



Why Integrating Microfinance, Health Education, and Other Forms of Health Protection is Good for Your Clients and Good for Your MFI

On the morning of Thursday, April 9, **Christopher Dunford**, President of Freedom from Hunger in the USA, chaired the workshop on “Why Integrating Microfinance, Health Education, and Other Forms of Health Protection is Good for Your Clients and Good for Your MFI.” This workshop provided substantive background on programs that have successfully integrated microfinance with health care-related interventions, especially preventative health education, by training field officers at MFIs to on-train their clients at the local level. This panel of leading practitioners has deep knowledge and expertise in developing and implementing microfinance initiatives that embed health care-related elements into their programs and offered valuable insights to those who are currently or in the future engaging in similar practices in the field. The panelists included **Mahamadi Cissé**, Regional MAHP Manager in West Africa for Freedom from Hunger, based in Burkina Faso; **Dr. D.S.K. Rao**, Regional Organizer for Asia-Pacific for the Microcredit Summit Campaign, based in India; and **Daouda Sawadogo**, Director, Fédération des Caisses Populaires du Burkina (FCPB) in Burkina Faso.

Christopher Dunford, President of Freedom from Hunger in the USA, launched the workshop with the assertion, “the burning question is not *whether* health and microfinance integration is desirable or would be beneficial. Health problems seem to be the most common reason microfinance clients default or struggle to repay, and as a general cause and consequence of poverty, ill health ranks unquestionably near the top, perhaps number one or two, particularly in Africa. Moreover, many effective health interventions do not require medical expertise, especially preventative education and financing access to health care or selling health products like insecticide-treated nets. Now there are many examples of MFI’s providing or facilitating such health interventions. In summary, integration of microfinance and health care *can* and does occur and to good effect. So the question for this panel isn’t *whether* but *how* microfinance and health can be offered together to the poor.”

As the moderator, **Mr. Dunford** posed his first question to **Dr. Mahamadi Cissé**, Regional MAHP Manager-West Africa, Freedom from Hunger in Burkina Faso: “Given the experience you have had there [in West Africa] and elsewhere, what do you think are viable options for an MFI to provide its clients with health education and access to health services and medicines?”

Dr. Cissé began [*translated from French*], “Integrating microfinance with health care was and remains, even now, a new approach. We tested this integration process at five MFIs around the world with operations in various contexts. These five MFIs include the Réseau des Caisses Populaires au Burkina, PADME in Benin, Bandhan in India, CARD in the Philippines, and CRECER in Bolivia.”

Thursday, April 9, 2010

10:45 AM – 12:15 PM

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Panel:

Chair: Mr. Christopher Dunford, President, Freedom from Hunger, USA

Dr. Mahamadi Cissé, Regional MAHP Manager—West Africa, Freedom from Hunger, Burkina Faso

Dr. D.S.K. Rao, Regional Organizer for Asia-Pacific, Microcredit Summit Campaign, India

Mr. Daouda Sawadogo, Director, Fédération des Caisses Populaires du Burkina (FCPB), Burkina Faso

“We can see that these clients need information to protect their families' health and themselves,” he remarked. “... So microfinance institutions can respond ... by developing non-formal education services. Another concern is that even when clients have the [health care] information, they also need financial resources to pay for these health expenses. And microfinance institutions [can] respond by developing specific products to help them finance their health, including a health insurance program.”

“Another aspect is that even when people have resources to pay for health care, they also need providers who offer quality services ... [and MFIs can] facilitate access for people to quality health care services. Clients also need access to health protection products--for instance, to insecticide-treated mosquito netting whose impact on people's health is well-known--but accessing them is a problem, so what the microfinance institutions are doing is establishing alliances and facilitating their clients' access to those products,” Dr. Cissé suggested.

“Thus, in the case of our MAHP initiative, several options have been developed with microfinance institutions,” he shared. “One of those options is health education. This is an approach, rather than pedagogical teaching, because we know that rural people are most often illiterate. [We are] using participatory methodologies along with small group work and role playing to help clients understand the information. Another product that was developed is health savings, which encourages a saving-for-health mindset among clients in order to [ensure they] have revenue available to meet their health needs. ... Over the last four years we have been able to reach 486,000 clients, representing 15% of the active borrowers of the MFIs we have worked with.”

Dr. Cissé added, “[These products] contribute to the MFI's social mission, keeping in mind that microfinance institutions not only aim to earn a profit but also to improve their clients' living conditions. The MFI's liquidity increases thanks to the mobilization of savings; this also protects the business loan portfolio because when people get sick they don't have to figure out ‘What resources do I have? Do I use the loan I got for my business or some other related asset first?’” In fact, these products protect microloans, reducing non-reimbursements due to health care costs, serving as insurance for clients because they know what resources are available to take care of them in case of illness. It also makes early medical consultations easier, which means that clients can avoid complications and even reduce health care costs, thus increasing their income.

“And finally,” he concluded, “we noted enthusiasm on the part of the clients and even on the part of the microfinance institutions to such an extent that some told us, ‘If these products didn't exist you'd have to create them.’ And others say, ‘You sure dragged your feet before creating these products because we'd been waiting for them forever.’”

Mr. Dunford posed the second question to **Dr. D.S.K. Rao**, Regional Organizer for Asia-Pacific for the Microcredit Summit Campaign, based in India: “Given your great interaction with many MFIs, what is the level of interest that you have seen among MFIs, why are they interested, and what are their primary reasons for resisting integration and how do you respond to these points of resistance?”

Dr. Rao responded, “The Microcredit Summit Campaign has been working in Asia for the last five years on promoting integration of health education with

microfinance, with collaboration from Freedom from Hunger and funding from Johnson & Johnson. Initially, we started by conducting planning workshops and training of trainers in four Asian countries, and these, of course, were followed by implementing a pilot project in South India. We adopted and promoted the Freedom from Hunger methodology and curriculum, which involves field workers from microfinance institutions to facilitate the health lessons, because this is found to be the most cost effective and efficient way of integrating health education with microfinance with the least problems of coordination.”

“We found that involving field workers was very effective,” he continued. “And this project involved four practitioners [MFIs] and 100 field workers ... to deliver lessons to 16,000 clients. We covered three health topics namely: HIV/AIDS, women’s health, and childhood illnesses in a matter of one year. And after the pilot project ..., three out of the four of ... [these MFI practitioners] have mainstream health education in their operations. They are expanding their health education ... covering more clients and ... more health topics.”

“What we found in the pilot project experience, and also why the MFI’s were encouraged to mainstream, was that ... the field workers--who we originally thought ... would not be able to handle this work--started enjoying the presentation work because they got to learn ... more about health education [themselves],” Dr. Rao related. “And [of] the 16,000 clients, I hardly met anybody who found it a burden to attend these meetings and listen to 20 to 30 minutes of additional ... [information]. They enjoyed it; they got excited and wanted more. ... Evaluation of this whole pilot project also showed a lot of impact, particularly impact in the knowledge and information gained by the clients, and also the changes in their attitudes and practices.”

In terms of the challenges the program faced, Dr. Rao shared the feedback he received. “[Practitioners] are very much excited to introduce this product, but they say that the whole field-based process should be much more brief. One of the big practitioners in South India was recently telling me, ‘Look, my field workers are going to all the meetings, and if you give me some health messages in some sort of ‘blip type’ of information which can be read out and ... does not involve more than five to six minutes of time, I am prepared to introduce this product to all my clients. But if you want me to involve my field workers for a facilitation of 30 minutes per lesson, I think it would be too difficult. My productivity would be affected.’ So ... that is the kind of resistance [I have seen].”

“One more thing I feel is that MFI’s are not appreciating the benefits that can come to their institution by introducing health education. The facilitation process ... improves the field workers. They become much better field workers. That is what we noticed. The clients benefit, client loyalty is improved, the client retention and the dropout rate are reduced, [and] returns are increased. I perceive in the field we need to have much more empirical data to prove all these benefits which can accrue to the microfinance institution so that they are more and more excited to introduce this new product.”

In support of Dr. Rao’s comments, Mr. Dunford added, “[Dr. Rao’s] experience is actually not atypical, and we have certainly seen this kind of mixed reaction in Africa and Latin America as well: enthusiasm but emphasis n how can we do this for a low

cost and minimize the time involved. [We realize that] if you minimize the time and reduce the cost so much that you reduce the quality of the education, then people are not really learning. And more importantly, [if] they are not changing behaviors and practices that actually improve ... the health of the clients and their families, then why do it at all? So then obviously an optimization, a balance of cost and time involved and the quality of the education is really critical.”

The workshop continued with comments from **Daouda Sawadogo**, Director of the Fédération des Caisses Populaires du Burkina who shared his local experience with microfinance and health care in Burkina Faso. Mr. Sawadogo explained [*translated from French*], “[T]he Réseau des Caisses Populaires au Burkina¹, which started as a microfinance institution in 1972 and now counts over 103 credit unions, has mobilized over US\$514 million, with a loan portfolio of over US\$110 million, and 900 employees, 70% of whom are women. ... In 1993 we decided to ... introduce[e] a credit product called Credit with Education (CWE) ... [which] integrated training modules on health education. ... This first product led to satisfactory results; [and] currently there are over 100,000 women in Burkina who [are] enrolled ... [in] this product, and around US\$10 million of assets in credit; and the education [program] involves over 47,000 women. ... [However,] from 1993 to 2006, we did not have any financial health protection mechanism, [and] we began seeing an increase in client defaults because part of the money was being used for child health care [expenses]. We also started noticing a lack of trust between institutions and recipients, [which] led us to develop new products. ... [This] helped the women meet their own health-care needs and also pay their loans on time,” he shared.

