



MICROCREDIT SUMMIT CAMPAIGN
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Integrated Health and Microfinance:

Harnessing the Strengths of Two Sectors to Improve Health and Alleviate Poverty in the Andes

State of the Field of Integrated Health and Microfinance in Bolivia, Ecuador, and Peru, 2012



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Integrated Health and Microfinance: Harnessing the Strengths of Two Sectors to Improve Health and Alleviate Poverty in the Andes

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Health as an important criteria for the success of microentrepreneurs

Foreword by Soledad Ovando Green, General Manager,
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Those of us who are dedicated to microfinance know that beyond the volumes of credit, capital flows or risk assessments, what we really seek is to improve the lives of thousands and thousands of people whose daily activity provides their daily means of support.

When we truly see the micro-entrepreneur as a person, and not just as a credit recipient, we recognize that the life and livelihood of this person can be highly vulnerable to health problems.

The impact that illness and poor health has on the life of a micro-entrepreneur may be decisive, negatively affecting a business cycle and even its continuity. If we add other factors that particularly affect income-generating activities undertaken by women (who often also act as the head of their households) in precarious working conditions, and who face prolonged workdays for many years, the importance of maintaining good health is even more important.

Although the main focus of microfinance institutions (MFIs) is not health, many motivated by their social missions and their understanding of the health needs of their clients, seek to deliver a "comprehensive" package of solutions.

Those who have taken it seriously have undertaken a range of different approaches to protect the good health of the entrepreneur, or at least to minimize the risks of illness (a win-win situation). Some institutions have done so by providing loan protection against default - thus safeguarding the relationship between the micro-entrepreneur and the supporting MFI in the event of failure to make regular payments as the result of illness and loss of productivity. Other institutions have done so by delivering health education to their clients or by providing other financing mechanisms such as health savings or loans intended to help clients access and pay for needed health services.

Viewed from the perspective of dozens of public agencies concerned with the health of their citizens, the financial organizations that reach micro-entrepreneurs can play a key role to improve health: they can help by leading community awareness campaigns, building local distribution points and networks by facilitating linkages to healthcare providers for micro-entrepreneurs and their families and with the provision of health financing products.

MFIs are in a uniquely advantaged position to play this role. They have ongoing and regular interaction with clients and knowledge of client needs. Although MFIs do not necessarily need to provide healthcare services themselves, they can be instrumental in building linkages between the healthcare system and microfinance clients.

As practitioners, we have become familiar and experienced with community organizing, strengthening local leadership, coordination of education activities with local authorities and strengthening the micro-entrepreneurship efforts of our clients. This is what we do in our day-to-day practice. And it is from this experience that we can begin to look for innovative approaches to improve the health outcomes for entrepreneurs and generally, improve the quality of life of MFI clients and their families.

The starting point for success in this area is to further build our understanding of the needs of our clients to inform how to adapt and supplement the financial services that MFIs offer to their clients with other products and services that also meet the well-being and quality of life they deserve.

Preface

In September 2011, Freedom from Hunger and the Center for Health Market Innovations brought together a small group of health and microfinance leaders to explore interest in creating a community of practice for integrated health and microfinance in the Andean region. The group proposed to create a community of practice whose mission is to improve the state of the practice in the integration of microfinance and health through the involvement of relevant actors in the exchange, documentation and dissemination of experiences as well as the generation of evidence and advocacy.

To advance its mission, the group developed the following objectives:

- Develop and strengthen integration models for microfinance and health interventions.
- Advocate with donors, funders, investors, governments, regulators and other entities in favor of integrated microfinance and health strategies.
- Generate evidence through appropriate models for the evaluation and monitoring of the practice of integration of microfinance and health.
- Disseminate and promote models, results, best practices and recommendations.

Since then, the community has grown to include microfinance organizations, health and microfinance networks, investors, researchers, universities, healthcare non-profits, insurance companies, health-service providers and government officials. National organizing committees were formed in Bolivia, Ecuador and Peru to develop plans for advancing the community in each country. These efforts culminated in national-level learning and planning events in

each country, engaging more than 250 people representing more than 90 institutions across the region. This report synthesizes the primary learnings and conclusions shared during these events and the ongoing discussions within the community. We hope it will stimulate dialogue, provoke reflection and encourage further exploration of opportunities to integrate health and microfinance to improve the quality of life for the millions of Andean people still living in poverty.

In order to broaden our impact and connect our community with the global dialogue, we have joined forces with the Microfinance and Health Alliance, a collaboration between the Microcredit Summit Campaign and Freedom from Hunger that seeks to leverage their technical expertise and communications platforms for the specific purpose of building support for and expanding the practice of integrating microfinance and health.

This report is the product of collaboration between Freedom from Hunger, the Microcredit Summit Campaign, the Center for Health Market Innovations and the many members of our organizing committees. We are grateful for the support and collaboration of all who have contributed to this report. We are especially grateful for the financial support of the CHMI and Rockefeller Foundation that provided the seed money to launch this initiative. We would also like to extend a special thanks to all those visionary organizations that generously have shared their experiences bridging these two sectors to benefit the poor. May your examples serve as inspiration to others who share a common purpose.

