Microfinance, Microcredit and Health

Kevin Chan, MD, MPH, FRCPC, FAAP
Assistant Professor, University of Toronto and Hospital for Sick Children and Fellow, Munk Centre for International Studies

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Learning Objectives

• Describe microfinance and microcredit

• Describe possible relationship and mechanisms by which microcredit affects health

• Explore some examples of successful microcredit initiatives, including the Grameen Bank and the Self-Employed Women’s Association (SEWA)

This module is to examine the role of Microfinance, Microcredit, and health and provides an introduction into how Microfinance and Microcredit are related to health and how they can be integrated and utilized together.

We will look at three examples of successful Microcredit Initiatives: the Grameen Bank founded by Muhammad Yunus, the Self-Employed Women’s Association (SEWA) in India, and Pro Mujer in Latin America.
Case Study

The president of a sub-Saharan African country is concerned about achieving the Millennium Development Goals* (for more details, see http://www.un.org/millenniumgoals/). He has heard about this concept called microfinance, and wonders how it could be implemented in rural areas.

You stumble and say: “I’ll give you a presentation tomorrow …”

*In this module, we will concentrate on MDGs #1, 4, 5, and 6
Some Basic Facts about Poverty

• 1 billion people live on less than $1/day.

• Another 1 billion people live on less than $2/day

• Lack of income leads to poor access to information, education, health care and political power, and leads people to social exclusion, dependency and diminished capacity.
Notes on: Some Basic Facts about Poverty

Before we start examining the concept behind Microcredit and Microfinance, let’s examine facts about poverty. The World Development Report 2003 noted that 1 billion people live on less than 1 dollar per day. Another 1 billion people live on less than 2 dollars per day.


This map highlights where people are living on less than 1 dollar per day. As Amartya Sen (a Nobel Prize winner in Economics) puts it, poverty minimizes the capabilities of individuals to fully reach the lives that they value. This leads to a decrease in the access to information, education, health care and political participation. Poverty, in turn, leads to social exclusion, dependency, and a diminished capacity to participate. However, things are improving, especially with the growth of China and India. The 2007 World Bank Report “Global Economic Perspectives” predicts that by 2030 that those who earn less than $1 per day will fall by half to 550 million.

Some Basic Facts About Microfinance

• 113 million Microfinance clients

• 84% are women

• 72% are below their country’s poverty lines


There are over 100 million people who use Microfinance around the world. Of those that use Microfinance, 84% of them are women, and 72% are “very poor”, (as defined as living below their country’s poverty line or less than $1 per day).
What is Microcredit?

- Provides small loans to poor families
- Started back in the 1976 in Bangladesh and Brazil (popularized in the 80s)
- Subsidized loans with the emphasis on sustainable services for the poor

Source: http://www.theworld.org/files/images/microcreditgroup69.jpg

Microcredit is the concept of providing small loans to poor families. Although it has been widely attributed to Muhammad Yunus and his work with the Grameen Bank, starting in 1976, the concept of Microcredit can be traced back to Lysander Spooner in the mid-1800s, and to the Marshall Plan at the end of the Second World War. Microcredit became popular in the 1970s and 1980s through the Grameen. Microcredit gives small loans to entrepreneurs to generate employment, build social cohesion, and build services to the poor. Traditionally, microcredit has been given to women, because of the observation that women’s loans tend to benefit the whole family more than men’s loans do.
What is Microfinance?

- Providing poor families with credit, savings, insurance, transfer services and other financial products

Microfinance institutions are distributed into two broad categories:
1. A “Minimalist” Approach: Looking at financial services only.
2. An “Integrated” approach: Looking at financial services with other additional services, such as health, education and development.

The various financial services that can be combined include credit, savings, insurance, transfer services and other products may have a role in Microfinance. More recently, there has been an increase in tying other services with Microfinance, such as health, education and development.
Who uses Microfinance?

- Low-income individuals without access to formal financial institutions
- Self-employed
- Household-based entrepreneurs
- **Rural**: Small farms and Income-Generating Activities
- **Urban**: Shopkeepers, artisans, street vendors
- Provides a table source of income

Source: http://www.allianz.com/migration/images/jpg/saobj_1196773_microfinance_326.jpg

Microcredit provides access to low-income entrepreneurs to credit that *they would not otherwise have access to obtain*. The poor that utilize microfinance include the self-employed, household-based entrepreneurs, and poor individuals such as farmer, shopkeepers, artisans and street vendors. However, one of the qualities that they require to gain access is that their enterprise must be expected to provide a stable source of income, to allow repayment to occur.
Why Microfinance for the Poor?

