



Outlook

Microfinance and women's health: What do we know?

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The importance of evaluating and communicating the successes and failures of global health programs has received increased attention in recent years.¹ Robust and clear information is needed on the population benefit and increased efficiency of different approaches.

This issue of *Outlook* aims to review the evidence base for microfinance approaches to improve and address women's health. Interest in linkages between microfinance and women's health has been present for decades, and several reviews consider the impacts of microfinance on health broadly.²⁻⁶ A realistic appraisal of whether and how microfinance can improve a woman's health throughout her life cycle can help identify promising areas for investment and future exploration, especially in a constrained funding environment and period of intense scrutiny for both fields. This issue will begin with background on the microfinance sector, and links between microfinance and health. This will be followed by a review of relevant evidence and priorities for research going forward.

What is microfinance?

Microfinance is defined as "the supply of loans, savings, and other financial services to the poor."⁷ The primary objective of microfinance programs is poverty alleviation, operating under the assumption that certain groups in the population lack access to reliable financial resources and/or services that could enable them to improve their own and their families' living standards.

Microfinance is a broad term that includes loans or credit as a product for clients, as well as grants, savings, insurance, and business skills or life skills education and vocational training. The most common type of intervention is probably microcredit, in which organizations offer very small loans to a borrower, usually a woman, to help her grow her small-scale business or start a new one (in 2009, the average microfinance loan was about US\$550⁷). The Grameen Bank in Bangladesh was the first microcredit organization to achieve major growth,⁸ and arguably remains the most well-documented and well-known microcredit model to date.² The Grameen model involves voluntary group settings where individuals receive loans, and group members help ensure each other's repayment. Specific features vary depending on program design and regulatory context, but loan cycles are often relatively short; loan amounts increase as individuals successfully repay their loans, and savings—with limited opportunities for withdrawals—are generally involved. By the 1990s, microcredit programs had provided relatively strong evidence that the poor can and will repay loans, programs can become financially sustainable at scale (i.e., financed by client fees and interest rates rather than donor support), and women tend to have better repayment rates and higher levels of investment of resources in their families than men.³

Nongovernmental organizations (NGOs), community-based savings and loan associations, government development banks, and for-profit commercial lending institutions can all provide microcredit. Self-help groups, in which group members engage in credit management

with minimal external oversight, have been popular in India.⁹ Village banks are a common model in Latin America. A sponsoring organization provides a loan to a village bank comprised of 20 to 40 women; each woman receives an individual loan in turn, and they are all responsible for each other's repayment.¹⁰

While there have been impressive achievements by the Grameen Bank, Bangladesh Rural Advancement Committee (BRAC), Freedom from Hunger (FFH), Project Hope, and other smaller groups in microcredit and microfinance more broadly,² the performance of microfinance institutions overall has been uneven.¹¹ Many microfinance organizations face challenges effectively reaching the very poorest clients, as opposed to the economically active poor.^{8,12} Not all programs have been able to increase income or assets of poor individuals, empower female participants, or achieve financial sustainability. Experimental evaluations of microfinance interventions are rare, and sampling bias is a challenge.⁵ Some have argued that microfinance institutions can impose a problematic debt burden on already-vulnerable individuals.¹³

Scrutiny of the microfinance industry has also increased markedly in 2010–2011. In particular, there has been concern regarding the ethics of lending practices of some microfinance institutions, including those of SKS Microfinance, India's largest microlender (which transitioned to a publicly traded company in 2010). As a result, restrictions on activities of the microfinance sector have been proposed in parts of India and elsewhere.^{7,14} Disputes over research design and interpretation of results have also complicated previous assertions that microfinance has helped to reduce poverty and achieve progress in human development on a major scale.^{14–16}

Despite these criticisms, microfinance institutions currently serve approximately 92 million clients in more than 100 countries, with an overall portfolio of US\$65 billion in loans and US\$27

billion in savings.⁷ A key priority for microfinance in the coming decade is diversification of models to reach more vulnerable clients, including demand-driven approaches that emphasize client needs (e.g., by addressing social issues such as health and education; Figure 1).¹⁷

Microfinance and women's health: the arguments

Poverty impacts an individual's health, including the ability and opportunity to engage in health-seeking and health-promoting behavior. At the same time, poor health can deepen poverty by diminishing an individual's ability to be economically productive and by generating catastrophic health costs. Given these connections, it seems reasonable to anticipate that stand-alone microfinance programs focused on poverty alleviation could also achieve improvements in health.

