WHEC UPDATE

Briefings of worldwide activity of Women's Health and Education Center (WHEC)

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New Perspectives

Worldwide, health systems are proving to be inadequate at meeting population needs. The global community could broaden its contribution to achievement of the Millennium Development Goals (MDGs) and strengthening of health systems worldwide through intersectoral programming that utilizes a microfinance platform to reach poor and underserved populations. Microfinance institutions offer a unique opportunity, admittedly with challenges, to employ this global infrastructure for delivery for health-related services to those most in need. The world's poorest people bear a hugely disproportionate share of disease and ill-health. The World Bank study, *Voices of the poor*, gathered views from more than 60,000 poor people and reported that ill-health and inability to access medical care emerged as key factors inducing and resulting from poverty. Numerous impact evaluation studies support the effectiveness of microfinance and its impact on poverty. However, microfinance is not a silver bullet; legitimate issues exist, such as ability to address the needs of extremely poor people, the level of debt burden for individuals, and the uneven performance of microfinance institutions worldwide. More than 3,500 microfinance institutions around the world provide credit and other financial services to more than 155 million households in support of income generation and consumption. According to conservative estimates from United States Agency for International Development (USAID) studies, at least 34 million of these household are very poor, representing 170 million people, many of whom live in remote areas beyond the reach of health agencies, both private and government. Every day, thousands of microfinance workers travel to poor communities to provide microfinance services, often to groups of women convening on a regular basis over months and years to repay loans and deposit savings. Microcredit and micro-savings offer potential for providing predictable, low-cost health care where it otherwise may not have been accessible.

United Nations' Millennium Development Goals (MDGs) focus on the worldwide development agenda on reducing extreme poverty as well as improving health, education and human rights by 2015. At the same time, our effort –**WomensHealthSection.com,** is emphasizing the need to build health-system capacity, a global challenge that is most elusive in rural and resource-poor environments. Microfinance institutions have already shown themselves capable of contributing to improving health-care capacity and health outcomes by educating girls and women, facilitating access to public and private providers, making referrals to higher levels of skill and resources, providing health financing options (such as loans, savings and micro-insurance) and even directly delivering clinical care. Demonstrating the possibilities for local capacity-building, two studies from Uganda examined a project in which a variety of private health providers were given micro-loans and business skills training with the tandem goals of increasing the capacity of small-scale private health-care practices and improving public health outcomes. These clinics showed increased patient attendance and a significant improvement in clients' perceptions of quality of care. It is estimated 32% of women receiving education in Uganda about HIV/AIDS prevention through their micro-credit groups tried at least one HIV/AIDS prevention practice, compared to 18% of non-participants. In South Africa, a positive impact of a comprehensive training and education program on microfinance group members, for whom the risk of physical or sexual abuse by intimate partners was reduced by more than half as compared to a control group of microcredit-only members and to the general community. We believe microfinance institutions have indispensable role to play in proving healthcare services to poor populations in rich and poor countries alike. The World Health Organization and the World Bank should continue to make microfinance for health a consideration in technical advice given to governments on health-care financing and social protection.

Microfinance Institutions and Health

Rita Luthra MD

Your Questions, Our Reply

Why should microfinance institutions expand their services to include health?

Linking Health To Microfinance: There are two basic reasons – health services are a natural extension of their mission of financial security and social protection of the client, and healthier clients better serve the microfinance institutions' goals of growth and long-term viability. Clients are not the only beneficiary when a family member is ill, this affects productivity. Thus access to health related programs and services generally include the household, not just the client. Areas with positive outcomes from health education combined with microfinance are: reproductive health, preventive and primary health care for children, child nutrition, breastfeeding, child diarrhea, HIV prevention, domestic abuse/gender-based violence, sexually transmitted disease, and malaria. Studies of microfinance institutions delivering health-related services show increasing evidence of positive impact. Multiple studies show that adding health education alone, usually delivered during the routinely scheduled microfinance group meetings, improve knowledge that leads to behavioral change. These behaviors are associated with positive health outcomes in diverse areas that are critically important to achieving the Millennium Development Goals (MDGs), such as maternal and child health, and infectious disease.

