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## “The First Wealth is Health”

**Lessons and Best Practices from  
the European Microfinance Award 2021  
on ‘Inclusive Finance & Health Care’**

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EUROPEAN  
MICROFINANCE  
PLATFORM

NETWORKING WITH THE SOUTH

# FOREWORD

For almost everyone in the world this year, health care has been at the forefront of their minds. The vital nature of the roles of doctors, nurses, pharmacists, care staff, administrators, distributors and all the other people who facilitate access to health care, has never been clearer.

Covid-19 has put all countries' health care systems under a microscope, and one legacy of the pandemic will undoubtedly be a re-thinking of how all societies take care of their most vulnerable. This was the core part of this year's Award topic. While not about Covid-19 *per se*, many of the health care challenges and solutions that it has highlighted are applicable in all countries, and innovation in their design and delivery has surely been catalysed by the urgent demands of the pandemic. From initiatives on education to health insurance, screenings, and tele-medicine, the ten semi-finalists profiled in this paper – and all the others who applied for this Award – have revealed what a critical, dynamic field this is – and one which will only grow in relevance.

We at e-MFP are therefore extremely proud to publish *The First Wealth is Health*, which not only builds on a full year of work in the health care sector – talking to experts, publishing their ideas and innovations, and learning about this dynamic and emerging landscape – but also profiles these ten remarkable initiatives and seeks to extract the factors for success that others can use to learn from and replicate.

I would like to thank Micol Guarneri and Chiara Pescatori, the consultants who so professionally assisted the e-MFP Award team over the evaluation and selection processes. Thanks also to the many specialists who generously gave their time to share their ideas



and point us in the right direction. Thank you to InFiNe.lu, Luxembourg's Directorate for Development Cooperation and Humanitarian Affairs within the Ministry of Foreign and European Affairs, and all the members of the Selection Committee and the High Jury who took part in the rigorous evaluation process.

I would like to congratulate Sam and the rest of the e-MFP team involved in both the Award and the writing, editing and production of this paper. And finally, we at e-MFP would all like to express our gratitude to the 43 organisations who took part, and especially to congratulate the ten semi-finalists – and among them the three finalists – profiled in these pages. We are pleased and proud to have gotten to know you and your important work this year.

**Christoph Pausch,**  
e-MFP Executive Secretary

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# INCLUSIVE FINANCE & HEALTH CARE

*"When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied"*

*Herophilus*

The title of this paper, *The First Wealth is Health*, we owe to Ralph Waldo Emerson. Its sense is clear: good health (and the means to preserve it) is so significant that without it, what value is there in financial prosperity? Health drives and underpins everything else: it allows education to play its role in opening new opportunities; it allows people to earn, invest and employ others; it lets groups and societies prosper. And the obverse is true, too: without health – without health care to stop minor health issues becoming serious and to help people recover from serious health shocks – then all other metrics of progress are constrained.

This is particularly true for the global poor, for whom health is often the dividing line between the path to prosperity or a slide into destitution. To make matters worse, the combination of typically volatile and precarious incomes and the absence of high-quality universal health care where they live means low-income communities **not only need access** to health care, but also the **ability to pay for it**.

For these households, paying for health care is a two-fold problem: First, accessing and affording quality health care may be an insuperable barrier. And second, even for those who are successfully treated and fully recover from an illness or injury, the financial burden of the health shock can cast a shadow for years after. This is the health and poverty 'trap' faced by the poor; the consequences of low-quality or inaccessible health care for those on low, volatile, and

precarious incomes and in countries without a universal health care safety net to catch them when they're in need.

The **scale of the challenge** is immense. The WHO estimates that in 2015, over 926 million people incurred catastrophic out-of-pocket health spending, exceeding 10% of their household budget, with over 208 million people spending over 25% of their budget on health expenses. The WHO also





## Health as Human Development

The importance of health in human development is well established and at the forefront of international development efforts. Article 25 of the Universal Declaration of Human Rights states that access to health care is a fundamental human need. The Sustainable Development Goals (SDGs) link health outcomes to risk protection of poor households<sup>1</sup>, and are accompanied by a wide range of indicators to monitor progress in reducing the impact of catastrophic health on low income people by country. The SDGs are supported by many other

global initiatives, including the WHO's Triple Billion targets that set the goal of enabling 1 billion more people to gain health care access without financial hardship. And health drives development as much as development drives health; the Universal Health Coverage Coalition's states that 'Health is essential to eradicating extreme poverty and promoting growth of well-being. Over the decade to 2015, health improvements - measured by the value of life-years gained - constituted 24% of full income growth in low and middle income countries.'

predicts that 100 million are pushed into poverty as a result of unmanageable household health expenditure. The challenge has grown considerably since the emergence of Covid-19, and the consequences of the pandemic on the world's most vulnerable may take years or decades to undo.

Addressing this challenge is **not just a public health challenge, but a financial inclusion issue as well.** Financing, or smoothing, health expenditures is one of the main reasons clients borrow from microfinance institutions and health issues – not just the direct costs but also the opportunity costs of not working – are a driver of repayment issues for financial service providers as well.

The reasons why people would risk overindebtedness are very human and understandable by anyone.

When facing the emotional stress of a health emergency, family members will seek out any options, no matter how costly, to access treatment. For poor households in countries without universal health care, besides borrowing this can mean selling income-generating assets or even their own homes. For families where the health shock prevents an income earner from working, the loss of assets to pay for treatment is magnified by the loss of income. This risks a negative feedback loop: poverty leads to bad health which feeds back to poverty – **the health and poverty 'trap'.**

## The Health Care Needs of Low-Income Communities

To break free from this trap, low-income populations need education on preventive care and treatment,

as well as: a) access to **day-to-day 'maintenance' health care** and the means to pay for it; b) to be protected from the devastating financial consequences of **sudden high-cost health emergencies;** and c) the means to deal with **all the circumstances in between.**

Fundamentally, healthcare needs follow a continuum<sup>2</sup>, which can be subdivided into four segments based on their health situation and financial pressures:

- At one end is **regular and preventative maintenance:** the small but regular expenditures for vaccines, insecticide-treated nets (ITNs) to guard against malaria and other miscellaneous needs, including investments in hygiene. Some, like ITNs, are very cheap, while others, such as installing plumbing, may be more costly.

1 SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

2 This can also be considered as primary, secondary and tertiary care. Primary care is the broadest and first level of intervention when a patient sees a trained medical health provider, for advice, pharmaceuticals or physical treatment. Secondary care is acute care for a brief but possibly serious illness. Tertiary care refers to specialised inpatient treatment for serious illnesses or accidents.



But the majority are typically affordable to most households. As a result, these preventative needs can usually be met with existing savings, small and short-term credit, and non-financial services such as health camps.

- Level two includes **most health ailments**: influenza, minor wounds, snake bites, many digestive disorders and even

recurrent bouts of malaria. Most of these require medical (possibly urgent) care, but the cost is typically modest and affordable to most people. However, the challenge for these situations is that, even when predictable, they are still unplanned, meaning that cash-strapped households don’t have the funds at hand to address them on short notice. On the

other hand, most of these needs can be met effectively by savings and short-term credit.

- Level three includes **serious chronic diseases**: diabetes, certain disabilities, HIV and other long-term conditions. Most can be managed for years with modest costs, but they require continuous expenditures and can be a challenge to solve through financial services alone. In some cases, a combination of health insurance, savings and credit may meet the need. However, many chronic conditions may require expensive drugs that cannot be sustainably met without outside support.
- Finally, at level four are **serious and often sudden episodes of ill health** such as severe accidents, heart attacks and other emergency situations requiring costly in-patient care. These typically impose the biggest financial costs, with potentially catastrophic effects

FIGURE 1: A CONTINUUM OF HEALTH CARE NEEDS

	Level 1: Preventative & maintenance care	Level 2: Minor health needs	Level 3: Serious chronic conditions	Level 4: Severe health episodes
Examples	Vaccinations Dentistry Optometry Bed nets Good hygiene	Non-complication pregnancy Minor illnesses/ accidents	HIV Diabetes Organ disease	Heart attack Major trauma Cancer Complication pregnancy
Financial and non-financial products	Ready cash Short-term savings Health camps Telemedicine	Savings Short-term credit Telemedicine	Savings, credit and insurance Subsidy/state support	Insurance

Source: e-MFP



on low-income households. On the other hand, most individuals will only rarely experience level four episodes, which is what makes them perfectly suited to insurance that spreads the risk – and cost – across a large group of clients.

Healthcare needs are both generalised and individual. Beyond the needs that are applicable for

everyone (dentistry, optometry, and immunisation, for example) and the unique needs a person may have because of a particular condition, there are also **needs associated with certain groups**, based on age, gender, disability or genetic predisposition to certain diseases. Children obviously have specific health care requirements. The same is true for the elderly, those in ultra-poor or marginalised communities and ethnic groups with predisposition to certain illnesses. And women often have a dual role as child bearer - with all the antenatal and postnatal care that involves - and as primary household caregiver as well. All these groups face barriers to access in addition to those faced by the financially excluded in general.

Some **barriers to access** are specific to their circumstances and needs, and some are exacerbated by a combination of low income and financial exclusion. They may miss out on preventative care because of the costs of taking time away from work. Volatile incomes may mean delays in treatment of minor illnesses, turning treatable conditions into major or chronic problems. Rural and remote communities may not have certain medical services available at all. And the poor and vulnerable are often intimidated by health care professionals, and may be embarrassed to seek advice.