**CATCH-22:**

- Poor cannot access financing
- Access is expensive and cumbersome to arrange
- Targets those that can help themselves with cash.

If microcredit is successful it can lead to a more diversified range of financial services.

- Microcredit taps into entrepreneurial talent
- Increases income, savings and investment
- Sustains businesses
- Can empower women

There are some reasons for why microfinance is useful for the poor. Microfinance can give the poor access to financing. In general, this access to financing is expensive and cumbersome to arrange, and targets those that can help themselves with available cash.

Microfinance, if successful, can help facilitate trials of more financial services. Microfinance can increase income, but it can also be used a tool for savings and investment. In turn, savings and investment can help sustain businesses. This taps into a large pool of entrepreneurial talent. Finally, microfinance has traditionally helped women, who in turn, tend to help families obtain health, education and better social development.
How Microfinance helps development

Microfinance

- ↑ Income
- Build Business
- ↓ Outside Reliance
- Empower Women

- Food security
- Nutrition
- Education
- Health
- Community Development
How does Microcredit work?

- Receive loan to start business
- Business should generate income
- Loan paid back by sustained, regular, significant payments

Microcredit’s process is relatively simple.
1. Get the loan.
2. Use loan to generate business.
3. Pay back the loan through regular sustained payments.

When is Microcredit Not Useful?

- Microcredit is not useful for the extremely poor with no stable income.
  - Microcredit requires commitment
  - For Microcredit to work it requires high levels of repayment (>95%)
- When Microcredit substitutes for public health, welfare and education spending.
- Men may take the money from loans and saddle the women with the credit risk.
Notes on: When is Microcredit Not Useful?

There are times when Microcredit is not useful. For example, when the individuals seeking loans are extremely poor with no stable income. The reason is that Microcredit requires commitment and a high level of repayment to be sustainable.

Another concern is that Microcredit may replace needed government investment in public health, welfare and education spending (i.e. a substitution effect). As well, Microcredit loans that preferentially seek women, may be only lending vessels from men. Thus, instead of a true benefit, women are pushed out of waged work into the informal economy.

Also, with the exception of the Grameen Bank, most Microcredit institutions have been poor savings instruments, and the savings component behind Microfinance has helped lower the vulnerability to income shocks, including poor health, natural disaster, or volatility in income generation. (Millar H. “The paradox of savings mobilization in microfinance: why microfinance institutions in Bolia have virtually ignored savings.” Washington: Development Alternatives Inc and USAID, 2003.)
• Microcredit initiatives have high interest rates to cover the cost of administration. Even low administrative costs should be borne by the lender and makes the fees seem high.
• However, given the alternatives (higher interest rates and/or no access to credit), Microcredits are preferred.
• Microcredits simplify the transaction costs involved in retaining loans.
• Over time, with expansion of the program, loan rates come down with better access to credit.

One of the criticisms about Microcredit is the high interest rates that are charged. However, when once considers that there is a fixed cost of administration, no matter what the size of the loan, it could explain some of the high costs. For example, if there is a fixed cost of $10 to administer, create and monitor a loan, a $50 loan would have a 20% cost associated with the loan, while a $1000 loan would have only a 1% cost associated with the loan. Given the alternative of no access to credit, or even higher rates of loan, investors may be willing to take on this burden! Furthermore, Microcredits also lower search, transaction and information costs associated with these loans. With time and experience, these loan rates come down with better access to higher lines of credit and lower rates of interest.
• Started in 1976 (note that Microcredit started before then).

• “I started going to people’s houses, talking to them, trying to understand their life. I saw how people suffered for lack of a tiny amount of money …. We made a list of 42 people who needed a total of $27, less than $1 apiece … How can people suffer for want of such a small sum of money?”