Many microfinance institutions in Africa, Asia and Latin America already successfully offer services beyond microfinance, including training in business and financial management. An increasing number also offer health-related services, such as education, clinical care, health financing (loans, savings and health insurance) and establishing link-ages to public and private health providers to facilitate access to health care. This is a vast, private-sector infrastructure of service delivery that is mostly self-financed by interest or loans. Beyond the potential contributions to disease and mortality reduction, microfinance can strengthen health systems. This capacity-building ranges from national initiatives to targeted local strategies. Perhaps the best illustration of how microfinance and health programs strengthen national capacity is in Bangladesh. There are institutions such as BRAC (Bangladesh Rural Advancement Committee) have launched integrated programs over the past three decades to combat poverty by combining health, education and credit services, including partnering with the national government for large-scale tuberculosis- and malaria-control initiatives.

We at Women's Health and Education Center (WHEC) support these efforts and believe – poor populations need access to a coordinated set of financial and health services to have income security and better health.

About NGO Association with the UN

UN Partner on Millennium Development Goals (MDGs)
A Gateway to the UN System's Work on MDGs

World Trade Organization – WTO
A global partnership

International trade can lead to economic growth and development, and the World Trade Organization (WTO) is very much at the forefront of efforts to make this happen for developing countries. This, in fact, is what the WTO and the Doha Round of trade negotiations are all about. The economic and developmental benefits brought about by the multilateral trading system can go a long way towards helping countries achieve the goals set out in the UN Millennium Declaration to reduce extreme poverty by the year 2015.

The World Trade Organization (WTO) is the international organization dealing with the global rules of trade between nations. Its main function is to ensure that trade flows as smoothly,

predictably and freely as possible, with a level playing field for all its members. It seeks to place developing countries' needs and interests at the heart of its work program. The United Nations Millennium Development Goals (MDGs) are eight international development goals that all 192 members and a number of international organizations have agreed to achieve by the year 2015 to end poverty. They include reducing extreme poverty, reducing child mortality rates, fighting disease epidemics, such as HIV/AIDS, and creating a global partnership for development. The main goal that concerns the WTO is MDG 8, building a global partnership for development. However, WTO activities are also relevant to other goals, such as MDG 1, whose aim is to eradicate extreme poverty and hunger. In fact, the MDGs cannot be seen in isolation: they are all interconnected.
Details: http://www.wto.org/english/thewto_e/coher_e/mdg_e/mdg_e.pdf

Collaboration with World Health Organization (WHO)

Technical Briefs for Policy Makers
Shaping National Health Financing System: Can Micro-banking Contribute?

A major global health financing challenge is to develop national health financing systems, particularly in low- and middle-income countries, that protect people against financial catastrophe and impoverishment associated with paying for health services. Domestic resources, despite the increased external assistance since the Millennium Development Goals (MDGs) were agreed in 2000, still contribute about 75% of all funds for health in a typical low-income country, a percentage that can be as high as 99% in some low- and middle-income countries. Out-of-pocket payments (OOPs) made by patients directly to providers account for nearly 70% and 50% of total health expenditure respectively in low- and middle-income countries. Often financed through distress selling of assets, high-interest loans from local money lenders, and borrowing from relatives/friends, OOPs prevent many people from seeking/continuing health care besides imposing catastrophic financial burden and poverty on some of those who seek care. It is estimated that around 150 million individuals suffer severe financial hardship (and 100 million pushed under the poverty line) each year simply as a result of seeking care and having to pay for health care services they receive. These figures, however, exclude people who suffer financial hardship because they are unable to seek care and suffer extended period of ill-health as a result. Within countries, the risk of severe illness, early death and financial catastrophe linked to high OOP is highest among the poorest sections of the populations.