Gina Lagomarsino, Managing Director of the Center for Health Market Innovations, Results for Development Institute

Lisa Kuhn Fraioli, Vice President, Latin America, Freedom from Hunger

Larry Reed, Director, Microcredit Summit Campaign

Introduction

Over the last few decades, microfinance has been considered one of the most important strategies in alleviating poverty and addressing food-security issues. For years, microfinance providers have recognized that poverty and poor health are so intimately connected that it is virtually impossible to distinguish between the causes of one and the effects of the other. Many microfinance leaders and field agents report that health problems are often given as the reason clients fail to repay loans or build and sustain successful income-generating activities. In recent years, we have begun to see how the microfinance sector is increasingly becoming recognized as an effective platform for providing vital health education, products and services.

In the Andean countries of Bolivia, Ecuador and Peru, as well as in India and the Philippines, new learning communities of integrated microfinance and health are emerging. Within these communities of practice, microfinance providers, health practitioners and other stakeholders are working together to build capacity of participants to share experiences and lessons learned and to build the capacity of local organizations to develop and offer a range of integrated health products.

This state-of-the-field report is the second in a series of publications aimed at highlighting the innovative work of the many microfinance organizations globally to use their existing infrastructures to deliver effective and sustainable health-protection services to their clients. We see how, in the Andes region of Latin America, a number of microfinance and health organizations are working together with facilitation from Freedom from Hunger as part of the Center for Health Market Innovations (CHMI) project. This project, started with Rockefeller Foundation support, has played an organizing role in successfully bringing together practitioners, social funders, researchers and academic institutions to form partnerships and advance the state of the practice in microfinance and health in the region.

Information from a survey of MFIs, supplemented by much richer sharing of experiences and learning from national and regional meetings of microfinance

and health leaders across the three countries, reveals a vibrant and growing landscape of integrated health and financial services with great potential for further innovation, scale and impact. Microfinance organizations in this region reach more than 31.5 million clients with loans and other financial services. Reports from MFIs summarized in this report indicate that more than 500,000 families are currently benefiting from some type of health program offered by their microfinance provider—an impressive step towards reaching many millions of families who, despite what national health indicators might suggest, continue to lack access to crucial health information, appropriate health services and the means to protect their families from all-too-familiar health shocks. The potential in the Andes is especially robust; not only is the sector strong generally, but the field of integrated services is well-anchored with the experiences of MFIs that have been globally recognized for their success at placing financial services into a cohesive approach to development and poverty reduction.

This work in many ways mirrors what is also occurring elsewhere in the world, most notably Asia. In India, MFIs currently serve about 71 million rural poor, many of whom also receive health services. Surveys of the sector conducted in 2009 and 2011, similar to the survey conducted in the Andes, show that approximately 25% of 134 MFIs in the country provide some type of health services to their clients. The Microcredit Summit Campaign and Freedom from Hunger have formed a Health and Microfinance Alliance that is working with 33 MFIs, self-help group promoting institutions (SHPIs) and networks in India that are reaching some 330,000 clients and 1.65 million family members with microfinance and health-protection services. This number continues to grow as the Alliance partners scale up their operations and new partners join the Alliance. The partners have set a goal to reach 3.5 million of the country's poorest households by 2015.

Likewise in the Philippines, Freedom from Hunger and the Center for Agriculture and Rural Development (CARD) are partnering to bring together 16 MFIs reaching 4 to 5 million families

to collaborate in the replication of health and microfinance throughout the country. These MFIs have agreed to move forward together to provide collaborative health-protection services to millions of MFI clients in the Philippines and Southeast Asia, thereby assisting in addressing health inequalities in the region. In addition, this partnership is expected to result in a strong regional foundation for further extension of health and microfinance beyond the Philippines to other Southeast Asian countries such as Vietnam, Laos, Cambodia and Indonesia.

We know that improved health is a key factor to reducing poverty. This report aims to provide a current overview at a moment in time of how forward-thinking leaders and their organizations are working beyond the confines of sector boundaries to further leverage microfinance to address one of the Andean region's most persistent barriers to the economic advancement of its poor: ill health caused by lack of access to health services.

Healthcare in the Andean Region

Overall progress but persistent challenges regarding equity

In the last two decades, Bolivia, Ecuador and Peru have shown steady improvements in key health indicators such as life expectancy, maternal and child health and nutrition. However, inequalities persist. For example, under-5 child mortality is 21 per 1,000 in the urban areas in Peru and 35 per 1,000 in the rural areas (USAID, 2011). In Ecuador, malnutrition is an ongoing concern with greater impact in the rural and indigenous populations. Nationally, 23% of children under five years-of-age suffer from chronic malnutrition, but this figure doubles in indigenous children with 47% lacking adequate nutrition. Additionally, children of women with less education or who live in rural areas have higher levels of malnutrition (38% and 31% respectively) (PAHO, 2007).

Inequalities in health status are directly related to similar inequalities in access to basic services and living conditions. Although access to drinking water and sanitation services has increased in the region, there is a large discrepancy between urban and rural areas. While an average of 90–95% of the urban population has access to improved drinking water, only between 65–71% of rural areas have access to these services. Ecuador is notable by achieving access to improved drinking water for 90% of rural areas.

