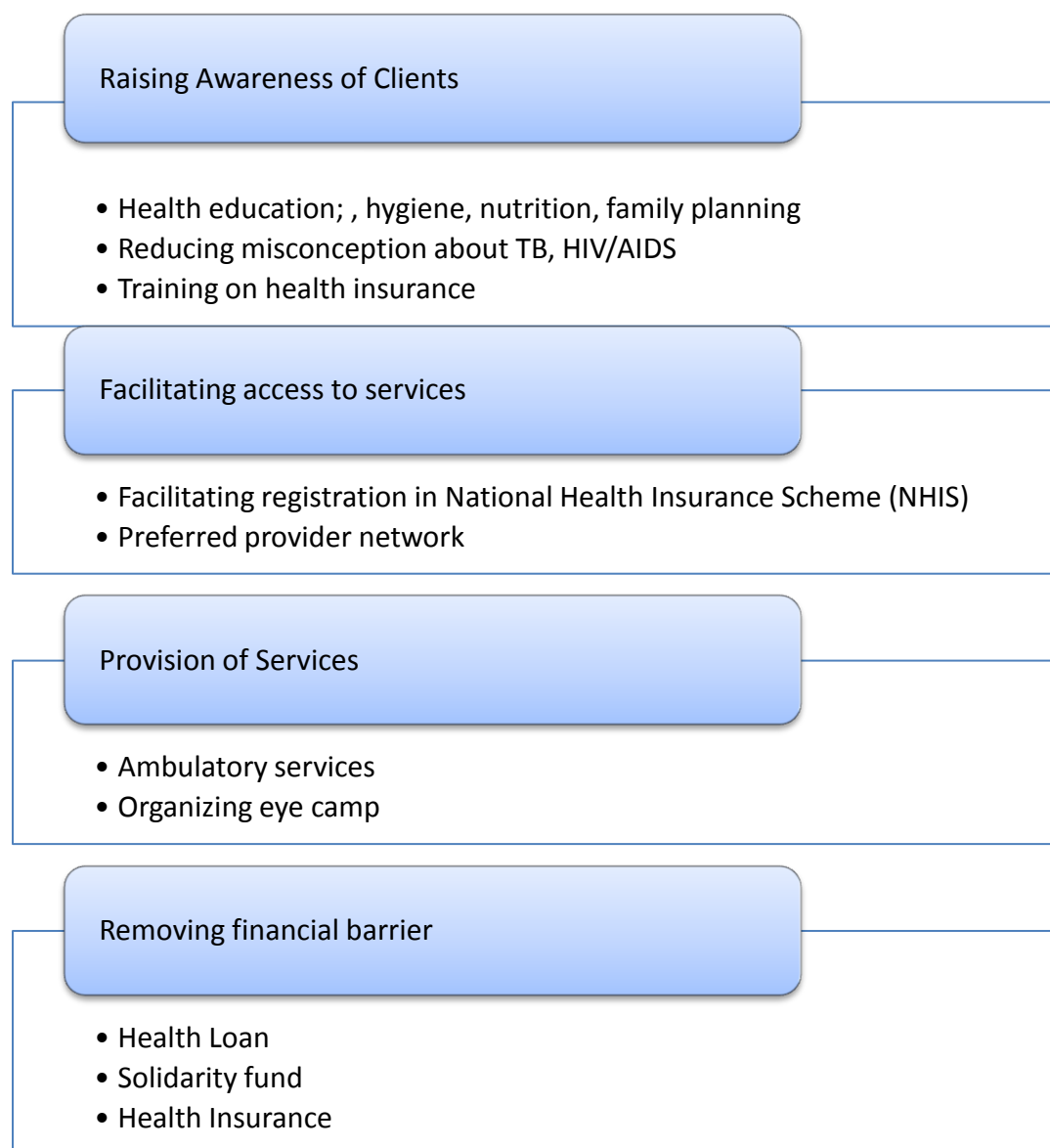


Program design

The design of health programs varies according to client needs. Based on responses received from MFIs, a broad typology of different health programs is discussed in Figure 6. These are

followed by selected quotes of responses to open-ended questions in the questionnaire.

Broadly health programs can be classified into four categories: raising awareness of clients; facilitating access to services; provision of services; and removing financial barrier. MFIs often implement programs on a pilot basis before establishing a routine set of programs to be pursued. This shows the need for and lack of evidence to effectively tailor-make health programs according to the need of clients, requiring each MFI to learn on its own rather than to be able to adopt and adapt “tried and true” approaches. This also underlies the role and need for technical assistance to help MFIs design effective, but evidence based health programs. Also from a sector perspective, this reinforces the need for effective demonstration projects and sharing of evidence among MFI practitioners.