Micro-banking is often discussed along with micro-insurance and other financial products for the poor under the umbrella of 'microfinance'; micro-insurance will be part of a forthcoming Technical Brief so is not discussed further. Here, we focus on micro-banking, a broad term generally referring to small loans (micro-credit) and savings (micro-savings) opportunities for the poor and other disadvantaged populations such as women. It provides affordable access to banking services by linking such population groups with the formal banking sector. In doing so, it can help to empower them to control their own lives. The most common micro-banking tool is micro-credit, which extends small loans, often without collateral requirements, to impoverished people.
Details: http://www.who.int/health_financing/documents/pb_e_09_2-microbanking.pdf

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Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Development Progress in sub-Saharan Africa: Lessons from Botswana, Ghana, Mauritius and South Africa

Botswana, Ghana, Mauritius and South Africa are sub-Saharan African countries that stand out for their development progress. Each of these countries has succeeded against the odds, against expectations. This paper synthesizes the common ingredients of these countries' success, and derives lessons. It concludes that smallness, land-lockedness, tropical location, distance from world markets, racism, colonialism and other challenges can be overcome through appropriate institutions, governance and good economic policies. In the development literature, some countries are cited more often than others as examples of development success. These countries are believed to have policies and institutions that could be transferred, at least in part, to less successful countries both within their own regions, and elsewhere in the developing world. As such they might be said to constitute 'role models of development'. The project will examine individual cases of development success to understand better their root causes, and whether (and how) these experiences are transferable to today's poorer countries.

Publisher: UNU-WIDER ; Series: WIDER Working Paper; Author: Wim Naudé; Sponsor: UNU-WIDER gratefully acknowledges the financial contributions to the project by the Finnish Ministry for Foreign Affairs, and the financial contributions to the research programme by the governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Finnish Ministry for Foreign Affairs), Sweden (Swedish International Development Cooperation Agency—Sida) and the United Kingdom (Department for International Development).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page of WomensHealthSection.com)

55th United Nations Commission On The Status Of Women

The fifty-fifth session of the Commission on the Status of Women took place at United Nations Headquarters in New York from Tuesday, 22 February to Friday, 4 March 2011. The Commission on the Status of Women (CSW) was established in 1946 by the Economic and Social Council to prepare recommendations and reports for the Council on promoting women's rights in the political, economic, civil, social and educational fields. The Commission also makes recommendations to the Council on urgent problems requiring immediate attention in the field of women's rights. The CSW consists of 45 members elected by Economic and Social Council for a period of four years. Members, who are appointed by governments, are elected on the following basis: 13 from African states, 11 from Asian states, 4 from Eastern European states, 9 from Latin American and Caribbean states, and 8 from Western European and other states. The commission meets annually for a period of 10 working days. The CSW is the primary global policy-making body of the UN that is entirely devoted to examining the state of progress for women. Women still comprise the majority of the world's absolute poor and those without access to education. Additionally, disparities in equal pay for equal work, unpaid work, continued high maternal mortality, HIV infection rates, and pandemic of violence against women are clear indications that Member States' commitments to those gender specific issues must be implemented now. The special needs of girls and women of all ages must be recognized in the context of human rights. Women's Health and Education Center (WHEC) sponsored a forum / presentation in Parallel Events on February 25th, 2011 title: Improving Maternal Health Through Education. It was well received by representatives from NGOs, UN Foundation and delegation from Africa. We will continue to collaborate with NGOs active with CSW and hope to develop useful and meaningful projects and programs in women's health and education. WHEC is planning to have a panel discussion next year. If you wish to participate please contact us; we would like you to join us.

Constitution Of The World Health Organization
(Continued)

CHAPTER XIII – VOTING

Article 59
Each Member shall have one vote in the Health Assembly.