Epidemiological Transition

Data from the National Statistical Institute of each country demonstrate that in the region respiratory and gastrointestinal infections continue to be common, and although decreasing, tuberculosis, dengue and malaria continue to have significant prevalence among the poorest. Concurrently, the overall incidence of non-communicable chronic diseases like hypertension, diabetes and cancer is increasing and are among the most common reasons for mortality in the last years (65% of deaths in Ecuador were the result of chronic diseases) (WHO, 2011).

Healthcare systems

The healthcare systems of the Andean nations include both public and private sectors. In Peru and Bolivia, the public sector plays a larger role in the financing and provision of care (54% and 62.8% of the total healthcare expenditures are public, respectively); while in Ecuador, public healthcare expenditures represent 37.3% of total health spending.

In all three countries, the public healthcare sector is regulated by Ministries of Health, which establish national priorities and health care guidelines and provide healthcare services through public hospitals and health centers that are generally administered by local governments and municipal authorities with little coordination at the national level.

All three countries have social security systems that provide health insurance programs to formal sector workers. However this insurance covers only 20–30% of the population, leaving the low income and poor population who mostly work in the informal sector without financing or risk protection from health care events.

Insurance companies and for-profit and non-profit service providers comprise the private health care sector. In some cases, the Roman Catholic Church, academic institutions and non-governmental organizations also support special healthcare initiatives directed at the under-served.

Efforts to serve the healthcare needs of the population

The three countries maintain as a premise free healthcare for the entire population. For several years, the Governments have been trying to implement social programs providing greater protection and access to excluded and vulnerable populations. Nevertheless, there are still gaps due to limitations on coverage, or because it is still early in the process of extending national programs.

For example, Bolivia offers a Universal Mother-Child Coverage (SUMI, Spanish acronym) and Senior Citizen Coverage, covering women of child-bearing age, children younger than 5 years-of-age and adults older than 65 years-of-age. However, the youth, who represent a growing share of the productive population in the nation, remain excluded from those benefits.

In 2006, Ecuador launched the Rural Social Security or Farmers' Insurance program. Members become affiliated with a symbolic contribution of 1% of their estimated income. This insurance is increasingly providing coverage to this segment of the population, although it is still in the experimental phase.

Similarly, the government of Peru is in the process of expanding the Comprehensive Health Insurance (SIS, Spanish acronym) provided for the most impoverished at no cost and to the poor at minimal cost in accordance with their capacity to pay the premiums based on their income. Although the goal is to provide full coverage by 2013, its implementation is still limited.

The private sector has also implemented initiatives to meet popular healthcare needs, especially with education programs, mobile services or medical brigades that reach remote areas. Furthermore, the prevention and early detection of chronic diseases is beginning to gain attention. In addition, progress is being made with the development of health microinsurance products for low-income populations. Nevertheless, current coverage is minimal (in 2011, Ecuador estimated that these would only cover 3% of the population).

Given the problem of fragmentation of the healthcare system both within and across the public and private sectors, efforts are being made to create coordinating bodies that can coordinate services between public and private sectors, as well as nationally, regionally and locally. For example in Bolivia the network of private health organizations

(PROCOSI) is making efforts to coordinate and create alliances within both sectors in order to achieve common objectives. Public-private partnerships in Bolivia and Ecuador utilize private facilities to expand the outreach and efficacy of public social programs.

Common challenges to the health of the poor

Coverage

These efforts, however, have not been sufficient. There are not enough resources and skilled providers to satisfy the need of the poor. According to the Pan American Health Organization (PAHO), in the three countries, the number of physicians per 1,000 inhabitants is 0.4 in Bolivia, 1.7 in Ecuador and 0.9 in Peru. Moreover, doctors concentrate in urban areas. For example, in Loreto, a city in the Peruvian Amazon, the coverage of physicians is only 0.2 per 1,000 inhabitants.¹ According to national surveys in Bolivia and Ecuador, 80–95% of physicians work in urban areas.

Thus, in situations of illness, these people do not go to the village health clinic or dispensaries, but rather self-medicate and only seek medical care when the illness has already become severe. This, of course, entails increased costs.

Expenses and Financing

The most vulnerable populations, not covered by public insurance or government social programs, faced with emergencies or illness not treated in a timely fashion, must use their own money.

Private healthcare expenses represent approximately one-third of all healthcare expenditures in Bolivia and Peru and 47% in Ecuador. This presents a great threat of financial crisis to poor families, even more so if related to chronic illnesses needing much

¹INEI Peru- Regional Information System for decision-making, <http://bit.ly/INEIPeru>

more expensive treatment and leaving prolonged consequences. In a 2005 survey conducted in Peru, the cost of treatment of illnesses was the second most common cause of economic shocks for the families (Baeza y Packard, 2006). Another study from 2002 shows that 13% of Bolivian households experienced catastrophic healthcare expenses that year (UDAPE-OPS/OMS, 2004).

Chronic Diseases

The epidemiological transition represents another challenge for the healthcare systems of Andean nations since they still do not have infrastructure and programs to help them provide an effective response to an aging population with an increasing incidence of chronic illnesses. In this regard, the efforts of the private sector are still isolated and provide limited coverage.