On the other hand, many factors complicate the potential for health impacts of stand-alone microfinance programs.¹⁰ Beyond increases in income, essential knowledge about health is often also needed for behavior change. Many social and contextual realities, including a woman's relation-

ship with her partner and the accessibility, affordability, and quality of health services, also affect her ability to act in the interest of her health and her family. Therefore, integrated programs that directly address health can also be considered (Figure 1 and Box 1).

Support for integration: a health-sector perspective

Greater demand for health care and limited resources in many settings have led to an increased interest in alternative financing mechanisms for health. Microfinance institutions that support provision of health services through client fees, operational revenues (e.g., interest on loans or from savings), and health loans or health savings accounts present an appealing option. Additionally, the impressive scale and financial sustainability achieved by Grameen Bank, BRAC, and other microfinance organizations may provide models for delivering cost-effective health interventions at scale.¹⁸ Microfinance institutions often have established mechanisms for reaching the poor repeatedly over time that can be leveraged to deliver and reinforce simple and effective health interventions.

Figure 1. Range of health-related interventions to serve microfinance client needs

Client needs	Awareness/knowledge of health practices.	Ability to pay for health expenses.	Access to competent health care workers in community.	Access to health-related products and services.	Access to predictable health coverage.
Illustrative responses	Health education and promotion.	Health loans and savings accounts.	Linkages to health providers. Facilitated referrals. Trained community health workers. Microloans to private providers for capital investment.	Coordination with public providers. Social health entrepreneurs. Community dispensaries.	Prepaid health and insurance plans. Contracted arrangements with government programs.

Adopted from Leatherman S, Metcalfe M, Gessler K, Dunford C.⁶

Integrated interventions may also incentivize health-seeking or health-promoting behaviors. Microfinance institutions, by offering the incentive of financial services, may facilitate health care for individuals who otherwise find the actual or opportunity cost of seeking health services to be too high. Similarly, increased financial resources may enable individuals to act on what they learn through simultaneous health education programs, or to increase consumption of health services and commodities that are offered jointly.

Support for integration: a microfinance-sector perspective

Addressing health may help a microfinance organization to advance the mission of providing both financial security and social protection for clients and the communities in which they live.¹¹ Healthier clients can also contribute to growth and long-term viability of a microfinance institution through good repayment practices and increasing entrepreneurial activity, among other things. From a practical standpoint, existing client groups that meet regularly provide an avenue for education, basic services, or even collection of premium payments if a microfinance organization decides to offer insurance.¹⁷ There is also the possibility of attracting new clients and increasing the loyalty of existing clients by offering health education or services.

Microfinance and women's health: the evidence

Both program evaluations and experimental designs have assessed health-related impacts of stand-alone microfinance programs and integrated approaches. Evidence is primarily available and is summarized below on family planning and women's utilization of and access to health services. A short overview addressing a few other women's health topics is also included.

Family planning

Microcredit programs in Bangladesh demonstrated a positive impact on contraceptive use during the 1990s.