Figure 6: Broad typology of health program

*“We give **training about the benefits of health insurance** on a regular basis. Once a sufficient number of beneficiaries are willing to enroll for NHIS in one of our 7 branches, we organize with the Health Ministry’s government agent a **registration session** in our branch premises and registration happens in bulk over a couple of hours...” – ID, Ghana*

*“The **Credit with Education** is delivered during weekly center meetings on topics such as dengue and other health topics such as health insurance and the Using Health Services.*

*The **Preferred Provider program** is a partnership with private practicing health providers in the area who are willing to give discounts on their services to CARD members and qualified dependents. They are from different fields such as general medicine, pediatrics, surgery, obstetrics and gynecology, medical technology.*

*The CARD **health loan** is a loan provided to qualified and interested members who want **insurance** coverage. Like the other loans of CARD, it is paid on a weekly basis thus making payments easier for them... Currently, CARD is looking for a model fit for CARD and CARD members.” – CARD, Philippines*

*“...The main focus of CHC NGO is to reduce **tuberculosis and HIVs** by reducing poverty. However healing and providing them medicine alone could not reach its goal... The fund was limited and the need was huge and this kind of activities would not be able to stay long-term sustainable ... CHC-Limited gives support to the CHC-NGO by introducing the sick to them and CHC-NGO gives helps back with the health education training like TB prevention, General health care based and HIVS’ prevention to the CHC-Limited’ clients.” – CHC Ltd., Cambodia*

*“... We **organized free Eye Camps** with one of the top Ophthalmic hospitals in Bangalore, since December 2006. The camps run monthly; sequentially at each of the Ujjivan Branches for the customers and their families. Low cost eye glasses and cataract surgeries are provided and if patients cannot pay, they are done free. Similarly with the more serious eye operations - customers pay what they can, we find donors for rest of the cost.*

*We had launched a **microhealth insurance** product with one of the major insurance companies in India in June 2007. Sadly the quality of service by the primary provider (hospitals) was way below standard and we shut it down in July 2008...” – Ujjivan, India*

*“ Provide women credit services and savings in order to increase their savings and income. Provide **learning opportunities to the women in the area of health, nutrition, and family planning** in order to reinforce their behaviors. Improving the self confidence of the women as well as their skills in decision-making through the combined efforts of increased revenues, improvement in knowledge and the learning from the experience gained in managing their credit associations and their own affairs.” - Nyesigiso, Mali*

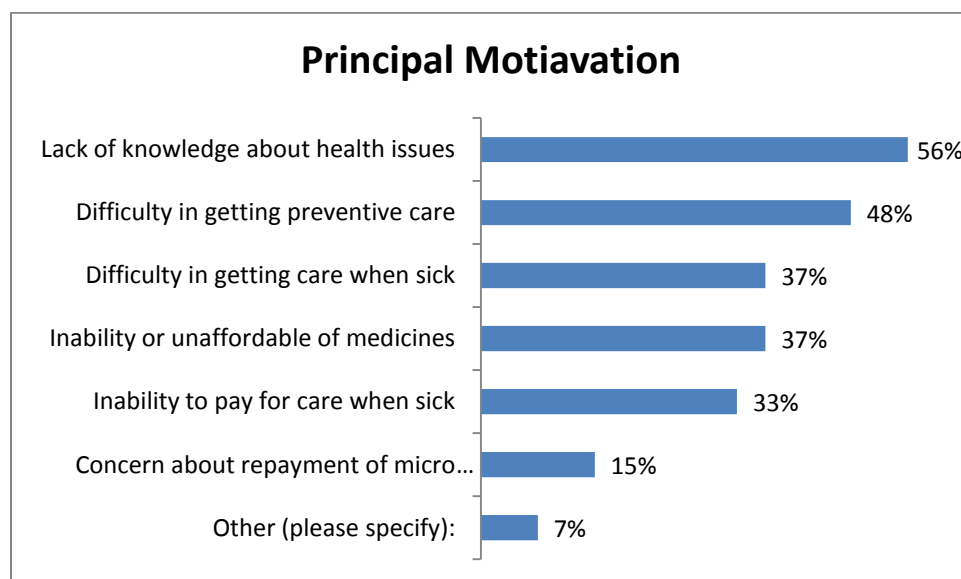
*“This initiative (Microfinance and Health) provide members of credit unions a range of financial products and services such as health **savings and loans and solidarity funds** aimed at caring for the individual and community health needs. The education and advocacy activities accompany the financial products.” – RCPB, Burkino Faso*