Microfinance and the Context in the Andean Region

For over 30 years in Latin America, microfinance has been a poverty alleviation strategy as well as a powerful instrument for the financial inclusion of the demonstrating that they are indeed creditworthy, accountable and capable of saving to cope with future expenses. According to “Microscope 2011”, a study and annual rating by the Economist Intelligence Unit and the IDB, the environment in Latin America is the most conducive and favorable for the development of microfinance in the world. This is especially true in the Andean nations: Peru holds first place, followed by Bolivia and Ecuador in eighth place among 55 countries evaluated (Economist Intelligence Unit, 2011).

There are more than 150 regulated and unregulated institutions in Bolivia, Ecuador and Peru that provide microfinance services and report periodically to the MIX Market;² however, the number of organizations providing financial services to the poor is greater. Across these three Andean countries, the microfinance loan portfolio is more than \$14 billion with more than 5 million borrowers, and there is more than \$10.6 billion in savings from 7.3 million savers.³

Models and methodology

A variety of models have been developed including savings groups, credit associations and village banks, solidarity groups and a growing practice of individual loans. For group-based programs, borrowers hold regular meetings to make scheduled payments over a period of 6–12 months. The structure and processes provide an established and self-sustaining vehicle or platform for the integration of other much needed development services such as education and health. In the beginning microfinance offered only small working capital loans. Today, the diversity

of microfinance offerings has expanded to include business loans, consumer credit such as residential and student loans, ecological and health loans; savings products; remittances and micro-insurance (especially life and credit and more recently health micro-insurance).

The microfinance industry was initially dominated by non-governmental organizations (NGO) operating with donated funds. It has evolved to a competitive self-sustainable industry that, in addition to NGOs, includes development financial institutions, private finance companies, rural credit institutions, cooperatives and banks.

A driving force for the favorable environment present in the Andean region for microfinance is the nature of its institutional framework. The diverse range of microfinance institutions have organized themselves into networks that strengthen and coordinate the microfinance institutions as well as create their own frameworks for self-regulation and reporting. There are more than 10 of these networks in the 3 countries, connecting the vast majority of active institutions in each country. These networks have played an important part in the development of credit bureaus permitting better risk management.

Regulatory framework

The regulatory frameworks in Bolivia,⁴ Ecuador⁵ and Peru⁶ differ significantly. Even minor differences or small changes in regulation may have important impacts on the institutional behavior of the MFI due to the opportunities and challenges generated.

Peru

In Peru, the regulation does not limit interest rates and the administrative processes are simple making

²Financial data and social performance indicators for microfinance: www.mixmarket.org

³MIX Market country profiles: Bolivia (<http://bit.ly/MIXBolivia>), Ecuador (<http://bit.ly/MIXEcuador>), Peru (<http://bit.ly/MIXPeru>)

⁴Bolivia country profiles: Centro AFIN (<http://bit.ly/CentroAFIN>); CGAP (<http://bit.ly/CGAPBolivia>)

⁵CGAP country profile: Ecuador (<http://bit.ly/CGAPEcuador>)

⁶CGAP country profile: Peru (<http://bit.ly/CGAPPeru>)

it very easy to establish a financial institution. For that reason, supply is abundant giving rise to concerns about the risks of over-indebtedness and generating an ever-growing need for institutions to differentiate themselves by offering new or better products. Moreover, Peru is currently working on a mobile banking law intended to provide access to financial services to the most remote and impoverished populations. Peru will be one of the first countries in Latin America pass this type of legislation (COPEME Microfinanzas, 2012).

Ecuador

In Ecuador the regulatory framework establishes interest rate ceilings. In the case of microloans, interest rates are currently capped at 27.5% annually. This limits the extent to which institutions can cover additional costs from the provision of other development services. On the other hand, a new supervisory authority has been created as a parallel regulatory body—the Superintendant of the Public Economy and Solidarity—to oversee more than 14,000 savings, credit, housing and transportation cooperatives, as well as MFIs that had not previously been regulated. It is anticipated that this new oversight authority will include social performance as an important component of microfinance institutions, creating expectations that institutions must offer services and products driven by social purposes. Concurrently, the government is beginning to create a database that would operate in parallel with the existing private credit bureaus in order to provide better risk management.

Bolivia

In 2009, the Office of the Superintendant of Banks became the general Financial System Oversight Authority (ASFI, Spanish acronym), which now also includes microfinance institutions under its purview. One of the first changes was the prohibition on the collection of fees and other hidden charges. This has led to increased price transparency; however, for some organizations this has placed significant limitations on the business models that they can use to provide complementary development

services. The response by some institutions has been to increase interest rates or to change their legal structure to enable the ongoing provision of development services through a parallel social institution. Additionally, greater pressure on MFIs is expected for the purpose of protecting clients, strengthening social performance management and impact, all of which is addressed in the new Banking and Financial Organizations Bill that is expected to pass in the near future.