While these programs did not provide any direct family planning education programs or services, they generally referenced the economic benefits of smaller families in their activities. One study found that Grameen Bank increased contraceptive use among both members and non-members in villages where the bank was active.¹⁹ Another evaluation found that Grameen Bank members had significantly higher rates of contraceptive use than women who lived in villages without Grameen Bank programs; this was partly explained by the Grameen Bank members' increased mobility.²⁰ Again, the study found that even non-members in villages where Grameen Bank programs were active had higher rates of contraceptive use than did women living in the "comparison" villages. These studies also note that the family planning infrastructure in rural Bangladesh was relatively strong, so services were available even if they were not provided by the microcredit programs themselves. A more recent short report of a microcredit program in Peru found that longer participation in the program was

significantly associated with less family planning knowledge, and there was no impact on use of reproductive health services in either direction. No explanation was offered by the authors for why this may have occurred.²¹

It is not clear whether microcredit programs can also affect women's actual fertility patterns. One study from Bangladesh found that participation in a credit program increased contraceptive use and desire for smaller families, but not fertility rates.²² Evidence is also lacking on the impact of provision of family planning education or services through an integrated approach.

Health services utilization and access

Evidence on the effects of microfinance on women's access to and utilization of health services has been mixed. Four primary approaches to addressing women's access to health services through microfinance are documented in the literature: stand-alone microcredit programs, health education, supply-side interventions, and health financing mechanisms.

Box 1. Sample microfinance platforms for improving client health

There are a range of options for how to provide microfinance and health services in a joint fashion.^{3,23} For example, **demand-side** health interventions can generate demand and willingness or ability to pay for health services. These might include health education or extension of health insurance, health loans, or health savings to low-income and vulnerable groups. By contrast, **supply-side** health interventions can increase the efficiency and management of health care providers and/or create new health-related enterprises. An example would be a program to increase the quality of services provided by small-scale health providers, such as midwives.²⁴ See Figure 1 for an illustration of potential microfinance and health interventions that can meet a range of client needs.

Operational approaches to integrating microfinance and health services include:

- **Linked:** microfinance and health services are provided by two independent organizations that are strategically aligned and serve the same clients in the same geographic area.
- **Parallel:** one organization provides both microfinance and health services through two autonomous, separately staffed programs.
- **Unified:** one organization provides both types of services within the same program by the same staff.

Stand-alone microcredit

One evaluation of BRAC's microcredit program in Bangladesh identified an increase in women's demand for formal health care as a result of participation, likely due to increased control over financial resources.²⁵ Another study in India showed that participation in self-help groups with no formal health component can help protect against exclusion to health services; it was speculated that this was mainly because women could use loans to cover health costs (according to self-report), rather than due to increases in income.²⁶

Health education

A targeted BRAC intervention that provided grants, skills training, health education, products, and financial assistance to the very poor achieved increased health services utilization, but women were less able to access formal providers than men; on the other hand, women did have increased perceived self-health and contraceptive use as a result of the intervention.²⁷ In Bolivia, a microfinance program that included health education on financial planning for health and rational use of health services resulted in increased use of preventive health services by clients.²⁸ An evaluation in the Dominican Republic found that parallel microcredit and health promotion programs, compared with microcredit programs alone, did not affect reported frequency of breast self-exams, even though there were improvements on other health indicators.²⁹

Supply-side interventions

Another way microfinance institutions might be leveraged to improve health care services for women is through supply-side interventions, or providing financial resources and support to providers of women's health services. An evaluation in Uganda of such loans to midwives found that client perceptions of quality of midwives' services improved, including specifically four out of eight quality indicators: availability of drugs, fair charges, cleanliness, and privacy.²⁴

Health financing mechanisms

Health financing mechanisms are a relatively recent offering of microfinance programs; a major project on microfinance and health implemented by FFH in five countries found that health financing was a major barrier to meeting clients' health needs.²⁸ FFH supported organizations in India, Bolivia, and Burkina Faso to provide health loans to their clients at lower interest rates and with more flexible terms than their business loans. Clients in Burkina Faso could also establish health savings accounts. FFH's partner in the Philippines offered health microinsurance, in which the premiums to join the national insurance program were financed by a health loan repaid by clients in small installments along with their regular microcredit loan payments. Clients in these programs (the majority of whom were women) were highly satisfied with these services and viewed health loans, savings, and/or insurance as important sources of financing for health expenses. Clients in Burkina Faso with access to health savings and loans reported higher use of preventive health services as a result. FFH's economic analyses also found these programs to be relatively inexpensive for their microfinance institution partners. Many clients still experienced gaps in health financing, however.²⁸