### The Health Care Barriers Facing Women



Women face particular barriers in accessing and affording adequate health care, a consequence not only of some cultural norms that restrict their financial autonomy but also women's typical role as primary household caregiver. Women's unique and additional health care

needs are as true in high income countries as in low-income parts of the world. Moreover, the Covid-19 pandemic has already had particularly negative

consequences on women. According to UNFPA, even by April 2020, 47 million women had lost access to family planning and in the first six months of the pandemic, there were seven million unwanted pregnancies in 114 low and middle-income countries. And this is just in the initial months – and only in the area of family planning. More recent research continues to show the outsized effect of the pandemic on women. What the unique health needs of women means in practice is that gender dimensions need particularly careful attention when designing products and solutions in health care. As the ILO has put it: "The relationship between women, family health and barriers to financial inclusion needs to be carefully understood before products and solutions are designed".

# THE ROLE OF THE FINANCIAL INCLUSION SECTOR



So, what does this all have to do with financial inclusion, and why was 'Inclusive Finance & Health Care' the topic of the European Microfinance Award 2021?

The financial inclusion sector can play an indispensable role in both helping households plan day-to-day medical spending and 'smoothing' health-related financial shocks. By encouraging savings, designing appropriate credit and perhaps most of all, facilitating access to insurance, financial services providers (FSPs) can direct their core service expertise towards financial products that give low-income clients the financial flexibility required to meet their health care expenses. Beyond this, FSPs have strong and frequently high-

touch relationships with a client base, often principally women and sometimes linked together via group models with high social cohesion, creating an invaluable opportunity to advise on good health practices and educate on prevention and treatment.

Inclusive health care financing solutions are primarily *ex ante* arrangements set up to provide medically necessary care or the money to pay for it when needed. They may also include additional features aimed at ensuring the quality and cost-effectiveness of care, to bring about behaviour change or support grassroots health care workers. Often, low-income households finance their sudden needs for health care by

appealing to the solidarity of family and friends, liquidating formal and informal savings, taking up formal or informal loans or selling assets. However, FSPs can also offer health-specific financial products that go beyond generic savings accounts or microloans.

Yet health is a broad and complex sector. It is uncommon for financial institutions to have either the capacity or the regulatory rights to provide health care directly. And the specialisation needed for health care delivery means that many programmes are designed to operate in **partnership** with a broad spectrum of stakeholders in the health care sector. FSPs, including insurers, may often enter into agreements with local clinics, pharmacies, NGOs or hospitals that may feature price discounts that can be passed on to clients or enable the FSPs to provide a variety of non-financial and educational health services.

## Financial Products for Health Care

There is a diverse and growing landscape of financial products that can facilitate access to health care. Broadly, they include the three main categories of insurance, savings and credit, and some others too – vouchers and remittances among them. We'll introduce these





products here, before seeing in the following section how the ten EMA2021 semi-finalists offer them.

### Health Insurance

Insurance pools risks and transfers money to those who need it *at a particular time* from those who do not. It can cover both frequent and modest expenses as well as infrequent severe ones, and that range of coverage determines the price and affordability of a policy. But coverage even for very severe events is rarely unlimited, and small costs are likewise left to the client because insurance becomes administratively unsustainable for small, frequent expenditures.

Insurance is about the ‘law of large numbers’, which is why client-facing FSPs typically partner with insurance companies that can spread the risk across large groups of clients. The payment models of health insurance vary substantially, and can include **cashless** services, whereby the insurer rather than the patient pays the health provider directly; **managed care** models, where providers receive a fixed annual amount for everyone insured, in exchange for providing

care for members of the insured group; **indemnity insurance**, which reimburses for different amounts of incurred expenses such as hospital bills; or the simple model of **sum insurance**, attractive to the provider, which provides a fixed amount of money when the insured event happens (for example, a fixed amount paid for every night spent in hospital).

From the client’s perspective, an insurance premium is paid in advance, so, like saving, it functions as a **commitment device**. However, customers in emerging markets, who are often new to insurance, often struggle to understand the difference between insurance and savings – and expect their premium back if they do not use the insurance. Addressing these asymmetric expectations is a major challenge for insurance providers and can be mitigated through communication and add-on features (such as vouchers for regular care) that increase the likelihood that the insured will use and value their insurance during the coverage period.

### Savings

One of the most common reasons to save is for the proverbial ‘rainy day’. But the ‘rain’ most commonly appears in the form of unexpected health care costs. When such needs arise, liquid cash is needed – and savings are one of the least costly means to ensure the necessary sum. Unlike insurance premiums, the money in the savings account belongs to the saver and can be carried over from one year to the next, potentially incentivising health-promoting behaviour.

Any type of savings can be used to meet health care expenses, but a medical savings account that blocks the account from being used for non-medical expenses increases the chance that the funds will be there when needed. However, such accounts are typically limited to modest sums that might only cover regular health expenses. One exception to that is health care needs (for example, childbirth) that are both known and far enough in the future that a savings vehicle – particularly commitment savings – is almost perfectly suited for the purpose.

## Credit

Medical emergencies have always been among the top reasons for loans from microfinance institutions and other, often less formal, lenders, but it has rarely been a specific product. A main reason for this is that loan approval takes time and medical expenses are often urgent. However, this is an evolving part of the sector: personal loans specifically for medical emergencies, engineered for quick approval (using alternative credit scoring) and disbursement, and flexible repayment, are being increasingly offered. Generic ‘top-up’-style emergency loans can also be well-suited for health care expenses, and are frequently used for the purpose. And there are cases of specific loan products designed for certain health needs, such as a pregnancy loan for generally foreseeable antenatal and postnatal expenses.

However, using credit for health care needs can sometimes be a poor match because major health events (particularly for a household income-earner) often feature large shocks on both the expense and income sides. Taking on a large loan may solve the immediate problem of paying for the necessary care, but at the risk of overindebting and eventually impoverishing the family altogether. For this reason, credit is best reserved for mid-sized health care needs, leaving insurance as the best answer for severe situations.

## Other Financial Products

An alternative commitment device primarily used for recurrent moderate expenses is often called

**pre-paid medicine.** Such schemes are generally offered by health care providers or networks thereof, and function very much like insurance except they are not normally regulated as insurance companies, and anticipate providing annual care to their members in roughly equal value to the annual contributions they collect. For consumers, it is a commitment device; for providers, it allows them to better forecast and budget their services. Schemes vary greatly from country to country, but they can provide a reasonable alternative to health insurance, albeit to a limited number of people.

**Vouchers** that enable persons to make use of usually specific (e.g. reproductive health) services aim to strengthen demand for certain health care services in the expectation that (1) supply will follow, and (2) that people will use their voucher where they perceive the best quality of service, thus rewarding good health care providers. Vouchers have the added benefit of increasing awareness among clients of the importance of preventative and maintenance health care. The cost of such vouchers is generally financed by governments or donors.

While rarely designed for health care specifically, relying on **remittances** from family members (whether elsewhere in the country or abroad) is a very common means of paying for health expenses. In most cases, this entails remitting the required funds directly to the family, but payment providers can offer remitters the opportunity to settle health bills directly, thus reducing the risks of the funds being repurposed for other uses.

## Non-Financial and Value-Added Services

Financial products are important ways of mitigating shocks and smoothing health expenditures. But typically, their efficacy as standalone products is limited – they need to be combined with **non-financial services** to improve health outcomes of the recipients. This can range from value-added services such as providing discounts on pharmaceuticals, diagnostics, or medical products, to health camps, screenings, vaccinations, education, and awareness-building, and – increasingly during the Covid-19 pandemic – remote medical services such as tele-medicine consultations.

As we will see in the following sections, all the EMA2021 semi-finalists, to some extent, combine different non-financial services with financial products to maximise their impact and reach. Moreover, for some, a health care initiative might be truly holistic – offering a range of different financial products combined with different non-financial services: health insurance or emergency loans to mitigate financial shocks, savings to build buffers, and education and intervention programmes to encourage prevention and early treatment of health issues before they become serious or even critical.

In the next part, we’ll briefly describe the EMA2021 objectives, eligibility, and selection process, before introducing the ten semi-finalists (and among them the three finalists), and the three broad approaches they represent.

# THE EUROPEAN MICROFINANCE AWARD 2021



## Objectives & Eligibility Criteria

The European Microfinance Award 2021 (EMA2021) sought to highlight organisations and programmes that **facilitate access to quality and affordable health care for low-income communities**.

Eligible applicants were organisations that facilitate access to health care among low-income

populations through financial inclusion. This includes many different types of financial services providers (FSPs) that directly provide and/or facilitate access to health care, but could also include non-financial organisations that facilitate health care access, via partnerships or other relationships with FSPs.

Eligible organisations had to be based and operate in a Least Developed Country, Low Income

Country, Lower Middle Income Country or an Upper Middle Income Country as defined by the Development Assistance Committee (DAC) for ODA Recipients.

Relevant products and services had to be fully operational for at least one year, and eligible institutions had to be able to provide audited financial statements.

## THE AWARD SELECTION PROCESS

**43 APPLICATIONS FROM 32 COUNTRIES**

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**Round 1**

(short application form)

Committee composed of the e-MFP Secretariat and the Award consultants



**30 APPLICATIONS FROM 27 COUNTRIES**

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**Round 2**

(more comprehensive application form)

Committee composed of the e-MFP and InFiNe.lu Secretariats and the Award consultants



**19 PRESELECTED APPLICANTS FROM 18 COUNTRIES**

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**Selection Phase**

Committee composed of e-MFP and InFiNe.lu members



**10 SEMI-FINALISTS**



**3 FINALISTS**

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**Final Phase**

High Jury



**WINNER**





#### SEMI-FINALISTS & FINALISTS OF THE EUROPEAN MICROFINANCE AWARD 2021

Institution	Country	Category
CRECER IFD	Bolivia	<b>Finalist</b>
Dreamlopmments, Ltd.	Thailand	<b>Finalist</b>
Fonkoze	Haiti	<b>Finalist</b>
Al Amana Microfinance	Morocco	<b>Semi-finalist</b>
Asociación Salvadoreña de Extensionistas Empresariales del INCAE (ASEI)	El Salvador	<b>Semi-finalist</b>
Avanza Sólido	Mexico	<b>Semi-finalist</b>
Centre for Agriculture and Rural Development, Inc (CARD)	Philippines	<b>Semi-finalist</b>
Friendship Bridge	Guatemala	<b>Semi-finalist</b>
Microfund for Women	Jordan	<b>Semi-finalist</b>
Pro Mujer Argentina	Argentina	<b>Semi-finalist</b>

# THREE APPROACHES TO FACILITATING ACCESS TO HEALTH CARE



The 43 Award applicants – and especially the **ten semi-finalists profiled in this paper** – represent an extraordinarily diverse range of health care initiatives, provided by different types of organisations, and in all regions of the world. The qualities that distinguish the semi-finalists are varied and cannot ever fit into a discrete category.