In summary, at present the regulatory environment and framework in Peru is more flexible and therefore more favorable for MFIs that are considering diversifying their offerings to provide non-financial services. Regulatory provisions in Bolivia that require greater rigorousness with respect to transparency and client protection; and interest rate ceilings in Ecuador; are aimed at protecting clients. At the same time, MFIs seeking to go beyond financial services in these countries will need to be particularly innovative to design and deliver efficient, low-cost services with a measureable positive client value and impact on social performance.

Trends, opportunities and challenges

One important trend in the region is the growth of the microfinance market, increasing competition among MFIs. Currently the traditional microfinance sector is facing competition from commercial banks as well as from the Government as represented by development banks. This brings greater access and alternatives for poor people but, at the same time, creates the risk of over-indebtedness. Nevertheless, this also means better opportunities for clients, given that the MFIs face pressure to offer benefits and value-added products more efficiently to distinguish them from the competition.

The increasingly competitive market and the ever more frequent transformation of development organizations into financial entities seeking profit has given rise to a trend in the measurement and monitoring of social performance, as a call for the

return to the original social mission of microfinance. The emphasis on social performance goes beyond the demonstration of economic performance and sustainability to promote responsiveness to client needs, effectiveness in reaching the poor and the impact of the financial services on improving poverty status and food security.

The challenge of reaching the most impoverished people in the most remote areas also means greater risks for MFIs in serving the most vulnerable groups with the least access to education and with the greatest exposure to health risks that have the most impact on their family finances. Focusing on social performance requires the development of innovative strategies and products that respond to the needs of the target population, such as loans for urgent necessities, education services and access to health services and risk protection.

Current Landscape of Microfinance and Health Practitioners

MFI leaders and field agents report that the failure to repay loans or to build and sustain a successful income-generating activity that would help families alleviate poverty is most often the result of poor health and sometimes from even a single, but devastating health event. A number of Andean MFIs, motivated by their commitment to clients and social mission, have responded by adding one or more health services to the financial services they provide to clients. To further the understanding of the extent and types of health programs offered by MFIs, Freedom from Hunger, with support from the Center for Health Market Research (CHMI), conducted a survey and landscape analysis of MFI providers that are providing health services. The intent was to identify MFIs and health practitioners that were already involved in the provision of health and microfinance services and to learn more about what health needs were being met, services provided and MFI motivation. The initial survey was conducted during 2011 and has been supplemented and

updated with other sources, including information obtained in other CHMI health-market landscaping and from knowledge of the market and field gained through Freedom from Hunger's work with local MFI partners and networks.

Although this survey does not represent a comprehensive mapping of the practice of health and microfinance in the Andes region, it does provide an important overview of the types of organizations that are engaged in linking microfinance and health, client needs and the types of services provided.

Table 1 below shows the identified MFIs with known health programs. Collectively, these programs are reaching 636,985 clients with a range of health interventions. On average, the health services reach 66.6% and several of the MFIs have extended their health programs to provide access to all of their clients.

TABLE 1. MFIs WITH HEALTH INTERVENTIONS (2012)

MFI	Main Office	Date Founded	Active Borrowers	Year of Program Start	Access to a Health Program
Pro Mujer Bolivia	La Paz	1990	103,936	1990	103,936
CRECER	La Paz	1999	127,745	1992	127,745
ECOFUTURO FFP	La Paz	1999	46,027	2012	800
BancoSol	La Paz	1992	169,251	2009	46,000
EMPRENDER	La Paz	1999	9,269	2010	3,374
FINCA Perú	Lima	1993	16,407	1993	16,407
Pro Mujer Perú	Puno	1999	60,858	2000	60,858
ADRA Perú	Lima	1965	16,803	2012	6,351
MENTORS Perú	Lima	2003	886	2011	886
Financiera Confianza	Lima	1997	21,727	2006	15,209
Microfinanzas PRISMA	Lima	1986	18,194	2006	2,187
ALTERNATIVA	Lima	1982	2,912	1982	1,750
COOPROGRESO	Quito	1969	35,867	1994	29,330
CACMU	Ibarra	2000	3,244	2008	3,000
FACES	Loja	1991	8,568	1998	4,397
Espoir	Quito	1992	71,582	1993	71,582
FINCA Ecuador	Quito	1993	51,082	2003	51,082
D'Miro	Guayaquil	1996	41,182	2010	41,182
ASOF	Quito	1988	4,790	2002	4,790
23 de Julio	Cayambe	1964	8,000	2011	8,000
29 de Octubre	Quito	1967	7,896	2003	7,896
Fundación DECOF	Loja	2004	4,245	2010	3,627
Fundación Alternativa	Quito	1993	6,596	2005	6,596
Banco Solidario	Quito	1995	120,000	2009	20,000
TOTAL			957,067		636,985

Table 2 shows the type of health program offered at each of the MFIs. Most of the MFIs provide health education and a significant number of these are also providing more comprehensive packages of health services to help clients both access and pay for health. Programs include contracts with health

providers and regular or occasional health days or fairs; most notably, Pro Mujer and EMPRENDER provide health services directly. Interestingly, there are only three MFIs that did not report health education; all three of these provide health micro-insurance on either a mandatory or voluntary basis.

