Microfinance and Health Protection Initiative Research Summary Report: CRECER

FREEDOM FROM HUNGER RESEARCH REPORT NO. 9C

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Table of Contents

EXECUTIVE SUMMARY

Introduction

Many microfinance institutions (MFIs) have witnessed the significant impact that all-too-common health shocks can have on their clients' ability to make their loan payments, save and flourish in their microenterprise endeavors. These MFIs seek sustainable approaches that help safeguard their clients' health without negatively impacting the financial sustainability of the institution. In 2006, Freedom from Hunger, with support from the Bill & Melinda Gates Foundation, launched the Microfinance and Health Protection (MAHP) Initiative in partnership with the Bolivian MFI CRECER (Crédito con Educación Rural) to research, develop and implement a set of comprehensive health protection services with two main benefits in mind: 1) improve client health outcomes through improved access to both preventative and curative health care and 2) enhance CRECER's financial sustainability through improved competitiveness and cost-neutral products.

Through the MAHP initiative, CRECER continued to develop and refine their "health days" (*jornadas*), linkages to health services, and developed a new health loan product to help clients cover the costs incurred from seeking essential treatment for medical issues. As CRECER is one of Freedom from Hunger's longest-standing *Credit with Education* partners in Latin America, it has also continued to provide health education to its village banking clients, particularly health education around health costs and seeking health services. By the end of December 2009, 102,000 had access to education across all of CRECER, and 26,296 clients had access to the full MAHP package, including health education, the health days and the new health loans; approximately 24,000 clients had actually participated in various *jornadas* and 256 clients had taken out a health loan during the four-year initiative. As CRECER named their "MAHP" initiative CRECER *Saludable*, ("Healthy CRECER") the rest of this paper will refer to anything completed under the MAHP initiative as such.

This report highlights and summarizes[8] the key client-level and institutional-level results from the seven main evaluation components conducted during the four-year CRECER *Saludable* initiative. Research components include: 1) a household level financial and health study that included pre- and post-intervention surveys and included monthly survey interviews with a statistically representative subset of clients; 2) a health loan-use study; 3) a *jornada* use study; 4) a qualitative client "impact" story study; 5) client satisfaction, client exit and competitors analysis studies; 6) a mini-survey assessing the "Healthy Habits" education; and 7) an institutional assessment.

Results

Between 2007 and 2009, the clients who participated in the financial and health survey (n=240) experienced improved income, improved food security, increased personal savings, but also increased use of their microenterprise loan for non-business expenses. More people reported an illness in 2009 compared to 2007, but clients seeking preventive care increased by 2009. The increase in reporting of illnesses in 2009 is similar across several MAHP partners. This might suggest increased awareness of health issues among family members and an enhanced awareness of illness episodes.

[8] There are full results for each of the studies documented in this final report; thus, not all results are provided in this report.

When clients were asked specifically about their experiences with the *jornadas* and health loans, most were quite satisfied (76%). Those with health loans indicated they were able to avoid taking loans from family and friends, selling assets and postponing or cancelling treatment altogether. Twenty-four percent of those who participated in the *jornada* use study indicated they had never been to a doctor before and 74 percent indicated they were very likely to seek treatment from the physicians they met through the *jornada* campaigns.

The results across the evaluation studies suggest that the providing a health protection package, including health education, *jornadas* and health loans played an important part in CRECER's competitive advantage against other MFIs, enhancing its widely recognized competence in meeting the loan and savings needs of rural and peri-urban populations. During the program period, CRECER was mandated by the Bolivian government to begin the process of becoming a regulated financial institution. This important institutional transformation impacted CRECER's ability to focus on innovative new programs. Still, even under this reduced focus, CRECER *Saludable* resulted in some important client and institutional outcomes.

Analysis

While other factors may influence people's behavior, our evaluation suggests that CRECER *Saludable* efforts resulted in an increase in use of preventive health care from 2007 to 2009. Nearly 24,000 clients and their family members benefited from preventive medical services such as Pap smears, dental care and screenings for diabetes, gall bladder and kidney diseases during the same time period, indicating that the *jornadas* had some influence. This demonstrates CRECER's outreach and the important role and influence that a microfinance organization can have on public health goals.