Nevertheless, from the Award evaluation and selection process there have emerged **three general approaches** by which financial services providers can increase access to affordable health care, and into which the semi-finalists can be categorised:

- 1 **Preventing and treating illness**
- 2 **Mitigating the risk of health shocks**
- 3 **Delivering health care to those who need it most**

The following sections will examine each of the three, and profile the Award semi-finalists that most embody each approach.



## 1

# PREVENTING AND TREATING ILLNESS

*"An ounce of  
prevention is worth  
a pound of cure"*

*Benjamin Franklin*

Health care can be conceptualised in different ways. These include the four 'tiers' outlined in the earlier section – from basic health maintenance via serious illnesses up to critical and catastrophic events – but there is also a 'time cycle' too. As Benjamin Franklin observed, prevention is much better than trying to cure someone after they're sick. But where prevention isn't possible, there are countless diseases where *early* treatment is more effective and affordable than waiting until something becomes more serious. In some cases, though, treatment of an illness (and especially of a sudden injury) will be complicated, expensive and involve a lengthy period of convalescence. In these situations, the financial shock of the health emergency can be devastating. Here, the priority in inclusive health care is creating a safety net for clients to minimise the impact on a household of the adverse health event.

And beyond this natural time cycle is a broad variation in *need* too: some communities have very low access to doctors, nurses, facilities, equipment, and medications. They, for whom any increase in access to these services will be transformative, are among those that microfinance institutions are best placed to help.



We'll start with how some of the EMA2021 semi-finalists focus on **preventing or treating health issues before they become serious enough to cause a serious financial shock** – or even death.



**CRECER IFD**, one of the three EMA2021 finalists, epitomises how an FSP can identify and understand the context of its clients' needs to respond to a specific health care challenge. Bolivia has extremely high rates of fatal cervical cancer, especially among young women, which preventive screening and treatment, seldom available in the remote areas CRECER IFD serves, can drastically reduce. Health education and awareness raising has been an integral part of CRECER IFD's mission since inception, with an initial focus on women and children's nutrition and family planning, but which since 2013 has expanded with its launch of the cervical cancer prevention initiative *Programa de Prevención de Cáncer Cérvico Uterino* (CACU).

## CRECER IFD Bolivia



CRECER IFD (Crédito con Educación Rural) is a Bolivian NBFI originating from a social development programme that was

founded as an NGO starting in 1999. With over 221,000 clients and over 1,300 staff, CRECER offers savings, credit and village banking along with educational and community development services, especially to women in poor and vulnerable communities in rural and peri-urban zones of Bolivia.

Between 4 and 5 women die every day in Bolivia from cervical cancer, according to WHO estimates, at an average age of 39, making it the leading cause of death among Bolivian women. Most of these deaths could be avoided through preventive screening and treatments but access to effective prevention services is very limited in Bolivia, particularly in the most remote areas. Bolivia's public health service is overstretched, and illnesses are often only treated with natural medicine, because private services are expensive and there is limited access to public health services in remote areas a situation exacerbated by low levels of education on cervical cancer and the importance of early diagnosis and treatment. Although CRECER IFD has focused on health education since the beginning, since 2013 it has expanded its focus to cervical cancer prevention via the CACU programme, with the main objective to empower women and develop their capacity for self-diagnosis and preventive care.

CACU started with health campaigns and health days, through which clients are provided with information about cervical cancer prevention and are offered screening tests, including VIA (Visual Inspection with Acetic Acid) colposcopy screening, at a considerable discount. Since 2018 the programme has been extended to family members, staff, and the overall community (6,464 non-clients received preventive screenings or exams in 2019, and 42% of the institution's clients were reached that year). As of 2020, 70,000 women have benefited from the CACU programme. Beneficiaries are relatively young, with 30% under 25 years of age, and a quarter are below the national poverty line. In 2020, Covid-19 forced several adjustments to the programme, with a tele-consultation service implemented in certain branches.

CACU has highly embedded strategic partnerships, with both public and private health care providers and with Bolivia's Ministry for Health. Remote areas with the greatest need are prioritised, and new staff are comprehensively trained on the health programme at induction. There are extensive education modules for clients and potential beneficiaries, developed with medical professionals and public sector partners, from a manual with basic content and key messages to increase awareness on the incidence, prevention, identification, and treatment of cervical cancer, to other awareness-raising material in print, audio and visual forms featuring client-patient testimonials. Finally, there is a management information system which allows tracking of clients undergoing screenings and the frequency of uptake and standardised reporting about the progress of the health programme.

Since 2017, CRECER also offers a health loan facility to cover health expenditures (even those expenses incurred up to 90 days before the loan application), such as medical treatments, consultations, and high-risk surgeries (both in the country and abroad) as well as the purchase of medical equipment/accessories and medicines.



CRECER IFD is an example of an MFI that focuses its resources on much-needed prevention and treatment of a specific disease. Over in El Salvador, **ASEI** tackles a different challenge. An MFI which focuses on mostly female-led microenterprise support, ASEI is in a country



whose health system is overloaded and unreliable, with rural and remote communities in particular lacking access to (or ability to afford) consultations and examinations with specialists. ASEI has therefore focused on making **specialised consultations more available and affordable to its clients**.

ASEI opened its first clinic in 2014 at a branch in San Salvador with just a single electrocardiograph. Since then ASEI's health initiative has become much more ambitious, comprising MediCredit (an emergency loan product up to USD 1,000 (EUR 800) to purchase medicines, conduct tests or cover medical emergencies); life and cancer microinsurance, which allow clients to access mammograms or prostate antigen screening after six months of the policy term; and automatic enrolment of all loan clients in the health programme, with free general consultations, telemedicine since 2020, and discounted specialist consultations and examinations. To continue to grow and manage the health programme, ASEI created a sister NGO called FUSACI (*Fundación de Salud Comunitaria*).

All borrowers are automatically enrolled in the health programme and can access free general consultations through the two clinics (a small monthly fee is applied on the loan instalment and corresponds to USD 0.78 (EUR 0.66) for the branches equipped with a clinic and USD 0.25 (EUR 0.21) for those without). 3,637 clients received generation consultations in 2019 and 2,760 in 2020. Specialist consultation is made available through partnerships with 21 specialists at a discounted rate that starts from USD 7 (EUR 5.7), and specialist examinations are also accessible at discounted rates, including cytology examinations for USD 5 (EUR 4) and electrocardiograms for USD 10 (EUR 8).

Medical campaigns take place in those branches that are not supported by a dedicated clinic, and ASEI continues to expand its outreach to clients: since 2020, in response to the pandemic, telemedicine service via a proprietary platform has also been offered, and as of June 2021 a mobile clinic project has been launched.



While its initiative has many elements, ASEI's primary focus is on bringing affordable specialist care to those who would have no way of otherwise affording it.

## ASEI Salvador

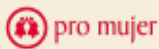


ASEI (Asociación Salvadoreña de Extensionistas Empresariales del INCAE) is an MFI in El Salvador founded in 1990 to facilitate income generation activities through self-employment of small enterprises, mostly led by women. With 130 staff serving over 22,000 clients, ASEI's strategic approach is grounded on three pillars: Credit, Training, and Health (*Crédito-Capacitación-Salud*).

The public health sector in El Salvador covers most of the population but lacks quality services, is often saturated and overcrowded, not geared to treat chronic illnesses and mostly available in the capital city, San Salvador. Private sector screenings and medicines are unaffordable for most people, and informal sector workers, who make up two-thirds of the economically active population, are more likely to contract infectious and chronic diseases but are least able to access quality health facilities.

In 2014 ASEI's first clinic was opened at a branch in San Salvador, equipped with an electrocardiograph, the initial idea being to test clients' blood pressure while waiting for their loan disbursements. ASEI's health initiative has grown to include MediCredit (an emergency loan product); life and cancer microinsurance, which allow clients to access mammograms or prostate antigen screening after six months of the policy term, and automatic enrolment of all loan clients in the health programme, with free general consultations, telemedicine since 2020, and discounted specialist consultations and examinations.

## Pro Mujer Argentina Argentina



Pro Mujer Argentina (PMA) is an Argentine MFI which began operations in 2005 and provides financial services, healthcare and education in three of the poorest and most marginalized provinces of the country. Argentina has very unequal access to health care, which is overwhelmingly concentrated in urban areas. Health care is also a financial strain for the most vulnerable, with over 27% of health spending being out-of-pocket, and the private sector is loosely regulated. Argentina faces rising rates of non-communicable diseases (NCDs), with nearly 10% of the population diabetic and 62.2% overweight. Women are most at risk, with about up to 80% obese or overweight. Women-centric healthcare services are poor, with low access to (and education about) contraceptives and family planning services, and gender-based violence is increasing.