Other examples are available from Nicaragua and Bangladesh. For example, one program in Nicaragua attempted to enroll informal-sector workers in a subsidized insurance program using microfinance groups as an outreach mechanism. Evaluations found that individuals had more trust in government institutions than microfinance institutions as a mechanism for insurance enrollment and provision; insurance was not seen as an area of expertise for microfinance organizations.³⁰ Use of health services did not increase for women who enrolled in the insurance program. Additionally, while the insurance coverage reduced out-of-pocket health expenditures for beneficiaries, it did not reduce them enough to cover the cost of the premium. The

authors concluded that microfinance institutions may be most effective as insurance delivery channels in places without strong government social security programs. In Bangladesh, microinsurance programs with relatively low premiums and profit margins have increased women's access to services by decreasing the costs of basic preventive health care.³¹ However, microinsurance that focuses on preventive care is not sufficient to protect women and their families from shocks and associated significant health expenses (e.g., emergency cesarean sections). This is in contrast with the experience in India, where microinsurance tends to cover higher-cost services.

Other women's health outcomes

Evidence on actual improvements in women's health achieved through microfinance programs is minimal.⁷ One of the strongest examples is the IMAGE program in South Africa (Box 2). An evaluation of a microcredit program in drought-impacted and food-insecure areas of Ethiopia found that women who received loans were significantly less likely to be malnourished than were female community controls.³² Evidence from Nigeria indicates some potential for microfinance approaches to support fistula survivors.³³ Effects of microfinance interventions on women's mental health overall are ambiguous.^{13,20,34,35}

There is some evidence that participation in microfinance programs with integrated health education can improve knowledge regarding women's health issues, including pre- and post-natal care.^{36,37}

Microfinance and women's HIV risk: the evidence

Women, especially young women, face a disproportionate vulnerability to HIV/AIDS everywhere in the world. Reasons include economic deprivation and dependence that drives unsafe

* Improvements in health knowledge or behaviors related to child health, malaria, and other health areas have been documented,^{6,17,28} but are outside the scope of this review, which is focused specifically on women's health.

sexual behavior, as well as gender inequality that places women at risk in many ways (e.g., inability to negotiate condom use and lack of sexual and reproductive health knowledge). Given that microfinance interventions are associated with both economic empowerment and women's empowerment more broadly, there has been recent interest in whether these programs might be applied to reduce HIV risk among women. A study in the Dominican Republic found that women who perceive higher levels of control over their own money also feel more empowered to negotiate safe sex behavior with their partners, for example.³⁸

On their own, microfinance programs show mixed results regarding economic empowerment of women; it is also unclear at this stage which elements of these programs may be leveraged most effectively to reduce a woman's HIV risk.³⁹ More detailed evaluations and reports are available about integrated microfinance and risk-reduction interventions for young women in sub-Saharan Africa who are at high risk for HIV infection.

HIV prevention in young women

There have been a few well-documented attempts in sub-Saharan Africa to apply the microfinance model to HIV prevention among young women. For example, the Tap and Reposition Youth (TRY) program in Kenya aimed to reduce adolescent girls' vulnerability to HIV infection and other adverse reproductive health outcomes by improving their options for livelihoods. The project was set in low-income and slum areas of Nairobi. At first, the intervention followed a fairly rigorous microcredit model that emphasized entrepreneurship and repeated borrowing. It was found, however, that the young women were more in need of support groups, friendships, mentorships, and opportunities for safe, accessible savings (although a minority of older participants worked effectively within the traditional approach). Basic education, skills training, savings, and financial

education may be more important for younger and more vulnerable girls; and vocational, technical, or business training combined with microcredit for older and more experienced girls.⁴⁰

Another program, Shaping the Health of Adolescents in Zimbabwe (SHAZ!), which focused on providing microcredit to adolescent female orphans in Zimbabwe in order to prevent HIV, experienced low repayment rates. This was due in great part to a lack of social support for participants outside the program and the ineffectiveness of the program mentors. In fact, an unintended consequence of the program was that participants were

exposed to physical harm, sexual abuse, and coercion in the context of their new economic activities. Based on these early findings, the program transitioned to a livelihoods approach focused on life skills education and increasing social support.⁴¹