Although CRECER's offer of a health loan suffered from administrative difficulties resulting in a high percentage of the portfolio-at-risk during the program period, those difficulties through the learning period have been resolved resulting in a near 100 percent repayment by the end of the program period. Two-hundred-and-fifty-six CRECER clients and their family members benefited from the health loan program, which helped them avoid borrowing from family and friends, selling an important asset and forgoing medical treatment altogether.

Long-term research will help determine whether offering these health protection products directly contribute to important institutional goals of improved competitiveness, growth and retention, and improved preventive care-seeking behavior, client health, and family food security.

Conclusion

Due to CRECER's satisfaction and client satisfaction with and client demand for the health days and health loans in particular (and the added benefit of the health education), CRECER is scaling CRECER *Saludable* into its remaining program areas throughout Bolivia, with the potential of providing access to the health days and health loans for more than 100,000 clients.

INTRODUCTION

Many microfinance institutions (MFIs) have witnessed the significant impact that all-too-common health shocks can have on their clients' ability to repay, save and flourish in their microenterprise endeavors. These institutions seek sustainable approaches that help safeguard their clients' health while also protecting the institutional bottom line.

Freedom from Hunger, a recognized expert in integrated financial and nonfinancial services ("Value-added Microfinance") for the poor, launched the Microfinance and Health Protection (MAHP) initiative in January 2006 with funding from the Bill & Melinda Gates Foundation. This initiative enabled Freedom from Hunger and its partner MFIs to add new health protection options to existing microfinance services, including health education, health savings, health loans, health micro-insurance, healthcare provider linkages and access to health products. The pilot projects for these new services were implemented in Bénin with PADME, in Bolivia with CRECER, in Burkina Faso with RCPB, in India with Bandhan and in the Philippines with CARD. In keeping with Freedom from Hunger's longstanding commitment to proving progress and documenting effectiveness, the grant also underwrote evaluation and impact studies and other assessments of MAHP-related innovations.

Types of Health Protection Services

The following types of health protection services were pilot-tested as part of the MAHP initiative.

Health education services

- Interactive education sessions on topics such as prenatal health, malaria, dengue fever, common childhood illnesses and HIV/AIDS
- Interactive education on coping with health-related financial shocks, using health financing services and getting the most out of local healthcare services

Health financing and insurance

- Health loans
- Health savings
- Health micro-insurance
- Community investments in health protection services and products

Linkages to health care providers and products

- Mobile healthcare providers offering health education, preventive and diagnostic services in rural areas
- Referrals to private and public providers for primary and secondary care
- Preferred provider program with discounted primary care for rural microfinance clients
- Sale of health products by a network of volunteers in rural areas

Freedom from Hunger emphasizes holistic, cohesive and sustainable approaches to tackling the pressing needs of the chronically hungry poor. With technical support from Freedom from Hunger's MAHP initiative, each MFI developed a unique package of health protection services based on market research and institutional capacity. These packages were reaching more than 300,000 microfinance clients combined by the end of 2009.

With the creation of the MAHP initiative, Freedom from Hunger is initiating a new era in microfinance, one that responds to the desires of microfinance institutions to help their clients stay healthy, flourish in their microenterprises and meet the most pressing health needs of families living in poverty.

This report will focus on the findings and experiences with one of the MAHP partners, Crédito con Educación Rural (CRECER), one of the largest microfinance organizations dedicated to serving the poor in Bolivia.

CRECER

Created by Freedom from Hunger in 1990, CRECER became an independent Bolivian microfinance institution in 1999. It has grown to become the largest village banking institution in South America and serves poor, primarily rural, women clients. CRECER's flagship product is *Credit with Education* —group-based microfinance and non-formal education delivered by the same field agent at regular meetings in clients' communities. CRECER has achieved high levels of efficiency (each field officer reaches 466 clients) and financial self-sufficiency, while maintaining a high portfolio quality (consistently one of the lowest PAR rates in the crowded Bolivian microfinance market). Although CRECER is prohibited by law from collecting savings, each credit group does so using a group account at a regulated financial institution. Prior to the MAHP initiative, CRECER had also worked closely with Freedom from Hunger to develop and implement community-based distribution of contraceptives. It also established a system of agreements with local health service providers and a referral system for its clients. CRECER sponsored "health days" (*jornadas*) for its clients and explored other opportunities to promote the health of its clients and families.

With a strong social mission and a business need to differentiate itself from competitors, beginning in 2006 CRECER sought to expand its health-related offerings by developing a cohesive package of health protection products that would have significant impact on clients while being provided in an efficient, systematized and cost-effective manner.