To address some of these issues, PMA offers a health package called "*Beneficio Universal*" that provides primary healthcare services and educational trainings through its own programme, as well as through 3rd party specialist services. All PMA borrower-clients are automatically entitled to the "*Beneficio Universal*" insurance coverage that is paid via a flat fee of ARS 4 (EUR 0.4) included as a commission for "non-financial services". The insurance grants access to health care not just for the client but for family members too.

By contrast, **Pro Mujer Argentina (PMA)** focuses particularly on health education and primary services relating to non-communicable diseases (NCDs) – especially for women. Argentina is notable for its extremely unequal access to health care, most of which is concentrated in large urban centres. As an illustration of this imbalance, Buenos Aires has 10.2 doctors and 7.3 beds per 1,000 people, whereas one of the rural provinces where Pro Mujer Argentina works, Jujuy, has only 2 doctors and 4.3 beds per 1,000 people. Rates of NCDs such as diabetes, against which education is often the most valuable tool, are high, and health care services focusing on women's particular needs are often poor. To address some of these challenges, PMA offers a health package called *Beneficio Universal* that provides primary healthcare services and educational trainings through its own programme, as well as through 3rd party specialist services.

*Beneficio Universal* is operated in PMA branches by a Health Manager, with a support staff of 6 nurses and administrative staff that coordinate over 60 health professionals and partner medical institutions. Clients typically visit PMA facilities for basic screenings at no cost, and if the nurse suspects a more serious health issue, the patient is referred to one of a network of health providers. PMA has partnerships with pharmacies, laboratories, diagnostic imaging centres, and 11 local government institutions where patients/clients can be diagnosed and treated for diseases that are beyond PMA's scope and capacity. If the illness still cannot be treated, the specialist can refer the patient to the public health system, often bypassing the bureaucracy thus ensuring quick access to more intensive care.

*Beneficio Universal* is supplemented by a health education programme, comprising compulsory onboarding training that helps clients to understand its benefits and how to access them. Beneficiaries are then introduced to medical staff who set up the initial assessment consultations. Ongoing follow up is performed by the Health Advisors and nurses through phone calls, WhatsApp messages or emails to create awareness on preventive health care and help clients set up a care schedule for themselves and their families.



### The Centre for Agriculture and Rural

**Development, Inc. (CARD)** in the Philippines is a very large MFI, notable for the large scale and holistic approach of its Microfinance and Health Protection programme (MAHP), which combines CARD's strong commitment to education with partnerships with health providers, free clinics in remote areas, health days, telemedicine, laboratory services, as well as credit, savings, and insurance products.

CARD, Inc. is the umbrella organisation of 22 CARD Mutually Reinforcing Institutions (CARD MRI) offering a variety of products and services to almost 8 million clients in remote and under-served areas. CARD serves clients throughout the Philippines, but with a special focus on remote and rural areas that feature enormous barriers to healthcare access, as well as low awareness of prevention and early treatment options.

CARD's health programme has reached over 4 million people, across a variety of initiatives. This includes 14 CARD Community Clinics – non-profit clinics in remote areas which provide free (or very low cost) medical service to both members and non-members. These clinics served almost 280,000 clients in 2019 alone. CARD also organises community health days in areas that are beyond the reach of a Community Clinic. Recognising the challenges of providing poor and excluded communities with affordable, quality-controlled generic medications and health products as well as free, over-the-counter health advice, CARD has established BotiCARD pharmacy, which as of July 2021 had served almost 1.5 million clients across 12 branches. CARD Laboratory provides laboratory services for clients, staff, and their family members. CARD e-Doctor is a Facebook page offering online consultations and webinars run by medical professionals, with live discussions and Q&A on different health topics such as hypertension, diabetes, pneumonia, Covid-19, and family planning. Expanded rapidly during the pandemic, it provided 25,020 virtual consultations in 2020.

Some elements of CARD's health programme are integrated with its financial products. 'Credit with Education on Health' offers health-related discussions during center meetings for microfinance clients. The Preferred Provider programme (PPP) gives CARD clients

### Centre for Agriculture and Rural Development, Inc. (CARD)



The Center for Agriculture and Rural Development (CARD, Inc.) began in 1986 as a social development organization with the vision of setting-up a bank owned and managed by landless women, which has since evolved into one of the leading MFIs in the Philippines. CARD, Inc. is the umbrella organisation of the 22 CARD Mutually Reinforcing Institutions (CARD MRI) which focus on empowering underprivileged communities (women and their families) with access to financial services: microcredit with education, micro-insurance products, and community development services including health, education, livelihood, and other capacity building services.

People living in rural and remote areas of the Philippines face significant barriers in access to health care services, exacerbated by financial and travel limitations, as well as low awareness about the importance of health and availability of health care programmes. Card MRI understands that the health needs of clients are related to availability and access to affordable medical consultations; prescription of quality drugs to treat the most common diseases; and information about how to use health care services that are available and when to seek treatments.

To respond to these clients' needs, CARD MRI has created several partnerships with doctors, hospitals, and clinics willing to provide basic health services to low-income vulnerable people. The Microfinance and Health Protection programme (MAHP) includes education, discounted consultation fees, health insurance, free clinics in remote areas, community health days, partnerships with pharmacies for affordable medications, and a laboratory service for clients, staff, and their family members.



access to discounted consultations with private health service providers. CARD's KaSAPI programme (described on page 25) provides health insurance in partnership with PhilHealth – with loans available to help with upfront insurance premiums to ensure maximum coverage for clients.

Finally, in partnership with Freedom from Hunger, the Microcredit Summit Campaign and the UN Population Fund, CARD has implemented a maternal health programme called *Healthy Mothers, Healthy Babies*, which has reached well over 800,000 women and comprises health fairs with free consultations, seminars, provision of health kits for mothers and babies, and access to other maternal health products and services such as urine tests, OB/GYN consultations, ultrasounds, sonograms, and vitamins.



Finally in this section, **Microfund for Women** in Jordan (profiled in the following section on page 24) is notable too, not for preventing or treating illness *per se*, but for facilitating access to extensive women-specific health care. This includes: MFW's Maternity Loan for pregnant women who cannot afford the quality products, supplements, and services they will need during pregnancy; free Medical Days, which since 2015 have offered free medical examinations, screenings, consultations, and medication for women in the most under-served communities; and free awareness lectures on breast cancer, nutrition, first aid and smoking cessation.





## 2

## MITIGATING THE RISK OF HEALTH SHOCKS

*“It’s not certain that everything is certain”*

*Blaise Pascal*

In the previous section, we saw examples of how FSPs can help prevent or at least ensure early treatment of illnesses – before they become acute and therefore pose a financial shock to poor clients and their households. Prevention and early treatment are important elements of health care, but for the reasons outlined in the introduction to this paper, health shocks can still push households into destitution, undoing years of progress. This section examines **how FSPs can cushion the impact of these shocks** – primarily with health insurance products.

**Dreamlopmments, Ltd. (DLP)** is a social enterprise and foundation in Thailand whose M-FUND initiative provides health insurance to migrant workers and communities on the Thailand and Myanmar border. After two years of surveys and pilots, DLP launched M-FUND in 2017 in the Tak Province of Thailand, focusing on insurance for pregnant women and seniors. The scheme has been progressively expanded to border communities and with more flexible product options.

DLP’s pre-pilot field surveys of migrant households yielded important insights into this community’s healthcare needs. These include the structural barriers associated with the existing government health insurance, and in particular its eligibility limitations for migrants – the majority of whom are unregistered, are paid daily with little income security,



and cannot afford an upfront payment. More than 90% indicated a strong interest for needs-tailored insurance, coverage for care in multiple facilities in Thailand and Myanmar, and enrolment/renewal in their communities – all of which are now features of M-FUND.

M-FUND has various plan options, from a Base Plan to a School Plan, Chronic illness, Senior and Pregnancy coverage options. It works by using a team of full-time, employed community workers (CWs) who are deployed in project areas to promote M-FUND and enrol interested individuals on-site using tablets or mobile phones via a secure, custom designed M-FUND web-based application. Membership cards, with member’s photograph and coverage details, are issued upon enrolment. The CW informs the members about how and where to access services and their ID card has a linked QR Code. In M-FUND network hospitals (there are 28 health facilities in the network, including 2 NGOs clinics), staff scan the QR Code and clients access the services right away.

## Dreamlopmments, Ltd.

Thailand



Dreamlopmments Ltd. (DLP), an EMA2021 Finalist, is a non-profit social enterprise and foundation registered in Thailand, which since 2015 runs two development projects for migrant workers and border communities in Thailand and Myanmar. It has over 21,000 clients and 60 staff administering its initiative to provide health microinsurance to migrants and border communities.

Thailand is a primary country of destination for more than 3 million migrant workers mainly from Myanmar, Laos and Cambodia. The Thai government provides access to social security and health insurance but not to illegal migrants (roughly one third of the foreign workers) and dependents above 18 years old. Unregistered migrants represent a marginalized and neglected population with no health protection and access to affordable healthcare. This is particularly true for female partners of migrant workers who are not eligible to apply for the government health insurance and are left unprotected. On the Myanmar side of the border, public health care does not provide quality services leaving local ethnic communities to *de facto* pay additional fees for care.

DLP's Migrant Fund (M-FUND) offers low-cost, not for profit, microinsurance for unregistered migrants in Thailand and poor border communities in Myawaddy Township of Myanmar. The first project started in 2017 in Tak Province with a microinsurance scheme open to seniors and pregnant women, who are often not supported by the Thai government scheme. Since 2019, the project has been replicated in Myanmar.

Members can be treated for free in any of the M-FUND network hospitals both in Thailand and Myanmar. The M-FUND directly pays for the cost of care in these health care facilities, up to their M-FUND's plan coverage. The Base Plan starts from a monthly minimum of THB 100/MMK 5,000 (EUR 2.6), with the additional plans costing more.