TABLE 2. MFIs BY TYPE OF HEALTH INTERVENTION (2012)

Programs	Health Interventions														
	Health Education			Health Products and Services							Financial Products				
	Group	Individual	Health promotion	Direct delivery	Agreements with health providers	Agreed discounts	Referrals	Mobile health	Volunteers or community health	Distribution of health products	Health loans (individual)	Health loans (group)	Health savings	Health microinsurance	OTHER
Pro Mujer Bolivia	●		●	●		●	●	●							
CRECER	●		●		●	●	●	●			●			●	
ECOFUTURO FFP					●									●	
BancoSol														●	
EMPRENDER	●	●	●	●											
FINCA Perú	●		●		●										●
Pro Mujer Perú	●		●	●	●	●		●							
ADRA Perú	●		●		●							●		●	
MENTORS Perú						●								●	
Financiera Confianza	●														
Microfinanzas PRISMA	●														
ALTERNATIVA			●		●	●			●	●					●
COOPROGRESO	●		●	●				●		●				●	
CACMU	●	●	●		●	●		●						●	
FACES	●		●	●				●							
Espoir	●		●	●	●			●							
FINCA Ecuador														●	
D'Miro	●														
ASOF	●														
23 de Julio	●														
29 de Octubre	●														
Fundación DECOF	●														
Fundación Alternativa	●														
Banco Solidario														●	
Frequency	18	2	11	6	8	6	2	6	2	2	1	1	0	9	2

Program Examples: Improving Health Knowledge, Behaviors and Access to Care

Health information through education

Health education is the most commonly provided health service by MFIs in the Andean region and globally and often represents a starting point for MFIs that decide to provide health-protection services. Education is relatively easy to implement; it can be delivered through various methods and therefore adapted for the context and needs of clients; there is a large body of well-developed materials and evaluation tools; and it is effective. Multiple studies show that adding health education alone, usually delivered during the routine microfinance group meetings, improves knowledge that leads to changes in behaviors that are known to be associated with positive health outcomes in areas such as maternal and child health, reproductive health and the prevention of infectious and chronic diseases.

FINCA Peru

Working in Peru for over 20 years, FINCA began offering healthcare services in 2007 with health education on childhood illnesses. Currently, the FINCA Peru healthcare program has two components: health education and access to services through health fairs and campaigns.

The organization uses various channels for health education. Using “Credit with Education”, developed by Freedom from Hunger, FINCA provides health education through 30-minute learning sessions for all of its members during regular loan meetings. The sessions are facilitated by FINCA Peru staff who have received training on adult education and facilitation of group learning as well as the content of the health education sessions. In addition FINCA Peru organizes specialized workshops for groups of client leaders through agreements with healthcare providers and the local government. Complementing this are key messages and basic health information disseminated through bulletin boards and a weekend radio broadcast. All these efforts to deliver health information and health education are coordinated with healthcare campaigns organized every six

months targeted to specific health needs. Last year, FINCA Peru focused on health issues of older women. Currently they are implementing a new education module focused on older women's health and to date have reached over 2,100 clients with it.

In a recent evaluation clients who have received this education expressed high levels of satisfaction with the training methodology due to its dynamism, clarity and use of easy to understand materials and pictures. Their favorite topics are women's health and cancer.

CACMU

CACMU (Cooperativa de Ahorro y Crédito Mujeres Unidas) in Ecuador began in 2008 with a health protection program for its members through insurance, agreements with health care providers and campaigns. One very important component of its health program is the health education, which is provided by credit agents during the members' meetings. In addition individual health education is a requirement of membership in CACMU and prior to enrollment in the health insurance. Health workshops and community health campaigns are organized by CACMU in collaboration with public and private organizations. As of the date of this publication, 3,730 clients have received health education on various topics such as nutrition, reproductive health, child health, first aid, oral health and healthy habits.

Access to appropriate and affordable healthcare services

Direct delivery of healthcare services by microfinance providers and/or the linkage of clients to independent care-providers are far less common than health education. This reflects the shortage of locally available health providers, especially in rural areas. Nevertheless, a number of MFIs are responding with programs that link clients to both public and private health providers and finding that these linkages directly benefit the providers as well as the clients. Other MFIs in the Andean region, most notably Pro Mujer, are directly providing health

services, affording them maximum control over the availability and quality of services available and providing services that are most important to meet the needs of their clients.

PRO MUJER (Bolivia and Perú)



© Courtesy of Pro Mujer

Pro Mujer is a development and microfinance organization committed to providing finance, health and human development services to women in five Latin American countries. Pro Mujer's health programs in Bolivia and in Peru offer access to healthcare by means of doctors' offices installed at nearly all of their branch locations, where clients or their family members may visit and be seen by skilled providers. Their services and healthcare principally focus on reproductive health, maternal-child health, women's health preventative services and diagnosis as well as medical specialty campaigns.

Additionally, they have mobile clinics equipped with dental and gynecological services including ultrasound and consultations by specialists and other doctors. The mobile services provide valuable access to advanced technology in rural areas where clients also receive health education in addition to financial services.

In 2010, 68% of Pro Mujer Bolivia clients had visited the health center at least once; the services most commonly used were check-ups, family planning, pre-natal consulting, Pap smears and diabetes control. The health program in Bolivia is almost completely self-sustained by a portion of the interest rate from loans.