*“**Health education** sessions are carried out through two educational modules of Freedom from Hunger: 1) main illnesses/sicknesses that affect our children and 2) family planning... The clients (female) de ESPIOR meet every fifteen days during the payment meetings and the preventative health education will be carried out as well as business education... The clients (women) and their families can receive **ambulatory services** to take care of their health in our doctor’s office through a symbolic monthly payment. ” – Fundacion Espoir, Ecuador*

Principal motivations for offering health services

Respondents were asked to rate their principal motivation for offering health services in their microfinance program, and respondents could chose more than one motivation. Among the 14 MFIs who responded to the question, the principal motivation appears to be acknowledgement of the lack of knowledge about health issues (56%) on the part of the MFI clients, followed by the difficulty in getting preventive care (48%), difficulty in getting care when sick (37%), inability to pay for or unaffordable medicines (37%), and inability to pay for care when sick (33%).

Interestingly although the motivation to provide health services is often attributed to a business interest, the concern about repayment of the client’s business loan, being compromised by sickness is not an important factor; rated by the MFI practitioners as just 15% (Figure 7).

Figure 7: Motivation behind implementing health programs

Key performance indicators

The questionnaire prompted MFIs to list their key performance indicators through an open ended question. As a guide the survey was designed with a list of key performance indicators from review of literature and personal experience.

Major performance indicators collected by MFIs can be classified into three categories: outreach indicators, behavioral indicators, and outcome indicators. The major performance indicators in order of frequency of reporting are listed below.

Outreach Indicators:

1. Number of microfinance clients
2. Number of clients with access to health loans
3. Number of clients with access to health insurance
4. Number of clients with access to public private partnership

Behavioral Indicators:

1. Improvement in health seeking behavior of clients
2. Improvement in nutrition of children
3. Decrease in misconception about AIDS
4. Improvement in women using family planning methods
5. Improvement in percentage of women who have had pap smears test

Outcome Indicators:

1. Increase in vaccination
2. Decrease in complications during pregnancy
3. Decrease in cases of diarrhea
4. Increase in rate of breastfeeding
5. Increase in level of food security among population

Discussion

The responses from the MFIs participating in the survey have highlighted several emerging issues about MFI participation in offering health-related services. Though a small number of MFIs reported in this survey, it does represent the views of MFIs reaching out to half a million clients in 11 countries on 3 continents. There is a wide range of experience among MFIs that responded to the survey; some with recent introduction of health programs, while other MFIs have conducted health programs for well over a decade. A combination of survey responses and review of the literature leads to the following emerging issues as summarized below:

1. MFIs are governed by their client needs in deciding to offer health services. Their concern about financial viability is rated low.
2. Although preventive health programs dominate the agenda of MFIs offering health services, curative services are also being promoted by MFIs. These include referring to formal health care provider and financing health services through extending health micro insurance and health loans at the individual level.
3. The majority of MFI's health programs focus on just group health education. However, there is a large unmet need in the sector to test out a wider range of innovative health interventions such as health loans at group or collective level, microloans to health

providers, health savings through community savings account, community pharmacies, and contracting arrangements with community providers and government programs to offer affordable and accessible health services.

4. There is a dearth of effective referable databases to understand the MFIs implementing health programs. This becomes essential given the emerging evidence that extending health services to the poor through microfinance programs is associated with improved health awareness, behaviors and associated health outcomes.
5. Often MFIs struggle to design appropriate community sensitive health programs which can result in failures. This underlies the necessity to build effective technical capacity in program design and implementation. Also the lack of evidence sharing in the sector, calls for more systematic efforts to strengthen evaluation and applied research. This observation is corroborated by two recommended actions outlined in UNFPA (2006) i. identify, collaborate with and support institutions – both practitioners and international technical assistance providers; and ii. 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.

Conclusions

This study is the first of its kind effort to document the experiences of microfinance practitioners with health programs through a survey. Although the data and conclusion are limited by a lower than expected response rate, some important information and insight into

the microfinance and health sector has been obtained. These data are valid to the extent that MFIs responding to the survey are representative of the larger population of MFIs.

Literature shows that MFI s offer health services to fulfill twin agendas: a social agenda to protect poor households against risk, and the commercial agenda to enhance stability and profitability of poor household, thus protecting the long-term sustainability of MFIs (Roth et.al. 2005, Brown 2000). In contrast, lack of client awareness about health issues is listed as the primary motivation to initiate health program by MFIs. The study confirms observations by Dunford (2002) on the importance of group-based delivery mechanisms for health services to microfinance clients. The struggle and instances of failure of MFIs in designing appropriate community sensitive health program was in confirmation with findings of Brown (2000) "... for every successful example of a micro-insurance product (linked to MFIs) there are several examples of spectacular failures that often leave clients without an protection (despite having paid their premiums) and the providing institution bankrupt." Many questions remain as to the most viable and effective approaches for integrating microfinance and health access strategies. There is a growing interest in the inter-sectoral approach of combining microfinance with health interventions to meet the needs of the poor in low income countries but there is no industry consensus how to respond (Sebstad and Cohen 2000). .