Migrants and residents of marginalized border communities can renew their membership and pay membership fees to CWs on a monthly basis – appropriate to their income pattern. A reward system called M-Coins is also in place for customers who provide referrals. Services to migrants are offered in various languages including Thai, English, Khmer and Burmese. Since inception, 24,041 individuals have been cumulatively enrolled, 68% of whom are women and 22% are children under 15.



In Morocco, the public health system is inaccessible and unaffordable for more than half of the population, who generally cannot afford private health insurance. This affordability barrier is compounded by a lack of doctors, beds, medication, and equipment – particularly in the most deprived areas.

**Al Amana Microfinance** is an MFI that has responded to research indicating that most of its clients are at risk of health shocks, and they typically cover their health expenses out of pocket, often placing unsustainable demands on household finances. Al Amana launched *Tayssir al Amana* in 2012, in partnership with insurer Saham Assistance, to meet the needs of its largely rural client base, with a simple single-policy coverage for





childbirth, serious disease, incapacity, hospitalisation and death-related expenses. Designing this product for simplicity and affordability for these target segments has been key: loan clients pay 1% of the loan instalment as premium, costing around EUR 1 per month. Since 2015, coverage has been extended to include a client's spouse and children under 21 (up to 25 years old, if still students). The simple premium gives fixed coverage of up to EUR 460 equivalent for household members per year and coverage of the transport to hospital, in case of emergency.

There is a simplified claim procedure, involving a 24/7 call centre, no need to present medical documentation or have visits from the insurer, and customer care officers available in all branches to assist clients in making claims, accessing the pay-out, or speaking to the call centre in cases of medical need. Further, for claims related to death, invalidity and childbirth allowance, reimbursement of expenses can be directly settled at Al Amana branches.

*Tayssir al Amana* is notable not only for its low cost and simplicity but for the very high outreach among Al Amana's clients. Al Amana has a network of 640 agents and 75 mobile vans to cover the most remote areas, in addition to its branch network – all of which offer *Tayssir al Amana*.



## Al Amana Microfinance Morocco



Al Amana is an MFI in Morocco that was founded in 1997 to offer financial and non-financial services to excluded people in rural and urban areas, with a focus on vulnerable micro entrepreneurs in need of working capital or investment loans. Al Amana's 2,500 staff serves almost 320,000 clients.

Most of the Moroccan population (53%), especially the vulnerable and those with low income, is not covered by the public healthcare system and cannot afford to pay for traditional private health insurance. Moreover, the lack of qualified doctors, hospital beds, medical drugs and equipment is a barrier to accessing quality health care in Morocco. A study conducted by Al Amana shows that 58% of clients must cover health expenses with their own resources, consistently impacting the household income.

In partnership with *Saham Assistance*, Al Amana launched its health micro-insurance programme (*Tayssir al Amana*) in 2012 to meet the needs of its vulnerable clients (in rural areas in particular) in covering medical/health expenses. The programme covers different life events (childbirth allowance, first time that a serious disease is detected, invalidity, hospitalisations, sicknesses, and death including expenses and funeral transport services) in a single product. As of 2020, over 250,000 clients and their families were insured with this product (79% of the MFI's client base) and 11,885 claims were settled, almost half of which were for childbirth, with hospitalisation costs, ambulance transport and funeral expenses also making up significant percentages.

In Jordan, **Microfund for Women (MFW)**, the country's largest non-profit MFI, has recognised the impact of health emergencies and premature death on its clients and their families and designed an insurance product called *Aftayuna*. *Aftayuna* is notable for its simple policy model and one-stop-shop coverage, bundling credit life and hospital cash micro-insurance alongside MFW's other financial products to cover the medical expenses of clients, their spouses, and any children between the ages of one month and 21 years. The programme also includes life insurance coverage in case of the death of the borrower and/or their spouse. Clients (and family members) are eligible for 15 JD (EUR 18) per night of hospitalisation; up to 24 consecutive nights, and up to a total of 36 nights within a year for each insured individual and dependent.

On the health insurance side, all beneficiaries under the age of 65 who have an outstanding loan of less than JD 3,500 (EUR 4000) are automatically approved, without needing to provide medical reports. Both acute and chronic health issues are covered. On the life insurance side, in case of the policy-holder's death, the partner insurance company, Jordan Insurance Company (JIC) – one of the country's largest insurers for over 70 years – pays the remaining loan of the deceased and the administrative expenses of MFW at the date of death. A check of JD 1,600 (EUR 1900) is also issued to a beneficiary previously selected by the deceased. Finally, in case of the death of a client's spouse, if that spouse is not over 65, the client also receives a payment of JD 750 (EUR 900).

*Aftayuna* is now well established, being first piloted in 2006 as two separate products (one for credit life, the other hospital cash) and in 2015 was bundled into a single package and extended to family members. Premiums are approximately EUR 3 per month, and claims are directly managed by MFW, to ensure effective and quick implementation. In 2020 there were 127,641 active subscribers, 11,659 claims for hospital insurance and 737 for death. 96% of clients are women.

The high level of trust and confidence between MFW and JIC, as well as the latter's track record of openness to sharing its expertise, has meant MFW has been able to launch its own in-house insurance department

## Microfund for Women

Jordan



Microfund for Women (MFW), founded in 1996, is Jordan's largest non-profit MFI, currently serving over 124,000 clients via 700 staff. The organization is dedicated to empowering entrepreneurs, in particular women, through an array of financial and non-financial services designed to support their businesses and livelihoods while helping them achieve financial inclusion. MFW targets women and community members with special emphasis placed on supporting women who lack access to traditional financial institutions and their services. MFW's beneficiaries typically live in underserved and remote communities across Jordan and are reached via the organisation's 62 branches throughout the country.

Health emergencies are among the first three common reasons that causes huge losses to micro businesses in the country, causing household overindebtedness and financial problems for the institutions. To help clients deal with such health emergencies, MFW's health care programme comprises a wide variety of financial and non-financial components, including: a bundled credit-life and hospital cash microinsurance product; maternity loans; insurance-linked savings accounts; a tele-health mobile application providing access to consultations from doctors; 'medical days' in under-served areas, including free mammograms, consultations and medication; and awareness lectures on breast cancer, nutrition, first aid and smoking cessation.

of five employees and a supervisor to manage all beneficiaries' claims up to a certain limit. In addition, JIC has delegated to MFW the approval of claims under 5,000 JD (EUR 5,600 EUR) without JIC approval. Finally, MFW also gives its loan officers free access to the health programme so that they can directly experience its benefits and then promote the service better with their clients.

In 2019, JIC and MFW expanded MFW's insurance offering to launch a savings-linked insurance programme called *Amani*, providing another way for clients to be able to deal with the shocks of health emergencies. This is an optional savings account with life insurance coverage, and is offered to all clients, generating 3.5% per annum. It was piloted in 2019 to help clients achieve their mid- and long-term goals. As of 2020, there were 101 active *Amani* accounts with a combined balance of EUR 110,963.

Dreamlopmments, Al Amana, and MFW are not the only EMA2021 semi-finalists that aim to mitigate their clients' risk of health shocks. **ASEI** from El Salvador, **CARD** from the Philippines and **Pro Mujer Argentina**, all profiled in the previous section of this paper, offer health insurance alongside their prevention and treatment initiatives.

**ASEI** offers life and cancer microinsurance for their clients to access mammograms or prostate antigen screening after six months from the start of their policy. The insurance is offered in partnership with Pan-American Life Insurance Company, and 755 policies were purchased in 2020.

All **Pro Mujer Argentina** clients, when taking a loan, are automatically entitled to the *Beneficio Universal* insurance coverage, a basic health care package that if elected is paid via a fixed fee of ARS 4 (EUR 0.4) for "non-financial services". *Beneficio Universal* includes preventive screenings such as pap smears, as well as specialised services such as gynaecology, nutrition and sexual and reproductive care, among others, and covers both clients and their family members.

Finally, **CARD's** insurance programme is called KaSAPI and involves a partnership with the Philippine Health Insurance Corporation (PhilHealth), providing affordable health insurance for members and qualified dependents; easy enrolments and payment through center meetings; and help to avoid indebtedness during hospitalisation.





## 3

## DELIVERING HEALTH CARE TO THOSE WHO NEED IT MOST

*"The merit of all things  
lies in their difficulty"*

Alexander Dumas

In the previous two sections, we've seen example of how organisations can facilitate access to affordable health care by focusing on prevention and early treatment of illnesses, and – in cases where this is not possible – how to minimise the financial shocks of a health problem that can risk plummeting a household into destitution and dependence.

In this final section, we look at ways some of the EMA2021 semi-finalists have sought to reach **particularly vulnerable and under-served groups by innovating in health care access and delivery.**



In Haiti, women and children in rural areas are also among those who need health care the most. Rural people may travel long distances on foot to reach clinics and pharmacies only to find out that clinics are closed, staff is absent and/or products are unavailable or ineffective. Thus, many only seek care and treatment when illnesses reach crisis levels – when it is often too late. The mortality rate for children under 5 is over 8%, and less than a quarter of rural households have access to adequate sanitation. Mortality in Haiti is largely preventable but addressing this is hampered by poor health infrastructure and services, expertise and reliable



supply of quality equipment and products, especially in rural areas.

Observing the impact that the lack of these services was having on its microfinance clients, and particularly the unavailability of medical products, in 2014 **Fonkoze** piloted and launched a social franchising initiative called *Boutik Sante*, which brings over-the-counter health products, education, and health care services to rural Haiti. Fonkoze's MFI (SFF) provides financial services to remote communities through its team of over 300 loan officers, who travel every day to hold monthly meetings with groups (called Credit Centers) – each of approximately 20 clients. Fonkoze Foundation, the MFI's non-profit sister organisation, has a dedicated specialised team, including doctors and public health experts, who train a team of registered nurses who visit Credit Centers and in turn train selected clients to become Community Health Entrepreneurs (CHEs). These CHEs (all women) then conduct basic health screenings for other clients and community members – such as on malnutrition, therapeutic feeding treatment

and pregnancy – as well as delivering health education sessions and procuring and selling health care products that Fonkoze has purchased.