“The product we developed consisted of a package of five products,” Mr. Sawadogo described, “three financial products and two non-financial products. The first financial product is health savings, where women are expected to save regularly over a six-month period, with a minimum of US\$1 [saved] per month. The second product is a health loan, in sizes ranging from \$20 to \$600. The, interest rate [on this loan] is below four points compared to the other products. ... The third financial product we set up was a solidarity fund, which is one of the options the institution has for supporting women's health. The other two non-financial products in the package ... are health education and counseling. At the education level, we have continued to provide training on the basis of a certain number of health-related modules. And counseling is a health service, and a strategy to listen to these women better, to respond to their needs.

“What are the outcomes from this experience?” he asked. “Right now, we have some 13,000 members who have subscribed to health savings, with about US\$170,000 in deposits; the health loan product has helped 23 members; and health education has reached ... 16,000 clients. We have seen that as a result of these products, our reimbursement rates have improved at the institutional level, and the health loan is most often used for children's health.”

The primary challenges that this program faced related to awareness building, communication and buy-in at both the client and the institutional level. Mr.

¹ Explain what the relationship is between FCPB and RCPB and translate: Network of People's Banks of Burkina and Federation of People's Banks of Burkina

Sawadogo took this opportunity to outline how these challenges were addressed. “We went through a market research study ... to better identify client needs, [because] you shouldn't try to produce before you sell; you have to do the selling ... [first]. That is an important part. The other part is developing an institutional image in the community.... Next, you have to develop a communications and promotion policy. ... We needed to reinforce the key actors' knowledge, whether staff, management, recipients, or community leaders. The procedures and policies need to be more flexible, and annual orientation, evaluation, testing and implementation workshops are needed. Because at present, the product has not been spread to all the branches of the network, maybe 40% of the branches are interested; however the results are already interesting.”

Following are a few key comments from the Q&A session:

Comment from Dr. Rao on the cost of integrating microfinance programs with health care: “The cost that is mainly involved is in terms of the training of the field workers. The initial training of the field workers ... takes a little time, maybe about four days ... because a lot of inputs have to be there in terms of the other learning principles also along with the health topic. Once the first training is over ... you do not have to repeat the ... [core] learning principles [in subsequent trainings] so it becomes a lot easier. Each health topic need not be more than two days of training. But the real cost is in terms of obtaining the training materials, getting them translated into local languages and then distributing them to the MFI--that is a cost.”

“I have estimated, in South India the cost to the microfinance institution is not more than half a dollar per client, per month, for providing this kind of facility; and normally each field worker can easily cover about 150 to 200 clients with health lessons.... If you are not going to pay the field worker any financial incentive, the cost is quite minimal because you are using the same field worker for delivering the health lessons [and] you are using the same meeting platform for delivering the health lessons, [so] the incremental costs will be very negligible.

Comment from Dr. Cissé on strategic alliances [*Translated from French*]: “Our experience with the microfinance institutions does not really involve replacing health services with microfinance institutions. Rather, it involves being able to establish alliances with health providers, who are the ones specialized in offering health care services, because what are the facts in our countries? [The reality is] that in certain localities, people do not even have access to quality health services. So even if they have the resources to benefit from health care services, they are not available. So the institutional role here is to facilitate their clients' access to health services and health products.”

Comment from Mr. Sawadogo on profitability [*Translated from French*]: “I think that even outside the health microinsurance framework, in general, whenever you create a company, the first year is not likely to be profitable. ... If the institution has not reached a certain size, I think a subsidy is inevitably needed to launch this kind of product. But if the institution has reached a certain size, it can, in fact, integrate these products even if the institution uses a product that is unprofitable but can fulfill its social mission, and ... attract clients for other products. I think this is an aspect we shouldn't lose sight of and it reminds us that we need the umbrella of a network precisely to offer this kind of product. If, for example, here in Kenya, I have 50 or so

MFIs, and I know that for a single MFI going it alone to offer those products, there are fixed costs that it cannot cover. Why not join together as a network to offer this product that is mutualizing costs? I think we must focus our thinking in that direction for the MFIs in a particular country to talk about maybe offering a product that can be used by all of the MFIs.”



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