A review of programs integrating microfinance and HIV prevention among adolescents found "the link to be weaker than expected."³⁸ Adolescents have a longer-term need for empowerment and transformation of gender dynamics in their relationships than do typical women participants in the traditional Grameen model; the latter tend to be women at somewhat stable

Box 2. The IMAGE approach

One of the most rigorously evaluated integrated interventions involving microfinance and women's health is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program in South Africa.^{18,34,42-44} This intervention involved a cluster-randomized trial design to find out whether combining a microfinance program with participatory training on HIV risk and prevention, gender norms, domestic violence, and sexuality can improve economic well-being, empower women, and lead to reductions in interpersonal violence against women. Violence against women is a public health issue: it increases their risk of injury and their HIV and unwanted pregnancy risk, can affect pregnancy outcomes, and negatively affects their physical and mental health.⁴⁵ Through the IMAGE program, a microfinance organization called the Small Enterprise Foundation implemented a Grameen-style program focused on group lending. Those in the intervention group received microfinance services together with a health and violence-prevention program developed with another NGO and delivered by a separate team of trainers. In the first phase of the health- and violence-prevention program, women participated in ten one-hour training sessions on a variety of topics over six months. The second phase focused more on community outreach and broader trainings on topics such as HIV and violence.

Results showed that participation in the intervention was associated with greater self- and financial confidence, more participation in social groups and activities outside the home, and for partnered women, more autonomy in decision-making and better communication and relationships with their partners. Levels of interpersonal violence also consistently decreased in all four villages where the intervention took place, whereas they either stayed the same or increased in the four control villages with microfinance programs alone. The researchers collected supporting qualitative data to explore the reasons for this difference, and found that women in intervention communities were empowered to challenge the acceptability of violence and expect better treatment from their partners, as well as to leave violent relationships and/or offer support to those experiencing abuse. Results also showed that mobilization of groups in the community and increased public awareness played a role in preventing or reducing violence.⁴³ Direct health impact was not assessed.

stages of their lives, unlikely to physically relocate, and who have completed childbearing.⁴⁶

Some adaptations of the microfinance model have been suggested in order to better support the goal of HIV prevention in young women: for example, a sustainable livelihoods approach that focuses more broadly on safe and productive employment opportunities, including wage employment and home-based work as well as self-employment and entrepreneurship. This approach also tends to invest in building capabilities and making resources available (savings or loans, housing, or social networks) for adolescents.⁸ Another model that may apply to adolescents is a program implemented by Grameen Bank in 2005, which emphasizes mentorship of struggling members by regular members who provide guidance and support; loans are collateral and interest-free.⁸

The evidence: overview and synthesis

There is limited evidence that stand-alone or integrated microfinance programs have direct effects on women's health. Increased contraceptive use of microcredit clients in Bangladesh in the early 1990s is a notable exception. However, it has not been established to date that these results are widely replicable.

There is some encouraging evidence that microfinance programs, including health financing tools, may improve women's health utilization and access. The IMAGE program was able to achieve some impressive reductions in interpersonal violence against women through a relatively cost-effective program linking microcredit and health education.¹⁸ Some important components of IMAGE include the collaboration of individuals with both expertise in microfinance and violence prevention, and efforts to address the broader social environment that shaped women's vulnerability to violence.⁴³

Operational considerations for integration

Limited evidence is available on what specific elements of integrated programs have been successful. It may be helpful to inform these decisions with input from clients on their needs and assessments of organizational capacity to implement new or strengthened programs. PATH and the microfinance organization Global Partnerships have recently documented their experience working with Pro Mujer in Nicaragua to develop a stronger health package for microfinance clients (Box 3). Key questions that can help shape opportunities for integrated programs include the following:

- Does an enabling environment exist for integrated approaches (e.g., laws and policies, service delivery infrastructure for referrals or specialized care, a stable or promising for-profit sector)?
- Is there funding available to support some creative or relatively higher-risk approaches for reaching the most vulnerable populations (e.g., through grants or savings for very poor populations or investments in younger populations)?
- What capacity does an organization have to plan for and provide new health services (e.g., to recruit, train, incentivize, and supervise staff to provide new programs)? Is required staff expertise locally available?
- How can an integrated program ensure that health programs are not marginalized in the context of "bottom-line" concerns about loan repayment and client retention? What role can supportive institutional leaders play?