If there is one name synonymous with Microcredit, it’s Muhammad Yunus. Back in 1976, he saw the need for small loans to help the poor. Muhammad Yunus was born in 1940 in Cittagong, British India (which became Bangladesh). Early on, he was an active Boy Scout and attend Jamborees around the world. His education started in Dhaka University (completing a BA in 1960 and a MA in 1961). In 1965, he went to the United States on a Fulbright scholarship, and graduated with a PhD in economics in 1969. After the Liberation War in Bangladesh, he returned to work with the Planning Commission. Soon after, he became head of Economics at Chittagong University, and became deeply involved in poverty reduction after the famine in 1974. It was during his visits to Jobra near Chittagong University, that he found out the value of small loans could make a large difference to a poor person. His first loan consisted of USD 27 from his own pocket to 42 women in the village. He made 2 cents on each loan.
The Grameen Bank

- Dec. 1976: Secured a loan from the government Janata Bank
- Wide-spread opposition at start
- As of February 2008: Issued US $6.82 billion to 7.4 million borrowers, 97% of loans to women, 98.2% recovery rate
- Uses “solidarity groups” to ensure repayment
Notes on the Grameen Bank

Muhammad Yunus helped found the Grameen Bank in Dec. 1976, with help from the national Janata Bank. The major objectives were as follows:

1) To extend banking facilities to poor men and women;
2) Eliminate the exploitation of the poor by money lenders;
3) Create opportunities for self-employment for unemployed individuals in Bangladesh;
4) To help bring women into an organizational structure to help manage businesses; and
5) To eliminate the cycle of poverty, into a cycle of investment, savings and income.

The original project was successful in Jobra, and extended to Tangail district in 1979. By October 1983, the Grameen Bank was created by government legislation. The Bank is owned by the rural poor (90% of its shares are owned by borrowers of the bank, and 10% is owned by the government). The Grameen Bank follows 16 key decisions. For the full list, see www.grameen-info.org/bank/the16.html
Where Credit Goes and The Grameen Umbrella

Credit Principles

• Focus on the Poorest of the Poor
• Organize borrowers into groups
• Make conditions suitable for the poor
• Social Development Agenda
• Design and develop organization and management systems
• Expand loan portfolio to meet diverse development needs

The Grameen Umbrella

• Fisheries
• Agriculture
• Trust
• Software
• Cybernet
• Knitwear
• Telecoms: Grameenphone
Notes on: Where Credit Goes and the Grameen Umbrella

There are some fundamental principles by which Grameen operates.

1) There is a focus on targeting the poorest of the poor. To achieve this, there are rigorous screening criteria and a preference toward women lenders.

2) One of the core concepts of the Grameen Bank was to organize small groups to help develop capacity of planning and to help generate microlevel decisions. Each group aims to have approximately 5 people.

3) The loans suited the poor. First, the loans were small and did not require any collateral. The loans were repayable every week with installments over the year. Future loan acceptance was dependent on payment of the first loan. It concentrated on projects that were feasible given the skill level of the individual. There was close supervision by bank staff, and peer pressure within the group. There were also forced savings mechanisms. Finally, there was transparency at bank meetings.

4) There was also a social development agenda addressing the needs of the poor. This is reflected in the 16 key decisions (see previous slide). The focus was also on women, and an emphasis was placed on social and physical infrastructure projects (education, water and sanitation, housing).

5) There was also capacity-building of organization management, with skills and techniques, increasingly decentralized and involving the poor. With time, the loans went to broader development projects (water and sanitation, agriculture, equipment such as cell phones, and novel projects).

This lead to the broader Grameen Umbrella, with a list of different foci and projects.
The 2006 Nobel Peace Prize

- In 2005, the UN declared the year, the year of Microcredit
- In 2006, Muhammad Yunus and the Grameen Bank shared the Nobel Peace Prize

“Lend the poor money in amounts which suit them, teach them a few sound financial principles, and they manage on their own.”