Pro Mujer continually evaluates and refines its health services in order to serve the client needs and is planning to improve the Bolivia programs so as to increase life expectancy through improvement of the nutritional conditions of an estimated 65,000 clients.

COOPROGRESO



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COOPROGRESO is a savings and loan cooperative in Ecuador and has been operating for more than 40 years. In 2010 as part of its social responsibility mission and thanks to alliances with private providers, COOPROGRESO began to conduct preventive health medical brigades that reach distant areas where the population has little access to primary medical services. The services delivered by the brigades are free for the cooperative's members and the community. In addition to medical visits, the brigades provide other services such as diagnostic tests for bone density, mammograms, abdominal ultrasounds, electrocardiograms, eyesight examinations and de-worming. A total of 9,481 community members were served through these activities in 2012.

CRECER

In addition to its longstanding health education program, in 2006 CRECER (Crédito con Educación Rural) in Bolivia developed two strategies to increase client access to health services. One strategy is based on a referral system, which enables clients to access private healthcare service providers. The organization negotiates significant discounts for office visits, examinations and medications



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and then actively promotes these providers to its clients. The other strategy, called *Jornadas de Salud* (Health Days), brings specific diagnostic and primary medical care services to peri-urban and rural areas for an entire day. This is achieved through alliances with private healthcare providers who make their services available at greatly discounted prices at CRECER offices or at strategic points accessible for the entire population. The CRECER health program has emphasized the prevention and early treatment of cervical cancer. As of October 2012, a total of 11,932 PAP smears, colposcopies and other cervical screening tests have been performed at over 800 Health Days.

A study conducted by CRECER and Freedom from Hunger in 2008-2009 found that CRECER health program positively affects access to primary care services: 24% of the clients who participated in Health Days indicated that it was the first time they had visited a doctor. Likewise, a cost-benefit analysis found that CRECER could provide Health Days at a cost of \$0.40 per client annually and that Health Days positively affected client growth and retention rates (Freedom from Hunger, 2010).

Financing for health

Poor families in the Andes remain extremely vulnerable to the impact of the direct costs of health care when needed, as well as the indirect costs from lost productivity. These families use a variety of mechanisms for financing direct health costs—

savings, borrowing from family and moneylenders, selling assets and using their business loans. MFI clients report that they put off or forego care altogether because of cost. Experiences in the Andes and elsewhere demonstrate how MFIs can be crucial partners for helping poor families cope with health costs to improve the financial stability of households. Health-financing tools such as health loans, health savings, prepaid health programs and health micro-insurance can be sustainable for MFIs to provide and valued products for clients to improve access to healthcare services and products as well as protect their assets from the risks of health shocks.

Universidad San Francisco de Quito Medical Systems

Universidad San Francisco de Quito (USFQ) Medical Systems is a medical-dental program that combines large outreach with a sustainable prepaid financing approach to provide affordable outpatient services in Ecuador. MFIs are ideal partners with their ability to promote the program, enroll clients, provide credit to enable clients to more easily afford the monthly payments and remit payments directly to USFQ. In return for an affordable and fixed monthly payment (between \$1 and \$2.50 per month), microfinance clients have access to a network of private healthcare providers over a broad geography. Currently, there are 250 providers in 93 cities in Ecuador that are also networked through an on-line system. At present, USFQ works with seven MFIs. Since initiating operations in 2008, they have provided 72,000 medical visits in areas such as General Medicine and Gynecology and 72,000 dental procedures and provided 64,800 prescriptions to its 181,000 enrolled members.

ADRA Perú

Adventist Development and Relief Agency (ADRA) Perú recently developed a package of health protection products for its microfinance clients. This includes education and the provision of a package of health services that includes office visits and diagnostic services at an affordable price provided by private clinics who partner with ADRA. Clients pay



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for the health benefits in small monthly installments made at the same time as their scheduled loan payments. The members, or any other family member, may access care as soon as the first installment is paid and the entire package can be paid in full at the end of the loan cycle.

These products were introduced recently and are still in the pilot testing phase. At present, nearly one thousand members in Juliaca have access to these benefits.

ALTERNATIVA Perú



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Another way for microfinance to help health protection is through the improvement of access to drinking water and sanitary facilities. In this regard, ALTERNATIVA in Perú has offered its clients loans to finance the installation of water facilities since 2006. Through group loans to community members, the MFI facilitates the financing of sanitary equipment and accessories, tanks or reservoirs, as well as the

installation of water lines in their residences.

The size of loans varies between \$200 and \$3,000 for the entire group. In some cases, ALTERNATIVA's support extended throughout the entire construction project through various loan cycles covering the purchase of supplies, the installation of equipment and bathroom finishing elements.

The loans for water and sanitation are accompanied by environmental education, promotion of good water use practices and fairs where manufacturers showcase their products and offer them at discount prices.

Conclusions: Call to Action and for Support

The integration of microfinance and health shows enormous potential for reducing the vulnerability of the poor in the Andean region. The microfinance sector in Bolivia, Ecuador and Peru is in a phase of maturation and consolidation. In the region, the microfinance sector provides services to more than 7 million families or about 28 million people, who represent 50% of the population in those countries. With increasing competition and the saturation of urban markets, microfinance institutions are investing in new technologies and strategies to expand their services to distant areas.