Priorities for future research

A number of positive experiences with microfinance and women's health signify that this is an area that merits increased attention; yet more evidence of impact would be helpful to inform work in this area. In particular are the following areas for careful consideration:

Box 3. A systematic approach to integration in Nicaragua

In 2009–2010, PATH, Global Partnerships, and Pro Mujer Nicaragua collaborated to integrate health services and health education into a microfinance platform. While Pro Mujer already had 20 years of experience providing low-cost health care and preventive health education to its microfinance clients in Latin America, the three organizations developed an innovative systematic approach to identifying an evidence-based health care package.

The initial nine-month planning process involved an operational assessment of Pro Mujer's capacity, a health assessment to identify prevalent health issues and problems faced by Pro Mujer clients, and an assessment of the market for health services in which Pro Mujer operates (including gaps between client needs and available services). A financial assessment was conducted to ensure sustainability, and focus groups with clients helped refine a proposed health package. As an example, the health package was broadened to address chronic diseases like diabetes and hypertension, in response to both a review of data on disease burden and feedback from Pro Mujer clients.

In October 2010, Pro Mujer launched a three-year pilot project to test the new health package. Evaluations conducted to date show that clients are accessing the services and that client satisfaction is high. The decision to emphasize chronic disease prevention and care appears well-founded: 36 percent of clients so far have been diagnosed with a chronic or metabolic disease (e.g., diabetes or hypertension), and 65 percent of clients are overweight or obese. By the end of 2011, Pro Mujer anticipates that the package will be ready for delivery throughout Nicaragua. *For more information on this approach, please contact PATH at outlook@path.org.*

- Integrated programs should develop evaluation frameworks from the beginning and collect information on traditional microfinance indicators of success (e.g., loan repayments and client retention) as well as health outcomes. Collecting data on both will help to assess the sustainability, scalability, and financial benefits of integrated approaches, as well as how programs benefit participants. An initial assessment of the capacity, time, and other resources needed to complete these crucial activities (and for the program to achieve actual health impacts) will be helpful.
- Many types of groups can work together in shaping integrated interventions; more information on how to forge links among, for example, health providers, youth-serving groups, or groups working on poverty alleviation, food security, violence, and women's rights might facilitate success. Many integrated approaches to date have been initiated by microfinance groups themselves; health providers and other social service NGOs might consider how they can reach out to and collaborate with microfinance institutions to expand their reach.
- Poverty and poor health care are complex issues driven by larger structural forces. Some microfinance organizations or health programs may be hesitant to take on controversial issues like gender equality for fear of community or political opposition⁴⁷; more information on the benefits and risks of such comprehensive approaches would be helpful.
- Even where microfinance programs have yielded strong health-related results, it is not always clear what elements of a particular program are critical to achieving change. More guidance on best practices of adapting microfinance interventions to address health is badly needed.⁴¹ Setting up real-time monitoring processes, rather than traditional baseline, midline, and endline moni-

toring, may help to yield that type of information.

Perhaps most importantly, much of the research to date has focused on traditional microcredit approaches and health education interventions; more evidence is needed on innovative health financing mechanisms, sustainable livelihoods programs, and supply-side approaches to health service delivery. Compelling evidence of program approaches to reach vulnerable groups facing obstacles to both health and economic participation (e.g., young women vulnerable to HIV infection, older women living with HIV/AIDS or chronic disease or caring for others, and the very poor) can justify investment of increasingly precious global health and development funds.

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