In 2005, the United Nations named it the Year of Microcredit. The year following, Muhammad Yunus and the Grameen Bank shared the Nobel Peace Prize “for their efforts to create economic and social development from below.”
As Bill Clinton stated in 2002: “Dr. Yunus is a man who long ago should have won the Nobel Prize and I'll keep saying that until they give it to him.” The Nobel Peace Prize Committee granted Dr. Yunus the prize for his dialogue with the Muslim world, his unique emphasis on the women’s perspective and on the fight against poverty, and the lessons that Bangladesh has taught the West. His Nobel prize winning lecture can be found here:

Microfinance and Health

• Poor health can lead to:
  – Poverty
  – Delayed loan repayment or default of loans
  – Poor attendance at microfinance meetings
  – Social cohesion impacts
  – Poor business performance

• Microfinance to women
  ▲ women’s demand for quality health care
  – Women seek Traditional Birth Attendants
  – Better clothing for women
Notes on: Microfinance and Health

So the natural question, is how is microfinance related to health? The World Bank report, Dying for Change (2002), stated that the number one cause of poverty is **illness**. Poor health can lead to poverty. This in turn, leads to delayed loan repayments or default of loans. Without comprehensive buy-in, it also leads to poor attendance at microfinance meeting that destroys one of the key elements of successful microfinance: strengthening social cohesion. This leads to poor business performance.

So it makes sense to protect health, if we’re trying to develop an individual’s income.

There have been numerous cases that show that access to microcredit improves children’s health (Engle, 1995). Microcredit has also been known to be correlated with lower infant mortality rates, deaths from diarrhea, increased immunization coverage for children and women of reproductive age and overall nutrition. (Engle 1995).

Microfinance has specific benefits to women. It can increase the desire for quality women’s health care, seek traditional birth attendants, and provide better nutrition and clothing for themselves.
Microfinance and Health: Service Delivery

- Microfinance provides an effective outreach mechanism to help deliver health care services
  - Parallel Service Delivery
  - Unified Service Delivery
  - Linked Service Delivery
  - Strategic Alliances

- Areas of Commonality
  - Preventative and Primary health care
  - Secondary and Tertiary Health Care
  - Referrals to health care providers
  - Health Education
  - Health Insurance
  - Savings for health
Notes on Microfinance an Health: Service Delivery

There are many different ways to deliver a combination of microfinance and health services.

1) Parallel: This is where one organization has different specialized staff (e.g. experts in both microfinance and in health services)

2) Unified: This is where one organization has the same staff deliver all services (i.e. the same staff would deliver both microfinance and health service knowledge.)

3) Linked: This is where there are different organizations with different staff providing separately Microfinance and health services, but there is a common link to the service providers.

4) Strategic Alliances: This is where different organization and staff have distinct service arrangements, but agree to work together

Some integrated health and microfinance services could include areas such as preventative and primary health care, secondary and tertiary health care health education, catastrophic health insurance, and saving programs for health.

Microfinance and Health Insurance

- **Catastrophic illness**
  - Affects savings
  - 30% of households in Kenya at risk of going broke with significant illness
- **Ordinary Illness**
  - 10-30% of total expenditures
- Insurance protects against health-related financial crises.
- This protection, in turn, leads to more income generating activities.

A study by Chuma et al. in Kenya showed that the bottom 20% of the socioeconomic scale spent 10% of their expenses on illness, and 30% could become broke if catastrophic illness occurred. (Chuma J, Gilson L, Molyneux C. “Treatment-seeking behaviour, cost burden and coping strategies among rural and urban households in Coastal Kenya: an equity analysis.” Tropical Medicine and International Health. 2007; 12 (5): 673-686.)

Freedom from Hunger, a California-based charity, found that in Benin and Burkina Faso that 30% of the income was spent to combat malaria. Microfinance protects against the income shocks of catastrophic illness. This can help prevent against the risk of sudden illness leading to bankruptcy and increases the willingness of individuals to take on loans to help generate income.

Source: http://www.stephenlewisfoundation.org/images/womanonfloor_photo.jpg
Microfinance and HIV/AIDS

• Poor ability for Microfinance to work in areas with high prevalence of HIV/AIDS
  – Can cause a 50% reduction in family income
  – Hard to build stable incomes with young adult population (ages 20-45) most affected by HIV/AIDS
  – With treatment, new programs couple Microfinance with HIV/AIDS treatment (e.g. Dignitas)
    www.dignitasinternational.org
Notes on: Microfinance and HIV/AIDS

One of the interesting observations is the failure of Microcredit in sub-Saharan Africa. One hypothesis is that HIV/AIDS is detracting from the successful delivery of an organized social community that allows Microcredit to flourish, especially since it attacks young adults, who are the key drivers of the economy.

