

Microfinance Programs and Better Health Prospects for Sub-Saharan Africa

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ALTHOUGH SOCIAL GRADIENTS IN MORBIDITY AND MORTALITY from scrofula, rickets, and scarlet fever were noticed in England as early as 1845,¹ current understanding of the relationship between poverty and ill health is still evolving. A detailed examination of the social determinants of health is the current focus of a World Health Organization Commission,² and a global agenda that addresses the overlapping vulnerabilities of poverty, social exclusion, and health recently has been articulated in the United Nations Millennium Development Goals (MDG) framework.³

Sub-Saharan Africa remains the area of the world at greatest risk of failing to meet any MDG targets.⁴ Some experts suggest that conditions of extreme deprivation characterizing much of the region create “poverty traps” that limit access to proven interventions and constrain potential gains in employment, income, food, shelter, and education, carrying dire immediate and longer-term health consequences.⁵ The interdependence of poverty, health, and development might seem obvious, but cross-sectoral experience on how and where to intervene remains limited.

Microfinance programs are increasingly at the center of this nexus, and new ideas can extend their potential benefits. Microfinance institutions (MFIs) provide poor households with access to financial services, allowing them to borrow and save in reliable and convenient forms. The success of the microfinance sector has been impressive. Across a wide variety of models, reported loan repayment rates, even among the poorest clients, often exceed 95%.⁶ Global experience has demonstrated that MFIs can recover all or most of their administrative costs through interest rates and user fees.⁶ Thus, rapid growth and wide scale are possible, even when donor funds are limited. By the end of 2005, more than 3000 MFIs were reported to have been providing services to 113 million clients, 84% of whom were women.⁷

The 2006 Nobel Peace Prize to Muhammad Yunus and Grameen Bank was given in recognition that microfinance also promises to effect social change. Small loans used for income generation have the potential to reduce poverty directly, while simultaneously catalyzing wider benefits including better health. At the most basic level, higher and steadier incomes make it easier to put food on the table each day. When health

problems emerge, access to reliable ways to borrow and save can make it easier to pay for medicines and clinic visits. Financial access also can help individuals cope with unemployment caused by illness and forestall their need to sell off valuable assets. Thus, interventions to improve financial access may complement interventions to improve health conditions.

Opportunities also are emerging for MFIs to broaden their scope and benefits that as yet remain largely unrealized. Microfinance institutions operate in villages, slums, and neighborhoods in which the lack of financial access is just one of many deprivations. In creating neighborhood-based associations of women that meet regularly and focus on tools to improve livelihoods, many MFIs may have the potential to more directly address health-related concerns. Doing so will not make sense for every institution and population, and microfinance leaders rightly have been wary of weighing down institutions with added responsibilities. But evidence is mounting to suggest that combining financial and health interventions can be powerful.

These understandings are evolving, and expectations need to be realistic. Despite a tide of global optimism, beneficial effects of microfinance programs have not been witnessed in all contexts, and experimental evaluations, common in assessing health interventions, are virtually absent in the microfinance sector.⁶ Furthermore, although sub-Saharan Africa has the highest proportion of people living in extreme poverty, with more than 40% living on less than \$1 per day, access to microfinance services remains extremely limited, extending to less than 10% of those who need it.⁷

In this Commentary, we discuss the global experience and available evidence on the potential for microfinance to contribute toward achieving MDG targets, with specific reference to health gains, and we examine the challenges and opportunities for expanding access to such services in sub-Saharan Africa.

Eradicating Poverty and Hunger

A number of mechanisms exist through which access to microfinance may stimulate wider health and social benefits. Foremost among these is supporting improvements in household

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economic well-being, including poverty reduction and an enhanced capacity to meet basic needs such as food security. Notably, the share of people living in extreme poverty in sub-Saharan Africa has changed little since 1980 and nearly 26% of children in the region are reported to be malnourished.⁴

Evidence of the effects of microfinance on poverty reduction from diverse settings is generally encouraging.⁸ For example, longitudinal studies from Bangladesh have found an association between poverty reduction and greater consumption attributable to microfinance participation, particularly among female loan recipients.⁹ Other evidence points to substantial financial returns to capital investments made by small-scale entrepreneurs (60% per year and higher).^{10,11} Although data from Africa are limited, a recent cluster randomized trial in South Africa reported improvements in household asset ownership after 2 years of microfinance program involvement.¹²

Several studies also suggest microfinance can positively influence nutritional outcomes. For example, longitudinal research from Ghana, comparing participants both with nonparticipants in the same communities and with residents of control communities, reports reductions in stunting and wasting in infants.¹³ Well-established programs in Bangladesh have demonstrated similar effects on nutrition, where significant improvements in upper arm circumference in children 6 to 72 months old¹⁴ and lower rates of general malnutrition have been noted among microfinance households relative to controls.¹⁵

Increasing Access to Primary Education

In the sub-Saharan African region as a whole, nearly one-third of children fail to enroll in primary school, and of those who do, nearly 20% do not reach grade 5.¹⁶ Although important in its own right, improving access to education also can have profound effects on health and well-being, including a better balance between family size and resources and lower rates of illness, malnutrition, and childhood mortality.