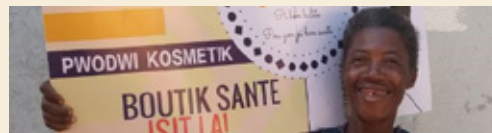
**Access to reliable and safe products** is an important element of this model. The typical street vendors who would otherwise sell health products to rural customers often lack knowledge of the products usage, efficacy and appropriateness, and illnesses that would be treatable with over-the-counter medicines used correctly can instead often reach acute stages. These conditions contribute to the spread of infectious disease, such as cholera and scabies epidemic.

This model has benefits not just for the end-clients, but the CHEs as well, who can procure critical products associated with better health, such as acetaminophen, antibacterial soap, alcohol pads, pregnancy tests, menstrual pads, nutrition supplements, disinfectant, and solar lighting products, and are provided with quality-assured market materials. For the CHEs (themselves SFF clients) this is a business opportunity too. They are eligible for a 'Business Development' loan (larger than a typical solidarity loan) for building an initial *Boutik Sante* inventory, buying products from Fonkoze (which purchases them in bulk at wholesale) and selling them with a markup, providing these CHEs with an average annual revenue stream of US\$183 in 2020 – and their average savings increased by 47%.

Quality control and monitoring is well established – critical when training people to provide health products and care. A digital platform tracks purchase and distribution of medicines and other health products. There is a toll-free number for clients' complaints and



## Fonkoze Haiti



Fonkoze, an EMA2021 finalist, is a family of three institutions, whose collective mission is to provide financial and non-financial services to empower Haitians – primarily women – to lift their families out of poverty. The Fonkoze MFI (SFF) is a leading microcredit provider, whilst the Fonkoze Foundation is its non-profit sister organisation that complements microfinance services by providing additional support to SFF clients and their communities in some of the most isolated areas of Haiti, such as health screening and guidelines, as well as other development services. The third, Fonkoze USA, is the outreach, communications, and capacity-building wing for the entire Fonkoze Family.

Rural Haiti suffers from extremely high child mortality and few households have access to adequate sanitation and health care services. The principal causes of mortality in Haiti are preventable, but the health services, infrastructure and medical supply are very poor, and the product market is characterized by expensive, unreliable or low-quality supply.

Because of the high rate of clients dropping out of SFF's loan programmes due to health shocks and based on its clients' systematic requests for health support, Fonkoze Foundation piloted and launched in 2014 *Boutik Sante* (BS), a Fonkoze social franchising initiative that brings over-the-counter health products, education, and health care services to rural Haiti. A Fonkoze team of registered nurses trains microfinance clients (electing Credit Center chiefs to become Community Health Entrepreneurs - CHEs), who learn to conduct basic health screenings (i.e., malnutrition, therapeutic feeding treatments, pregnancy), deliver health education sessions, and procure health products to sell.

queries. A team of nurses is responsible for monitoring the CHEs’ activities – including unannounced monthly visits to CHEs to gather client feedback and provide ongoing coaching, if needed. Each CHE also has the direct phone number of a *Boutik Sante* senior manager, in case of any issues with their designated nurse supervisor.

The programme continues to evolve. During 2020, *Boutik Sante* launched an initiative to explicitly address gender-based violence through its education curriculum. And in response to Covid-19, CHEs have been trained to sensitize clients on preventive measures and protective strategies and new inventory added, including masks, hand sanitiser and hand washing stations. Despite the pandemic, *Boutik Sante* has continued to grow – total average health product sales per month rose from US\$22,767 in 2019 to US\$89,410 in 2020, and this was complemented by 80,290 malnutrition screenings, 37,444 health education sessions and 52,769 children receiving vitamin A supplements in 2020. Fonzoze estimates that the *Boutik Sante* initiative saved the lives of approximately 1,617 children under 5 years old, calculated by reductions in diarrhoea-related mortality using the Lives Saved Tool. Surveys reveal that 66% of people in the areas Fonzoze serve have benefited directly from *Boutik Sante* products and services, meaning the lives of over 3.3 million rural Haitians have been improved due to this programme to date.



In Guatemala, remote communities share many of the same health challenges as in Haiti: lack of access to doctors, nurses, clinics, medications, and equipment. The country has some of the most unequal income distribution in the world, and women are far less likely to have access to education and other opportunities, leaving Guatemala in the bottom third of countries in the Global Gender Gap Index. Historic discrimination against its indigenous Mayan population endures, causing serious additional barriers to accessing health care, in a country which already only has 0.6 hospital beds per 1,000 population, and is even worse in rural communities.

**Friendship Bridge** is a Guatemalan cooperative and credit union which in 2015 launched its Health for Life

programme in partnership with Maya Health Alliance (Wuqu’ Kawoq), a local health provider employing indigenous health care workers to provide **medicine, culturally and language-appropriate care to help indigenous Maya communities.**

In regions where Health for Life operates, there is, on average, only one public health facility for every 10,000 people, meaning many Friendship Bridge clients lack access to even a single public health centre in their municipality. Moreover, most other healthcare providers are Spanish-speaking Ladino (non-Mayan of Spanish descent) men. For many Mayans, Spanish is at most a second language, and even this is rarely true for Mayan women, who are reluctant to visit a male doctor, especially for specialty care such as breast examinations or pap smears. Health for Life was therefore designed to particularly counter these healthcare challenges: clients do not have to travel for preventive healthcare, clients are seen by female medical staff, staff speak clients’ languages, and health education is provided.

The partnership with Maya Health Alliance (MHA) to bring this culturally sensitive health care to Friendship Bridge clients is vital. MHA recruits, trains (for approximately two months), and supports local indigenous nurses and nursing assistants. Each nurse is bilingual in Spanish and at least one Mayan language. Nurses are trained in in-classroom theory and clinical skills, as well as understanding of the online medical record system; hands-on, supervised field training paired with experienced clinicians; and coaching of new healthcare workers during actual clinic visits.

The programme provides a wide range of medical tests and screenings, including pap smears, cervical exams, breast exams, diabetes screening, hypertension screening, pregnancy tests, STI screening and antenatal care. Health education and family planning advice is also provided.

Pre-Covid, these services were provided solely through mobile clinics where nurses meet in one central, yet discreet, location where all members receive their tests and screenings, if desired. With social distancing restrictions in place starting mid-2020, Friendship Bridge developed a new methodology for delivering Health for Life services, called domiciliary clinics, which resulted in meeting with clients one-to-one within their

## Friendship Bridge Guatemala



Friendship Bridge is a Guatemalan-based cooperative and credit union founded in 1990 with a mission to create opportunities that empower Guatemalan women to build a better life. With over 22,000 clients as of 2020, Friendship Bridge launched the Health for Life programme back in 2015, which involves a partnership with Maya Health Alliance (Wuqu' Kawoq), a local health provider employing indigenous health care workers to provide medicine, culturally and language appropriate care to help indigenous Maya communities.

Guatemala's healthcare system is riddled with barriers for those needing access, especially in rural communities where proximity to healthcare is unlikely, and there are challenges for providers offering culturally sensitive care. Diabetes, hypertension, and breast and cervical cancer are prevalent nationally. Cervical cancer is the second cause of cancer-related deaths in Guatemalan women and the rate of type 2 diabetes and prediabetes among Maya people is 25% - more than double the national rate.

Friendship Bridge's Health for Life programme facilitates access to culturally sensitive healthcare services, where clients can receive life-saving detection and treatment for non-communicable diseases as well as other health complications. Medical care is provided by nurses with a door-to-door (domiciliary) model or via mobile clinics that travel to the villages. Maya Health Alliance (MHA) recruits, trains and supports these local indigenous nurses and nursing assistants. Each nurse is bilingual in Spanish and at least one Mayan language helping to remove cultural and linguistic barriers to care for indigenous patients.

homes. This approach has proven extremely successful as 77% of eligible clients participated in the clinics, as opposed to 43% of eligible clients pre-Covid. As well as domiciliary clinics, tele-medicine was introduced during the pandemic, with 9,991 clients receiving a telemedicine service and remote health education training in 2020.

Friendship Bridge clients get access to a General Healthcare Services Package as part of their loan if they belong to one of the four (out of 13) branches currently operating the Health for Life programme, have had a loan for 3+ cycles, no delinquency history, have 5+ months until loan expiration and have not visited any clinic in the past ten months (meaning roughly two-thirds of Friendship Bridge clients are currently eligible). The cost of delivering health care to beneficiaries is covered by the portfolio yield. For the first three loan cycles, clients are charged a flat monthly interest rate of 3% that declines to 2.6% from the fourth loan cycle. The interest rate drops further to 2.3% from the 11<sup>th</sup> loan cycle or more.

Clients with access to Friendship Bridge's Health for Life programme are three times more likely to pursue preventive health exams than clients without access; 50% more likely to rely on savings (than credit) to cope with unexpected health-related expenses; over a third of clients adopted family planning methods after a Health for Life education programme; and Health for Life recipients are more likely to remain as Friendship Bridge clients, with measurable benefits on household income and prosperity.