HIV/AIDS has a large impact on the incomes of family, with up to a 48% reduction in family income. (Russell S. “The economic burden of illness for households in developing countries: A review of studies focusing on malaria, tuberculosis and HIV/AIDS.” American Journal of Tropical Medicine and Hygiene. 2004. 7 (Suppl 2), pp 147-155.)

It will be interesting to see if increasing the amounts of anti-retroviral therapies, and improving life expectancies on HIV/AIDS, if microcredit programs couple with HIV/AIDS therapy can flourish in sub-Saharan Africa.

One organization that is promoting is Dignitas, headed by Dr. James Orbinski, former international president of Medecin Sans Frontieres. For more information, see www.dignitasinternational.org.
Microcredit and the Health Status of Children

- Credit given to women has a beneficial impact on children.
- Credit given to men had no impact.
- More likely to breastfeed.
- A 10% increase in credit to women increases mid-arm circumference of girls by 6.3%, compared to 3.0% in men. This effect was less in boys.
- Credit given to women improves height of children.
Notes on: Microcredit and the Health Status of Children

Pitt et al. looked at the effect of Credit Programs and the Health Status of Children in Rural Bangladesh using Grameen Bank, Bangladesh Rural Advancement Committee (BRAC) and Bangladesh Rural Development Board (BRDB) Rural Development TD-12 programs. Their focus was on the impact of participation between men and women and the health outcomes on their children. The main conclusion from their study was that credit given to women had a significant impact on key indicators of health, while credit given to men had no effect.

For example, women who were given a 10% credit increase, had a 6.25% increase in Mean Arm Circumference (MAC) in girls, and 5.63% reduction in boys, while men who were given a 10% credit increase had a non-significant 3.02% increase in MAC for girls, and a 1.94% decrease in boys.

Furthermore, a 10% increase in female credit increase the height of girls and boys by 0.36 and 0.50 centimeters per year at the mean height, while a 10% increase in male credit reduces the height of girls and boys by 0.16 and 0.11 centimeters per year at the mean height.

Credit did not have an effect on Body Mass Index (BMI, a nutritional status measurement) for boys and girls.
Self-Employed Women’s Association (SEWA)

- Formed in 1972 as a trade union in Ahmedabad, India
- Members are manual laborers
- 70% are rural
- 270,000 members in 6 states
- 80 cooperatives, 500 women and children groups and 850 savings and credit groups
- Runs a cooperative bank, social security program, rural development program, literacy courses and other training programs
Notes on: Self-Employed Women’s Association

In 1972, the Self-Employed Women’s Association (SEWA) was formed in Ahmedabad, India under founder Ela Bhatt. The purpose of the organization was to help women workers without salaried employment gain social benefits similar to those who were employed. **The underlying principle is women should be self-reliant and fully employed.** The majority were manual laborers such as small businesswomen, home-based workers, agricultural workers, and food vendors.

One of the keys behind SEWA is that it not only formed a cooperative, but it also created women and children groups, savings and credit groups, and developed institutions such as literacy and training programs, rural development programs, a cooperative bank, and worked in developing social security.

SEWA is run by a committee of 25 elected leaders. The majority of the paid staff and executive members are women, who have come through the membership.
SEWA and Health

- 1986: Training community health workers and providing basic health care and drugs
- Provides curative health service; later, health promotion and prevention
- Opened 5 health centers
- Revolving drug fund
- 1990: Health Education
- 1992: Health Insurance bulk purchased
- 1995: SEWA takes over health insurance.

Source:
http://www.sewainsurance.org/images/health_care.jpg
From the beginning in 1972, there was an interest in promoting basic health issues, such as hygiene, nutrition, health education, occupational health, and basic knowledge on common diseases.

In 1986, SEWA began to train Community Health Workers (CHWs), instituting revolving drug supplies, and promoting basic health. The thought process was to start with curative health services to get buy-in from the communities, and then extending it to health promotion and prevention. SEWA was very much focused not to replace the traditional midwives (dais), who were key in child birth and treatment of common diseases. The concept was to focus on 5 women to help with training: 2 were SEWA staff members and three from the slums of Ahmedabad. This training occurred at CHETNA, the Centre for Health Education, Training and Nutrition Awareness, in Ahmedabad. Over 2 years, 10-12 women attended 2-3 days per month. At the end, there was a training of trainers course that a SEWA senior staff member attended, and she became the coordinator of the SEWA health team.