Clearly more information is needed to fully understand the current and future trends in the sector and it is hoped that there will be an opportunity to follow-up with more detailed case studies of some of the participating MFIs as well as to increase the numbers of institutions responding to the survey.

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Appendix 1: Questionnaire

1. Our research indicates that your MFI has an active or past (within the past 3 years) health program. Is this correct?

Yes _____

No _____

2. What type of health-related activities is your MFI currently involved in?

We want to understand the type of health needs and problems you are addressing and the types of health programs or interventions you have implemented. To provide examples, we have listed sample health needs under list A below and sample health programs under list B ; these are suggestive and not complete.

List A. Types of Health needs that programs are designed to address;

1. Child illness
2. Hygiene and Sanitation
3. Women's Health
4. Malaria
5. Respiratory Illness
6. HIV/AIDS

List B. Types of Health Interventions

Education

Group health education
Individual education/ counseling
Health promotion events; ex health fairs, screening

Linkages to Health care services and products

Direct delivery of health services (ex. Clinics)
Contracts or other links with private/public providers
Facilitated referrals to care
Mobile services for remote locations
Microenterprise in health-related products

Financial

Health loans at level of individual or household
Health loans at collective/group level
Microinsurance
Health savings
Health vouchers

Community resourcing

Trained community health workers
Community pharmacies or dispensaries
Water and sanitation

Please list the health needs that you are addressing through your health program

1. List the health need/problem in Column A
2. List the health program /intervention in Column B.

Some programs may address more than one health needs.

Please list all of your programs and services;

Health Need	Program

3. What were the principal motivations for your MFI to offer health services?

- a. Clients have a lack of knowledge about health issues
- b. Clients have difficulty in getting preventive care
- c. Client have difficulty in getting care when sick
- d. Clients cannot afford essential medicines
- e. Clients are unable to pay for care when sick
- f. Concern about repayment of micro loan due to illnesses
- g. Others (Please specify)

4. Please provide some additional information on the programs and services you listed above. If you have multiple programs, please describe the 2-3 that have existed longest and have demonstrated results.

The goal of the program (please describe in 2-3 sentences)

How many years has the program been in existence?

How many clients have access to your health program in what geographic areas?

The design of the program (please describe in a paragraph)

5. Please provide us with the key performance indicators that you have used to assess the impact of your health program and have available data collected.

We list some suggestive indicators below for your reference only. Please draw from this list of appropriate and add others.

- a. Total number of microfinance clients
- b. Total number of clients with access to your health program
- c. Percentage of total MFI clients with access to your health services
- d. Number of clients in your target areas receiving health education
- e. Number of clients with MFI-facilitated linkages to health providers
- f. Estimated number of clients with MFI-facilitated access to health microinsurance
- g. Estimated number of clients with access to health savings accounts
- h. Estimated number of clients with access to individual health loans
- i. Number of clients with outstanding individual health loans
- j. Increase in immunizations
- k. Decrease in complications due to pregnancy
- l. Reduced diarrheal illness
- m. Better child nutrition
- n. Increased breastfeeding
- o. Reduced misconception about HIV/AIDS
- p. Increased uptake of PMTCT program

6. What are the principle sources of funding for the program?

7. Is there any written evaluation or case study available on the health related programs?

Yes

No

8. Would your organization be willing and interested to participate as a detailed case study?

YES -----

NO-----

9. Please provide the name, designation, address, telephone number and/or email of the key contact person of your organization, whom we can contact for future reference.

Appendix 2: List of MFIs completing the survey

MFI	Country	Region
CARD	Philippines	Southeast Asia
PADME	Benin	Africa
Kondo Jigima	Mali	Africa
Nyesigiso	Mali	Africa
PRISMA	Peru	Latin America
FUCEC	Togo	Africa
RCPB	Burkina Faso	Africa
Fundacion Espoir	Ecuador	Latin America
Manuela Ramos Credit Mujer	Peru	Latin America
CHC Limited	Cambodia	Southeast Asia
Ujjivan	India	Southeast Asia
Initiative Development	Ghana	Africa
Famer Microfinance	Togo	Africa
Development Action for Mobilization and Emancipation	Pakistan	Southeast Asia