Reaching marginalised and indigenous communities is also characteristic of **Avanza Sólido** in Mexico. The state of Chiapas in the south-east has the country's highest level of indigenous communities, who live in the most excluded and rural areas. Avanza Sólido is an MFI which works in Chiapas and five other states, offering financial and non-financial services predominantly to female entrepreneurs. 76.4% of Chiapas' population were living under the national poverty line in 2018, and there is only one health care facility per 2,716 inhabitants – the lowest in Mexico – and these facilities are disproportionately in central and coastal areas, leaving vast areas of the state, with

the highest incidents of poverty and economic equality, effectively without any access to health care. Finally, the increase in the number of female-headed households means that the Covid-19 pandemic has particularly affected women, who are more likely to be exposed to the virus than men, as well as suffering from higher incidences of domestic violence during the pandemic.

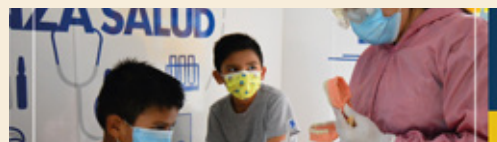
In response to high levels of maternal mortality and domestic violence in remote, rural areas, and lack of education and support to women, Avanza Sólido in 2017 launched its integrated health care programme *Avanza Tu Salud* (advance your health), offered for free to the MFI's existing clients.

Promotion of *Avanza Tu Salud* is primarily via *jornadas de salud* (health days) held twice per month in areas which the MFI's market research, with the support of government partners, identifies as being of extremely high poverty and health exclusion. Conducted and promoted in partnership with local government entities and private health providers, the *jornadas de salud* give priority to existing clients but is also an opportunity to reach potential clients as well. The health days cover awareness raising, prevention of non-transmissible illnesses such as diabetes and hypertension and include free general and specific medical and dental consultations as well as *Salud Materna Universal* – women-specific health services, including pap smears and breast exams, providing family planning products and usage guidelines – all free of charge.

Matching the health care services to its clients' actual barriers and needs is important. Avanza Sólido's social development and management department conducted market studies before designing the programme, and since then, client feedback and profile data – supported via the Poverty Probability Index – is gathered before and after the beneficiaries of the healthcare programme use these services, to revise the product offer and understand outcomes.

The extremely remote nature of Avanza Sólido's client base means that communication is a challenge that must be proactively addressed. The organisation uses a variety of communication channels, including an information phone number, extensive use of social media and, increasingly, mobile vans, to disseminate its financial and non-financial services. Avanza Sólido

## Avanza Sólido Mexico



Avanza Sólido is a Mexican MFI founded in 2011 to offer financial and non-financial services to excluded people in rural areas in the south-eastern region of Mexico. One of the regions it works is Chiapas, where there is only one health care facility per 2,716 inhabitants – the lowest in Mexico – and these facilities are disproportionately in central and coastal areas, leaving vast areas of the state, with the highest incidents of poverty and economic equality, effectively without any access to health care. Avanza Sólido has a particular focus in supporting female entrepreneurs to become economically independent, by providing working capital and investment loans, as well as loans for home improvement. In its non-financial services, the *Fortalecimiento Económico de la Mujer* initiative focuses on business development and soft skills training for women entrepreneurs. Through its network of 18 branches serving over 22,000 clients, Avanza Sólido covers 6 states, with a concentration of operations in the state of Chiapas, where the highest level of indigenous communities (30% of the state's population) is found in the most excluded, rural areas.

Avanza Sólido launched its integrated healthcare programme (*Avanza Tu Salud*) in 2017, with the objective of tackling maternity deaths and domestic violence in remote areas, where the level of awareness and services offered to support women with these issues are scarce. The healthcare programme, which includes screenings, education, examinations, and consultations, is offered free-of-charge to Avanza Sólido's existing and potential clients and comes in the form of health days, awareness campaigns, and health check services.



## Providing Health Care in a Pandemic: Responses to Covid-19

The application period for Round 1 was in March 2021, at which point the applicants had spent a year dealing with the complicated and stressful combination of economic and health challenges of the pandemic. While the Award this year looked for pre-existing health care initiatives (so that specific responses to Covid-19, by themselves, would not be within scope), it's clear that all organisations have had to respond to this challenge, and those with health care initiatives would 'pivot' to protect and support their clients from the virus and its impacts, and do so while facing challenging restrictions on the movement and meeting of people. The EMA2021 organisers therefore asked applicants to describe **how they have responded to the pandemic**.

### Education has been a key part of their response.

In Bolivia, **CRECER IFD** developed a preventive model based on awareness raising, capacity building, tele-consultation and Covid prevention. As early as February 2020, **Fonkoze** in Haiti used the *Boutik Sante* programme to train CHEs to give training in Creole on preventive measures and protective strategies, as well as adding masks, sanitiser and washing stations to their available inventory for sale. **Avanza Sólido** in Mexico also adapted and re-organised their existing health programme, to include, among other initiatives described on page 30, Prevención - providing Covid-19 prevention guidelines in indigenous languages as well as prevention kits (e.g., masks, gel, thermometer, and paracetamol), distributed using mobile vans.

Others have focused on **mitigating the economic impact** of lockdowns on their clients. **Dreamlopmments** in Thailand, recognising that Covid was driving up the default rates of migrants in Thailand and Myanmar, decided to subsidise premiums of M-FUND members who stayed in those areas to ensure coverage from March to mid-July 2020, with funding from the French Ministry for Europe and Foreign Affairs. Over January and February 2021, due to another Covid breakout in different sites, DLP again decided to subsidise premiums from its small reserve from members' contributions. For districts where the Covid impact was higher, the subsidies were extended until March 2021.

In Jordan, **Microfund for Women**, despite all loan repayments being deferred for two and a half months,

also ensured continuation of insurance coverage (including for Covid treatment), at a cost of EUR 100,000 to the organisation. During lockdown, a dedicated team called all beneficiaries of Al-Tibbi, MFW's mobile tele-health subscription service, offering them a use-now, pay-later service where they benefited from the advantage of the subscription with unlimited consultation, free for some and with deferred fees for others. 4,570 beneficiaries benefited from the service between March and December 2020.

Another focus was on ensuring **continuity of health care**. In El Salvador, **ASEI** kept its clinics open even when public hospitals were only treating Covid cases, and ASEI contacted clients with chronic illnesses to monitor them and provide consultations if needed. In the Philippines, branches of **CARD's** pharmacy, BotiCARD, remained operational to provide affordable and quality medicines and hygiene products to the public.

Continuity was also established via **technology solutions**. **CARD** scaled up its e-Doctor service, providing online consultations and hosting live discussions about Covid-19. At **Pro Mujer Argentina**, telehealth became an increasing alternative to in-person consultations, which were reserved for the most severe cases. When PMA realised that many clients could not access the service due to lack of experience with digital products and platforms, it began delivering basic digital literacy trainings to ensure that patients would be able to connect with their doctors. As a result, over 3,000 consultations took place, mainly via Zoom and WhatsApp.

Finally, there were **adaptations to how health care is delivered**, especially to the most excluded populations. With social distancing restrictions in place starting mid-2020, **Friendship Bridge** in Guatemala developed a new methodology for delivering Health for Life services, called domiciliary clinics, which resulted in meeting with clients one-to-one within their homes. This proved extremely successful, with 77% of eligible clients participating in the clinics, compared to 43% of eligible clients pre-Covid. As well as domiciliary clinics, tele-medicine was introduced during the pandemic, with 9,991 clients receiving a telemedicine service and remote health education training in 2020.



considers its health care programme an integral part of its overall sales strategy since it is used to gain the confidence and trust of its existing and potential clients, and the perceived value is high.

The medical staff within *Avanza Te Salud* are trained regularly on gender equality, non-discrimination, and the specific needs of indigenous communities. And in cases where *Avanza Sólido* clients are sent to 3<sup>rd</sup> party medical professionals, staff from the MFI attend the appointment to ensure the health care is provided in a way that is sensitive and culturally appropriate. Finally, when *Avanza Sólido* wishes to join a new health provider into its programme, priority is given to companies led by women.

During the pandemic, awareness raising and capacity building sessions have moved to Zoom calls and Facebook Live, and guidelines have been circulated via WhatsApp. Telemedicine consultations, which had started as a pilot at the beginning of 2020, were quickly reinforced. However, for specialised medical consultations such as ultrasounds, *Avanza Sólido* staff continue to travel to remote areas, with less frequency, but serving higher numbers of clients per visit. *Avanza*

*Sólido* also provided Covid-19 preventive kits and information in their clients' mother tongue, and ensured food security through food pantries to clients and non-clients. The distribution of these pantries was accompanied by gender violence awareness raising as well as *jornadas de salud* expressly on hypertension, diabetes, and reproductive health. In 2020, 5,557 people (94% of whom were women and 82% of whom live in remote areas) were served by the *Avanza tu Salud* programme and 8,524 food pantries were distributed.

Finally, we saw in the previous section how **Dreamlopmments** serves unregistered migrant populations who lack health protection and access to affordable health care, through its M-FUND insurance. In addition to its financial inclusion insurance via M-FUND, Dreamlopmments focuses on another group most in need of health care – the first community-based model of care in Thailand for **diagnosis and treatment of hepatitis C in intravenous drug users**. Studies in Thailand show up to 80-90% of intravenous drug users have been infected with the virus. Breakthrough therapy now exists to cure hepatitis C, but uptake is low because of cost barriers, and intravenous drug users are often denied treatment.

The programme, called C-FREE, uses a highly effective novel treatment combination called Sofosbuvir/Velpatasvir. The study is based at drop-in centers (DIC) run by partner organisations Ozone and Raks Thai Foundation and who travel to build awareness of the C-FREE services among drug users. Testing for Hepatitis C, as well as Hepatitis B and HIV are all done at the DIC by trained research nurses. Counselling is offered to all participants who test positive. For eligible participants with Hepatitis C, physicians give treatment with Sofosbuvir/Velpatasvir through weekly clinics at the DIC. 12 weeks after completion of treatment, a research nurse confirms cure of the infection with rapid viral load testing done on site.