Article 60
(a) Decisions of the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and inter-governmental organizations and agencies in accordance with Articles 69, 70 and 72; amendments to this Constitution.
(b) Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the Members present and voting.
(c) Voting on analogous matters in the Board and in committees of the Organization shall be made in accordance with paragraphs (a) and (b) of this Article.

To be continued…..

Top Two Articles Accessed in February 2011

1. Poverty and Maternal Mortality;
   http://www.womenshealthsection.com/content/heal/heal013.php3
   WHEC Publications. Special thanks to UN Chronicle, WHO, World Bank and International Monetary Fund for contributions.

2. Emergency Contraception;
   http://www.womenshealthsection.com/content/gyn/gyn031.php3
   WHEC Publications. Special thanks to WHO, US–CDC and International Consortium for Emergency Contraception for the contributions.

From Editor’s Desk

Voices of the poor: crying out for change

As the second book in a three-part series entitled Voices of the Poor, "Crying out for Change" accounts for the voices from comparative fieldwork among twenty three countries. Through participatory and qualitative research methods, the book presents very directly, poor people's own voices, and the realities of their lives. It outlines the multidimensional aspects of well-being, and how poor people see it, highlighting that in material terms, "enough" is not a lot for a good life, and, analyzes social well-being, security, and freedom of choice and action, in contrast to the "ill-being" aspects of material absence, reflecting on the experiences of humiliation, shame, anguish, and grief. The struggle for livelihoods is described through the scarcity of rural production, the diversified cities' bondage, and, the limited opportunities of life, and individual breakthroughs challenging their livelihoods. Further analysis reflect on the inadequacy, isolation, and lack of access to infrastructure; on the health aspects of mind and body; on gender relations in troubled subjugation; on social exclusion; and, on the uncertainties for survival. It finally challenges the meaning of development, and of power, calling for change, from material poverty to adequate assets and livelihoods, from exclusion to inclusion, organization, and empowerment.

What poor people share with us is sobering. A majority of them feel they are worse off and more insecure than in the past. Poor people care about many of the same things all of us care about: happiness, family, children, livelihood, peace, security, safety, dignity, and respect. Poor people's descriptions of encounters with a range of institutions call out for all of us to rethink our strategies. From the perspective of poor people, corruption, irrelevance, and abusive behavior often mar the formal institutions of the state. Nongovernmental organizations (NGOs), too, receive mixed ratings from the poor. Poor people would like NGOs to be accountable to them. Poor people's interactions with traders and markets are stamped with their powerlessness to negotiate fair prices. How then do poor people survive? They turn to their informal networks of family, kin, friends, and neighbors. But these are already stretched thin.

There are 2.8 billion poverty experts, the poor themselves. Yet the development discourse about poverty has been dominated by the perspectives and expertise of those who are not poor-professionals, politicians and agency officials. This book seeks to reverse this imbalance by focusing directly on the perspectives and expertise of poor people. It is based on a study that used open-ended participatory methods to engage more than 20,000 poor women and men from 23 countries to express their own perspectives and experiences of poverty, its causes and how it can be reduced. From poor people's perspectives, ill-being or bad quality of life is much more than just material poverty. It has multiple, interlocking dimensions. The dimensions combine to create and sustain powerlessness, a lack of freedom of choice and action. Each dimension can cause or compound the others. Not all apply all the time or in every case, but many apply much of the time. For those caught in multiple deprivations, escape is a struggle. To describe this trap poor people use the metaphor of bondage, of slavery, of being tied like bundles of straw. The psychological experience of multiple deprivations is intense and painful. Ten interlocking dimensions of powerlessness and ill-being emerge from poor people's experiences:
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,contentMDK:20622514~isCURL:Y~menuPK:336998~pagePK:148956~piPK:216618~theSitePK:336992,00.html

Words *of* Wisdom

Poverty is like heat: you cannot see it; you can only feel it; so to know poverty you have to go through it.

– A poor man, Adaboya, Ghana

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities