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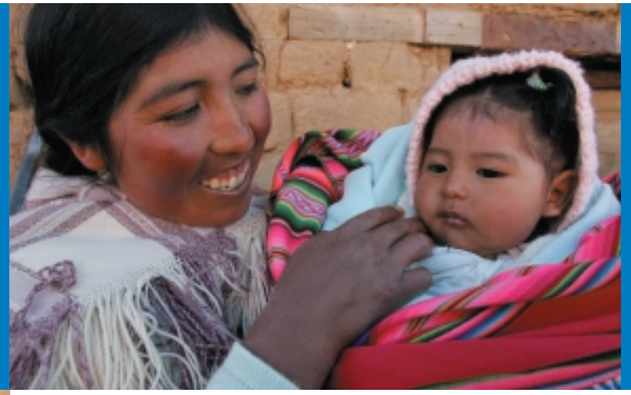
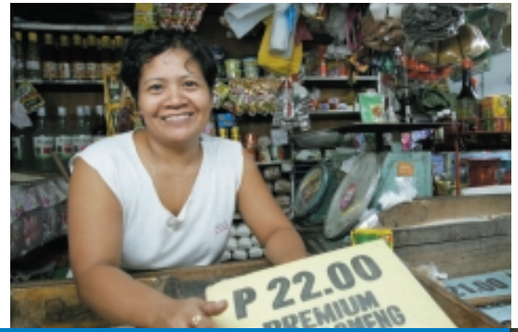


From Microfinance to Macro Change:

Integrating Health Education and Microfinance to Empower Women and Reduce Poverty



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

—Kofi Annan, United Nations Secretary General

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From Microfinance to Macro Change:
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Executive Summary

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

The time has come for action. This document calls on development agencies, governments, microfinance institutions (MFIs), and donors to help realize the goal of health and equal opportunity for all by investing in strategies with proven impact on the problem of global poverty and poor health. It proposes one specific strategy that acknowledges the intimate relationship between poverty and poor health, and has proven impacts for very large numbers of the poor and very poor[1]. This proposed strategy is the combination of microfinance and reproductive health education.

Dramatic findings are emerging on the macro level that support the importance of microfinance. A 14-year study by the World Bank of three MFIs in Bangladesh finds that 40 percent of the *entire* reduction of poverty in rural Bangladesh was directly attributable to microfinance[2]. Juxtaposed with other countrywide data presented in the HDR 2005, this evidence is even more powerful. The HDR 2005 cites Bangladesh's successes in human development by comparing it to India, a country with much higher income and economic growth, but lesser progress toward human development goals. It declares that, "Had India matched Bangladesh's rate of reduction in child mortality over the past decade, 732,000 fewer children would die this year." The HDR 2005 presents four strategies directly contributing to Bangladesh's advances, including *"expanded opportunities for employment and access to Microcredit."*

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

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

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

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

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

Introduction

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

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

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

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

The Millennium Development Goals

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

Poverty, Poor Health and Inequality

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

—Human Development Report 2005

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

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

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

The Results of Poverty, Poor Health and Inequality

- *One in five people in the world—more than one billion people—still survive on less than $1 a day, a level of poverty so abject that it threatens survival. Another 1.5 billion people live on $1–$2 a day. More than 40% of the world's population constitute, in effect, a global underclass, faced daily with the reality or the threat of extreme poverty.*
- *In 2004 an estimated three million people died from [HIV], and another five million became infected. Almost all of these deaths were in the developing world, with 70% of them in Africa.*
- *An estimated 530,000 women die each year in pregnancy or childbirth....At least 8 million women a year suffer severe complications in pregnancy or childbirth, with grave risks to their health....the vast majority of these deaths occur in developing countries.*

Source: Human Development Report 2005

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

Increases in household income are not the whole story for reducing poverty and poor health outcomes—neither can be achieved without gender equality and empowerment of women. Research has shown that inequalities in gender and women's lack of empowerment inhibit economic growth and development. A World Bank report on gender equality states, "In no region of the developing world are women equal to men in legal, social, and economic rights. Gender gaps are widespread in access to and control of resources, in economic opportunities, in power and political voice. Women and girls bear the largest and most direct costs of these inequalities—but the costs cut more broadly across society, ultimately harming everyone."[3] The MDGs recognize the importance of empowerment and gender equality to eliminating poverty by including it as the third of the eight goals: "Promote gender equality and empower women."