Few rigorous studies have examined the effect of microfinance on access to education, and thus the evidence base remains unclear. Studies from Bangladesh support positive associations between microfinance participation and rates of schooling, although differential effects in favor of male children have been noted.¹⁷ In Africa, controlled studies from Uganda also suggest that participation in microfinance is associated with increased investment in children's education.¹⁸ However, in South Africa, where access to education is already high, one study provided little evidence for increased enrollment, suggesting that beneficial effects associated with microfinance may be context specific.¹²

Improving Women's Lives

Participation in microfinance worldwide is predominantly female, which underscores its potential to promote gender equity and empower women.⁶ For many MFIs, women are considered a better credit risk than men and loans received by women have been found to have wider household-level benefits than those given to men.⁹

Despite concerns over a potential double burden placed on women as both caregivers and new entrepreneurs,¹⁹ evidence supports a positive association between microfinance and the enhanced health and social status of women.²⁰ Most experience comes from programs in South Asia, primarily India and Bangladesh, a region where microfinance has a 3-decade history, services are accessed by nearly half of poor households, and social and cultural norms differ substantially from those in sub-Saharan Africa. However, research from South Africa in communities with no prior exposure to microfinance has suggested that combining microfinance with a gender training curriculum can lead to a reduction in levels of intimate partner violence experienced by participants.²¹ In this study, regular loan center meetings served as an entry point to more directly address health concerns. The first part of this training consisted of structured 1-hour sessions and used participatory adult education techniques to cover topics such as gender roles, cultural beliefs, violence, and HIV with the aim of strengthening communication skills, critical thinking, and leadership. The second part of the training encouraged wider community mobilization to engage both youth and men in the intervention communities. The observed reduction in levels of violence was likely facilitated by positive shifts in numerous dimensions of empowerment, including self-confidence, challenging of entrenched gender norms, improvements in autonomy, communication, and the perceived value of a woman's contribution to the household.²¹

Maximizing the Impact of Microfinance on Health

In many respects, health indicators outlined in the MDG framework depict the downstream clinical consequences of social and economic vulnerabilities that have their source further upstream. Thus, in sub-Saharan Africa, which lags behind other lower- and middle-income regions of the world in relation to targets for poverty, education, and gender equity, this gap widens substantially for health outcomes, for which this region fares far worse for most indicators.⁴

Recognizing the potential synergy between economic and health gains, and similar to the South African example above, a number of microfinance programs have sought to provide additional inputs to their financial products such as basic health services, health education, or health insurance products.¹³ Such integrated packages may provide both the means (income/empowerment) and the knowledge to address priority health concerns, and present the possibility of substantial cost recovery for microfinance providers (through interest charges and fees for other services), allowing broader reach to target groups. Several evaluations have demonstrated positive effects of these programs. Quasi-experimental studies suggest such models can lead to higher immunization rates, the adoption of healthy breastfeeding practice, and better management of childhood diarrhea.¹³ Work from Bangladesh suggests that through high levels of outreach, such programs also may influence social norms,

leading to greater use of contraception among nonparticipating residents of villages where MFIs operate.²²

Despite these opportunities for synergy, a number of obstacles to integrated approaches remain. Microfinance institutions are under tremendous pressure to become financially sustainable. Public health interventions are outside their immediate expertise and offering such services carries inevitable costs. Many donors and policy makers argue that microfinance providers should stay focused on their core activities, pursuing efficiency in their operations and improving the quality of basic financial services.

Rigorous evidence to guide policy and practice, such as that derived from randomized trials, is only beginning to emerge within the microfinance sector. More research on health outcomes of competing models is needed, as well as research that evaluates the most effective institutional strategies to partner microfinance providers with public health programs.

Prospects for Sub-Saharan Africa

Expanding access to microfinance services has the potential to positively influence progress toward a number of MDG targets, for which progress in sub-Saharan Africa is urgently needed. Furthermore, finding ways to maximize the synergy between health interventions and these economic programs might further broaden potential health effects.

So why has the uptake of microfinance in Africa been historically low? Obstacles include the lack of commercial lending institutions with sufficient access to capital, political and economic instability, relatively expensive wage structures for skilled staff members, and weak legal and policy frameworks to regulate and support small-scale financial activities.²³ Thus the poor in many countries remain systematically excluded from participation in the financial sector.

A further challenge to addressing poverty in Africa involves ensuring that interventions reach the most vulnerable groups. Even where microfinance programs exist, many favor clients with previous business experience, often failing to reach those most in need.²⁴ The very poor often reside in the most remote and inaccessible areas; they may lack the confidence to participate in credit programs; because of their poverty, they may be formally or informally excluded from microfinance participation by staff or other members; and, once reached, they often take out smaller loans that generate less income and require greater support.

Despite these obstacles, nearly 1000 MFIs currently provide services to more than 7 million people in sub-Saharan Africa,⁷ and programs are introducing innovations to reach vulnerable groups. Examples include geographic targeting of programs to reach high-risk areas; active program in disadvantaged communities, including poverty targeting; ensuring MFI staff are committed to work with the poorest; and innovations to credit products that are adapted to the needs of the very poor.²⁵ Microfinance is just one entry point for linking economic interventions to concrete health and development outcomes, but the track record so far is en-

couraging. Conceptualization of new models is at a relatively early stage, and the time is right for further innovation and rigorous evaluation.

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