# FACTORS FOR SUCCESS

*"Any fool can know.  
The point is to understand"*

*Albert Einstein*

It's to be expected that a topic on facilitating access to health care among low-income populations would elicit a diverse field of initiatives and responses. After all, what can be more varied than people's health care needs – multiplied by the different challenges of the contexts in which they live?

The complexity of providing health care stems from three levels of need: First, countries' health care systems, capacity, resources, and priorities vary. Second, groups – children, men, women, migrants, the elderly, remote communities – all require unique and specific care. And third, no two people are the same, and

everyone has their own individual health needs or challenges. Effective health care, therefore, must somehow achieve the seemingly impossible – **being both general and specific; one-size-fits-all and bespoke, all at the same time.**

Impossible or not, the initiatives profiled in this paper have certain characteristics that cut across their heterogeneity – a list of distinguishing 'factors for success' that can serve as a blueprint for other financial service providers looking to expand their product and service offerings into this vital area.

First is a reliance on **partnerships and linkages**. More than most

previous EMA topics, health care is really outside the core expertise of a financial services provider, which will need to choose partners from a wide range of options – from public and/or private clinics and hospitals to insurance companies, government entities, NGOs, technology providers, pharmacies, laboratories, and education providers. The right partner (or more commonly, combination of partners) will depend on the financial product and non-financial services being provided and to whom. But throughout the ten cases in this paper, there are examples of them all.

Access to health care for vulnerable communities is always going to require a focus on the **particular needs of women**. While recognising that there are diseases and health concerns specific to men, women have unique and additional health care needs, and the barriers to meeting those needs (especially among poor and remote communities) can be devastating. From screenings and early detection of women-specific cancers to antenatal and post-natal products and support, family planning and education on gender violence – most of these outstanding initiatives to some degree or another focus on women.

Vulnerable groups may face many barriers to accessing health care, and not just logistical or financial or





technological. Some of them stem from cultural norms and result in **structural barriers**, such as fear, shame, mistrust of or apprehension talking to medical professionals. Understanding these barriers and designing health care initiatives in a way that is culturally sensitive, language-appropriate, client-centric and empathetic is crucial to expanding access, letting clients feel that health care providers are not a detached elite, but a part of the community – and that access to quality health care is a fundamental human right.

Another success factor is the high level of **integration of education and awareness building** into an initiative. Many of the health care challenges in low-income and vulnerable communities can be addressed by investing in education, ranging from nutrition and lifestyle choices to prevention, detection, and early treatment of diseases. To paraphrase Franklin from earlier in this paper, prevention is always preferable to cure.

**Technology** allows health care to be brought to more people at lower cost. The pandemic has naturally catalysed the use of tele-medicine, expanding access to specialist consultations that have previously been out of reach to low-income and remote households - at least to help determine if a person needs in-person treatment. Social networks and online discussion forums moderated by expert staff, and delivery of education via mobile devices, are among many ways that technology can reduce the barriers to health care access.

All the semi-finalists offer financial products for health care, but most use an **integrated and holistic model**, combining more than one financial product – insurance, credit, pre-paid models, bundled packages, for example – to give clients maximum flexibility and protection, whether from shocks of sudden costs to smoothing regular health expenditures. Furthermore, combining financial products with non-financial support is also characteristic of the semi-finalists, some of whom offer multiple

services of each. A **holistic view of health care** means that prevention, detection, early treatment, education, and the mitigation of financial shocks can complement one another. This is the 'gold standard' of access to health care - and requires ambition.

Finally, this **ambition** goes beyond just product offerings. Providers should where possible approach and define health care broadly, to include domestic violence prevention and mental health, and they should be encouraged and helped where possible to **try the most difficult things** – reaching the most remote communities, building the right partnerships, training local people, negotiating discounts, educating people on discomforting or even taboo subjects. One way or another, the ten organisations in this paper, as well as many others, have all been ambitious enough to move beyond their core services because they understand that however financially prosperous or resilient their clients may become, the first wealth is always health.







## ABOUT THE EUROPEAN MICROFINANCE AWARD



The European Microfinance Award is a prestigious annual award with EUR 100,000 for the winner and EUR 10,000 for the runners-up, which attracts applications from organisations active in financial services around the world that are innovating in a particular area of financial inclusion. The Award was launched in 2005 by the Luxembourg Ministry of Foreign and European Affairs – Directorate for Development Cooperation and Humanitarian Affairs and is jointly organised by the Luxembourg Ministry of Foreign and European Affairs, the European Microfinance Platform (e-MFP) and the Inclusive Finance Network Luxembourg, in cooperation with the European

Investment Bank. It serves two parallel goals: rewarding excellence and collecting and disseminating the most relevant practices for replication by others.

Previous editions addressed the following subjects:

- **2020, Encouraging Effective and Inclusive Savings**

How can FSPs design and offer savings products that respond to clients' real needs and encourage positive savings behaviour?

**Winner:** Muktinath Bikas Bank (Nepal), for its adapted solidarity group savings model with doorstep services, including dedicated pension and insurance savings

products, alongside extensive financial education.

- **2019, Strengthening Resilience to Climate Change**

How can FSPs provide products and services to increase the resilience of vulnerable populations (and the institutions themselves) to climate change?

**Winner:** APA Insurance Ltd (Kenya), for its index-based livestock and area yield insurance products for farmers

- **2018, Financial Inclusion through Technology**

How can FSPs leverage technology innovations to improve efficiencies





and service quality and increase outreach to new, excluded populations?

**Winner:** Advans Côte d'Ivoire (Ivory Coast), for its digital savings and payment solutions for cocoa farmers and cooperatives, and their small digital school loans for farmers

- **2017, Microfinance for Housing**

Can MFIs respond to the complex housing needs of low income and vulnerable populations, helping them access better quality residential housing?

**Winner:** Cooperativa Tosepantomin, for its holistic housing programme serving rural communities and promoting environmental responsibility.

- **2016, Microfinance and Access to Education**

How can MFIs increase access to education for children, or provide skills training for youth and adults to enhance their employment and self-employment opportunities?

**Winner:** Kashf Foundation (Pakistan), for its programme to serve low-cost private schools.

- **2015, Microfinance in Post-disaster, Post-conflict Areas & Fragile States**

What can MFIs do in order to operate in exceptionally difficult environments and circumstances, helping increase the resilience of the affected communities?

**Winner:** Crédit Rural de Guinée S.A (Guinea), for its innovative response to the Ebola outbreak in Guinea

- **2014, Microfinance and the Environment**

Is it possible to integrate environmental governance into the DNA of MFIs and promote initiatives to improve environmental sustainability?

**Winner:** Kompanion (Kyrgyzstan), for its Pasture Land Management Training Initiative

- **2012, Microfinance for Food Security**

Which microfinance initiatives contribute to improving food production and distribution conditions in developing countries?

**Winner:** ASKI (The Philippines), for serving smallholder farmers and fostering effective market linkages

- **2010, Value Chain Finance**

What are the outstanding microfinance initiatives in productive value chain schemes?

**Winner:** Harbu (Ethiopia), for an initiative financing a soybean value chain

- **2008, Socially Responsible Microfinance**

What innovative initiatives can MFIs undertake to promote, measure and increase the social performance of their activities?

**Winner:** Buusaa Gonofaa (Ethiopia), for the development of its client assessment system

- **2006, Innovation for Outreach**

What are breakthrough initiatives within microfinance that deepen or broaden rural outreach?

**Winner:** The Zakoura Foundation (Morocco), for its programme on rural tourism

## Selection Committee Members

Organisation	Judge(s)
ADA	Bénédicte Godefroid
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BNP Paribas	Claudia Belli
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## Luxembourg Ministry of Foreign and European Affairs

Directorate for Development Cooperation and Humanitarian Affairs

<https://cooperation.gouvernement.lu>

The inclusive finance sector has been actively supported by Luxembourg's Directorate for Development Cooperation and Humanitarian Affairs of the Ministry of Foreign and European Affairs over the last 20 years. The Ministry works closely with civil society stakeholders and networks specialised in microfinance to fund conceptual innovation, research and the development of new tools as well as political action in national and international fora, by focusing particularly on integrating the most vulnerable into the financial inclusion sector. Long-term commitment and strategic support have led to Luxembourg being globally recognised as a centre for financial inclusion.



## The European Microfinance Platform

[www.e-mfp.eu](http://www.e-mfp.eu)

The European Microfinance Platform (e-MFP) is the leading network of European organisations and individuals active in the microfinance/financial inclusion sector in developing countries. It numbers over 130 members from all geographic regions and specialisations of the microfinance community, including consultants & support service providers, investors, FSPs, multilateral & national development agencies, NGOs and researchers.

Up to two billion people remain financially excluded. To address this, the Platform seeks to promote co-operation, dialogue and innovation among these diverse stakeholders working in developing countries. e-MFP fosters activities which increase global access to affordable, quality sustainable and inclusive financial services for the un(der)banked by driving knowledge-sharing, partnership development and innovation.



## Inclusive Finance Network Luxembourg

[www.InFiNe.lu](http://www.InFiNe.lu)

The Inclusive Finance Network Luxembourg Asbl (InFiNe.lu) brings together Luxembourg stakeholders from the public, private and civil society sectors to promote economic inclusion and sustainable poverty alleviation through responsible and quality financial services for all. Capitalising on Luxembourg's leading position as financial and development center, InFiNe.lu aims at catalysing expertise and know-how in inclusive finance and stimulating synergies, and collaboration amongst its members in the sector. The network gathers 36 members and is supported by the Luxembourg Ministry of Foreign and European Affairs – Directorate for Development Cooperation and Humanitarian Affairs.



[www.e-mfp.eu](http://www.e-mfp.eu)

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