"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

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

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

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

[3] "Engendering development through gender equality in rights, resources, and voices." Report summary. http://www.worldbank.org/gender/prr/engendersummary.pdf

Microfinance:

An Effective Strategy to Reduce Global Poverty

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

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

What Is Microfinance?

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

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

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

Why Are Microfinance Services Offered Primarily to Women?

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

Microfinance Today

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

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

The Story of Sufia

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

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

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

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

The Story of Ana

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

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

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

The Evidence for Microfinance's Impacts on Poverty

> *Microfinance clients manage their cash flows and apply them to whatever household priority they judge most important for their own welfare. Thus microfinance is an especially participatory and non-paternalistic development input. Access to flexible, convenient, and affordable financial services empowers and equips the poor to make their own choices and build their way out of poverty in a sustained and self-determined way.*
>
> —*Is Microfinance an Effective Strategy to Reach the Millennium Development Goals? CGAP Focus Note No. 24 by Elizabeth Littlefield, Jonathan Morduch, and Syed Hashemi*

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

- After a two-year period, participants in three Ugandan microfinance programs showed an increase in both assets and savings compared to a non-participant group, and reported greater profits from their microbusinesses (Barnes 2001).

- An evaluation in India discovered that three-fourths of members who participated for longer periods experienced marked improvements in their economic status (Todd 2001).

- A study of Grameen Bank clients in Bangladesh found that after eight to ten years in the program, 57.5 percent of participant households were no longer poor (Todd 1996).

- Another study in Bangladesh revealed that the funds lent to women produced a 20 percent return to income from borrowing in the form of household expenditures (Khandker 2005).

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

Broader Impacts of Microfinance

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

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

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).

Most studies examining women's empowerment focus on women's decision-making power in various realms of their lives as a reflection of levels of empowerment. A study in Bangladesh found that Grameen Bank members were 7.5 times more likely than the comparison group to be empowered, and BRAC members were 4.5 times more likely to be empowered—and the level of empowerment increased with the duration of membership (Hashemi 1996). In Nepal, an evaluation found that 68 percent of microfinance participants in the Women's Empowerment Program experienced an increase in their decision-making roles in areas traditionally dominated by men (Cheston and Kuhn 2002). In Ghana, microfinance participants demonstrated increased empowerment when they began to give advice to others, and participants in Bolivia became more involved in local political life after joining the microfinance program (MkNelly and Dunford 1998 and 1999).

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

—Focus group participant and member of CARD in the Philippines

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

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

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

The Story of Hermelil

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

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

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

Microfinance as a Strategy to Alleviate Global Poverty

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

The HDR 2005 compares Bangladesh's successes in human development to India, a country with much higher income and economic growth than Bangladesh, but lesser progress toward human development goals. It declares that, "Had India matched Bangladesh's rate of reduction in child mortality over the past decade, 732,000 fewer children would die this year." The HDR presents four strategies directly contributing to Bangladesh's advances, specifically naming BRAC (an organization providing microfinance services, among other services) as one of the non-governmental organizations "improving access to basic services through innovative programs." Another of the four strategies, called "virtuous cycles and female agency" by the HDR, centers on the idea that:

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

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

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

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

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

Considering Bangladesh as an example of microfi
potential on a national scale, it is not such a stret
imagine its potential impact on global poverty. Re
of the intimate link between poverty, poor health
inequality along with the evidence of microfinanc
impacts in these areas demands the expansion of
finance services to the poor as a primary strategy
ing the MDGs.

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