Concurrently, the governments of the three nations are increasing efforts to bring health services to the most vulnerable population. In the last decade, significant advances have been made at the level of regional health indicators. Nevertheless, these data hide a profound inequality. Among the more important challenges confronting the health sector in the three nations in this report are the great distances between urban centers and the dispersed population in rural areas. This distance is not only geographic but also cultural.

The microfinance institutions, in many instances, are in a privileged position to maintain a permanent relationship with the communities. If MFIs decide to take advantage of this infrastructure and the solidarity and trust relationships involved, they may act as a platform for communicating preventive health messages and expanding the healthcare service coverage while contributing to improvement of the income of the people and to their ability to pay. On the other hand, as we have seen in the cases presented in this report, when working with microfinance institutions, health organizations gain access to a mass distribution channel. Therefore, the integration contributes to achievement of the social mission of the organizations in both the microfinance and health sectors.

The cases and programs documented in this report represent pioneering efforts to explore the potential of the integration of microfinance and health in the region. However, there is a great deal of work needed in order to establish the conditions that would allow us to fully take advantage of the potential offered by such integration. In the forefront, a regulatory and political environment supportive of the integration between sectors is required. Today, the standards and policies favor specialization with decreasing space for integrated strategies, above all, in microfinance. The best policies are based on evidence and, therefore, more experience and programs must be created for further study. To this end, the health and microfinance sectors require the support of donors and investors willing to invest their resources in integrated programs. Although programs show good potential for self-sustainability, in the short term, they need investment resources for their initial development. At the same time, it is necessary to commission studies, disseminate results and create spaces for learning and exchange of experiences that will enable the advance of the sector toward best practices that can be adopted both the public and private sectors.

References

- Baeza, C., Packard, T. (2006). *Beyond Survival: Protecting Households from Health Shocks in Latin America*. Washington, D.C.: Stanford University Press and the World Bank. <http://bit.ly/Baeza-Packard2006>
- COPEME Microfinanzas. (2012). *Reporte Financiero de Instituciones de Microfinanzas: Información a Junio 2012*. <http://bit.ly/COPEMEMicrofinanzas2012>
- Economist Intelligence Unit. (2011). *Global Microscope on the Microfinance Business Environment 2011*. <http://bit.ly/Microscope2011-EN>
- Freedom from Hunger. (2010). "A Microfinance Institution Expands its Services to Protect Clients' Health. Microfinance and Health Protection: CRECER, Bolivia," *Freedom from Hunger Research Brief*, July 2010. <http://bit.ly/FFH-MAHP-CRECER>
- Pan American Health Organization (PAHO). (2007). *Health in the Americas, 2007. Volume II*. Washington, DC: PAHO. <http://bit.ly/PAHO2007>
- UDAPE-OPS/OMS. (2004). *Caracterización de la exclusión social en Bolivia, Octubre 2004*. <http://bit.ly/UDAPE-OPS-OMS-Oct2004>
- U.S. Agency for International Development (USAID/Peru). (2011). "Health Fact Sheet, February 2011." <http://bit.ly/USAIDPeru2011>

About the Organizations

Center for Health and Market Innovations

The Center for Health Market Innovations (CHMI) promotes programs, policies, and practices that make quality health care delivered by private organizations affordable and accessible to the world's poor. Operated through a global network of partners since 2010, CHMI is represented in the Andes region of Latin America by Freedom from Hunger. Details on more than 1000 innovative health enterprises, nonprofits, public-private partnerships, and policies can be found online at HealthMarketInnovations.org.

www.healthmarketinnovations.org

Freedom from Hunger

Freedom from Hunger is an international development organization dedicated to bringing innovative and sustainable ways to support the self-help efforts of very poor families around the world. Freedom from Hunger partners with local organizations to demonstrate the value of these innovations and trains those partners to implement the programs sustainably. To ensure that our programs are beneficial and sustainable, we conduct extensive research, evaluate and monitor for impacts, and distribute successful interventions as widely as possible for others to adopt and adapt in their own anti-hunger and anti-poverty efforts. As of December 2011, Freedom from Hunger has trained and supported 150 partner organizations in 19 countries that are currently reaching over 3.9 million people (almost all women in poor, rural communities), benefiting a total of over 24 million when their family members are included.

www.freefromhunger.org

Microcredit Summit Campaign, a Project of RESULTS Educational Fund

The Microcredit Summit Campaign (the "Campaign"), a project of RESULTS Educational Fund, is the largest global network of institutions and individuals involved in microfinance. The Campaign is committed to achieving these two goals by 2015: (1) reaching 175 million poorest families with microfinance and (2) helping lift 100 million families out of extreme poverty. The Campaign convenes microcredit practitioners, advocates, educational institutions, donor agencies, international financial institutions, NGOs, and others involved with microcredit to promote best practices in the field, to stimulate the interchanging of knowledge, and to work towards alleviating world poverty through microfinance.

www.microcreditsummit.org

For questions on this report or to learn more about the field of health and microfinance in the Andes, contact:

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