From there, more training occurred. Originally, it was difficult because the women volunteers had issues about providing health services to their communities. At the start, there were 5 centers opened. SEWA purchased drugs, and allowed members to purchase drugs at 25% of market prices, starting the concept known as a revolving drug fund. The centers expanded from 5 centers in 1986 to 95 centers in 1997.

In 1990, there became an increasing emphasis on health education, including common diseases such as TB, malaria, scabies, and diarrhea. The original course lasted about 2-3 hours per disease topic.

In 1992, SEWA started negotiation for health insurance to be available for up to 1,000 Rupees per case. The reason was that there was an increasing recognition that when a worker became ill that it could have catastrophic effects on household assets and income. Furthermore, for maternity leave, 300 Rupees were available during the eighth month of the pregnancy. In addition, there was also asset insurance, and payment for the accidental death of the husband. In 1995, SEWA took responsibility of the health insurance.
Where is Microfinance Going?

• A tool to help reduce poverty
• More “integrated” services
  – Education
  – Health
  – Development
  – Communication and information
• But is integration feasible for everyone?

Microfinance is increasingly being used as a tool to help alleviate poverty, and to help address the first Millennium Development Goal: Reducing Poverty. There is evidence that microfinance is an effective poverty reduction strategy. However, there are questions related to other broad social development issues. Can microfinance improve education and health? This hypothesis and the early evidence suggest under the right circumstances, microfinance coupled with education and/or health can lead to better overall outcomes. But the key phrase is “under the right circumstances.” In particular, the social cohesion and networking provided by microfinance can lead to increased income and assets, and empower women to become decision-makers. However, the conditions should be put in place to allow this fusion and integration to occur. We’ll take a look at a successful organization that has done that in the next slides, Pro Mujer.
Pro Mujer: Integrating Microfinance and Health

- Founded in Bolivia
- Sites in Peru, Nicaragua, Mexico and Argentina
- Purpose is to build better futures for women and their families
- Started with maternal-child health, and then added microfinance services
- Sought to integrate health with microfinance
- Utilized parallel, unified, and linked methods in 3 different countries
Notes on Pro Mujer: Integrating Microfinance and Health

Pro Mujer is a program that integrates microfinance and health services to improve the lives of low-income women entrepreneurs in Latin America. They are located in 5 different countries.

In 2006, Junkin et al. Highlighted the concept of integrating Microfinance and Health. The main themes of this report were:

1. To do a cost-benefit of the different health and microfinance services that the 3 different “Pro Mujer” microfinance institutions offer;
2. Highlight differences in client needs, the market conditions and context led to different service provisions.
3. Identifies the key elements needed for a successful integration of microfinance and health services, and how sustainability was achieved.
4. The similarities and differences of health services, and how clients and partners value these services.

Source: www.promjuer.org
Pro Mujer: The Lessons

- Clients value financial and health services
- Multiple services utilizing existing infrastructure improves loyalty and strengthens competitive positions
- Requires significant institutional capacity to deliver both health and microfinance
- Integration can have a positive and sustainable impact.
The main conclusion was that most Pro Mujer clients value the financial and health services. In particular, credit and health services were the only services mentioned by 100% of all focus groups. Out of 126 votes, credit services received 100 votes and health services 74 votes. Down the list were savings services (mentioned by 56% of all focus groups, and 34/126 votes) and health education (mention by 44% of all focus groups and 21/126 votes).

Furthermore, by integrating health and financial services, the authors felt Pro Mujer leveraged utilizing existing infrastructure, building customer loyalty and strengthening its competitive position. In Bolivia, there was an additional perception that Pro Mujer did not discriminate against the poor. In Nicaragua, the perception was that the standards were higher. In Peru, where the microfinance did not provide services directly, Pro Mujer’s clout comes from having the ability to refuse to renew a service agreement.

The authors concluded for Pro Mujer’s project to be successfully replicated, these suggestion were made:

Commitment of top management;
Necessary upper management skills to manage a multi-service institution;
Capable medical staff available at an affordable cost;
Health education and poor access to health services;
Willingness to pay for health education and health services; and
Legal and regulatory license for multiple service provision.

However, on the downside, this does require significant institutional capacity, because finance and health have different managerial requirements. In the cost analysis that was conducted, Pro Mujer’s report on Healthy Women, Healthy Business concluded that the Microfinance components were subsidizing the health services.
How can I get involved in Microfinance?

www.kiva.org

- Partners donors with individuals/groups who require small loans
- As little as $25
- Loans are repaid

One interesting site partners donors with people who requires Microfinance at www.kiva.org. The site suggests loans of $25, which should get repaid, and allow other sites and places for loans. **Disclaimer**: The author has not participated in Kiva.org, but the organization comes recommended by colleagues and friends.
Quiz

• Now we invite you to take the module quiz and test your recent learning.

• This module quiz includes five questions reviewing some of the key points of this module.

• Note your answers on paper and then compare them with the answers on the slides following the quiz.

• After completing your quiz, come back for the summary and references of this module presentation.
1. How many people live on less than $2/day?

A  10 million
B  100 million
C  1 billion
D  2 billion
E  6 billion

2. What is Microcredit?

A  Small credit cards
B  Small loans, usually given to poor people.
C  Financial institutions that deal with poor people.
D  Businesses that provide loans to the poor.
E  Government handouts to the poor.
3. Which of the following groups would not benefit from Microcredit?

A. Women
B. Small farmers
C. Self-employed
D. Beggars
E. Street Vendor

4. Which of these is not a credit principle of the Grameen Bank?

A. Focus on the poorest of the poor.
B. Make good returns on investment
C. Make conditions suitable for the poor
D. Design and develop organization and management systems
E. Expand loan portfolios to meet diverse development needs.
5. Why are health and poverty closely inter-related? Select the BEST answer.

A Poor health and poverty are correlated
B Catastrophic illness can lead to bankruptcy
C People with poor health make poor borrowers of Microcredit.
D Health is a major component of expenditures for the poor.
E All of the above. Correct.
And now, compare your answers with those that follow
1. How many people live on less than $2/day?

C 1 billion – Incorrect. This refers to those who live on less than $1/day
D 2 billion -- Correct.

2. What is Microcredit?

A Small credit cards -- Incorrect. Microcredit refers to small loans usually given to the poor.
B Small loans, usually given to poor people. -- Correct.
C Financial institutions that deal with poor people. – Incorrect. This could be banks, credit unions, loan sharks, or microfinance institutions
D Businesses that provide loans to the poor. – Incorrect. Although businesses can sometime provides loans to people, this is incorrect.
E Government handouts to the poor. – Incorrect. Although governments may get involved in Microcredit endeavors, government handouts are usually a form of social security.
3. Which of the following groups would not benefit from Microcredit?

D  Beggars – Correct. One of the key requirements for Microcredit is a stable income. However, beggars do not have this and would not be good candidates for Microcredit.

4. Which of these is not a credit principle of the Grameen Bank?

B  Make good returns on investment. -- Correct. This is false. The Grameen Bank is focused on social development.

5. Why are health and poverty closely inter-related? Select the BEST answer.

E  All of the answers are true. -- Correct
Summary

- Microfinance is one method to help reduce poverty.
- Microcredit provides small loans to the poor, while Microfinance includes other financial structure and mechanisms. They target the poor, self-employed, and women.
- Microcredit gives access to the poor to loans that would not otherwise be available.
- Microcredit is best used for those with stable income, as it requires high levels of repayment.
- High interest rates are common because of the high cost of administration.
Summary

• The Grameen Bank, Self-Employed Women’s Association, and Pro Mujer are examples of successful Microfinance Institutions.
• Microfinance and Health are related, because poor health is the number one cause of poverty.
• One of the strengths of Microfinance is that it can build social cohesion.
• When Microfinance and Health are combined, there are different methods of delivery.
• Integration with education, health, and development is becoming more common.
PAPERS
BOOKS

Web Links
10. The Microfinance Gateway. www.microfinancegateway.com The Microfinance Gateway is the major link for articles and news in the world of Microfinance.
11. Grameen. www.grameen-info.org This is the website for the Grameen institutions, including the Grameen Bank.
Credits

Kevin Chan, MD, MPH, FRCPC, FAAP
Assistant Professor, University of Toronto and Hospital for Sick Children and Fellow,
Munk Centre for International Studies
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