As CRECER named their "MAHP" initiative CRECER *Saludable*, ("Healthy CRECER") the rest of this paper will refer to anything completed under the MAHP initiative as such. Table 1 highlights key institutional information on CRECER and key outreach data for CRECER *Saludable* products and services. The CRECER *Saludable* data will be explained throughout this paper.

Table 1: CRECER—Bolivia Institutional Data as of December 2009

MFI-wide	
Year MFI established	1990
Number of active borrowers	102,212 (95% women)
Outstanding loan portfolio (US$)	46,067,523
Portfolio-at-risk (30 days)	0.9%
Number of active savers	102,212
Operational self-sufficiency	111%
Health Protection Products	
Year started *Credit with Education*	1990
Number of *Credit with Education* clients	102,212
Number of Health Days (cumulative)	1,237
Number of Health Day participants (cumulative)	23,900
Number of health loans (cumulative)	256
Outstanding health loan portfolio ($)	25,161

CRECER's cohesive health protection package developed as part of the MAHP initiative includes the following:

- **Mobile health providers providing primary care and diagnostic services through health days** (hereafter, "health days" will be referred to as *jornadas*, which is the term used by CRECER to describe this service)**.** Health provider visits are organized by CRECER to occur at credit association meetings or at the closest CRECER branch; or organized to provide services directly in a community center for clients and community members.

- **Referrals to higher-level medical care when needed.** Doctors at the *jornada*s provide referral for follow-on treatments either at their office or the hospital or center with which they are associated. Referral arrangements also enable health loan proceeds to be paid directly to healthcare providers to cover costs of services for an agreed-upon total amount.

- **Contract linkages with private health providers.** Prior to the MAHP initiative, CRECER worked with local health providers and clinics to establish a range of preventive services, such as Pap smears, vaccinations, pre- and postnatal care and negotiated discounted rates (between 10 and 40 percent discount) for CRECER clients. Credit officers were tasked with promoting these health provider arrangements within their credit groups and providing clients with referral cards that they could use to obtain discounted rates.

- **Individual health loans to pay for major medical expenses.** Interest rate is lower than microenterprise loan (18 percent flat for health loan compared to 20 percent flat for business loan and loan payment is normally made directly to the provider versus to the client). Clients are also offered a grace period (up to three months for serious illness) as well as a longer repayment period for the health loan (6–24 months). Clients must also have a guarantor who is outside of the credit group and not a family member or provide personal property as collateral. Arrangement for cost of health service for the client is often negotiated by CRECER with the health provider prior to disbursing the loan and loan payment in most cases is paid directly to the health provider and not to the client.

- **Health education.** As a part of their normal village-banking product, health, business and financial education are provided to clients as part of regular credit group meetings. Those clients in the CRECER *Saludable* pilot also participated in sessions on women's health, planning ahead to pay for health expenses, how to use the local healthcare system and advocate for better health care, and prevention and management of common diseases.

CRECER recognizes that financial services alone cannot alleviate poverty. Through these health protection services, which were tested and studied for impact through 2010, CRECER seeks to better accomplish its mission of improving the living conditions of clients and their communities, while protecting its own financial sustainability and longevity as an MFI.

Healthcare Concerns in Bolivia[9]

Bolivia is among the poorest countries in the Western hemisphere. Almost two-thirds of its people and 80 percent of the rural population live in poverty. National health data show high infant (54 deaths per 1,000 live births estimated in 2004) and maternal mortality (230 deaths per 100,000 live births estimated in 1994), and the lowest life expectancy (65 years) in Latin America. Common illnesses include respiratory infections, diarrhea, dental problems, skin diseases and, in lower tropical regions, malaria and yellow fever. Illnesses that occur with less frequency but greater economic impact include female cancers, gallbladder disease, kidney disease and rheumatism. Government health centers provide immunizations as well as maternal and child health care. However, those services are widely viewed by clients as undependable due to scant availability of doctors and skilled health workers, an inconsistent supply of medicines and equipment, and frequently disrespectful or low-quality treatment. Hospital or private practitioner services are accessed only in cases judged to be serious because they are expensive and require travel to urban centers.

Cost is an important consideration for the population in deciding when and where to seek health care. In Bolivia, more than 80 percent of the cost of health care is borne by individuals paying out-of-pocket, and poor families spend a disproportionate percentage of their limited incomes on medical expenses. Pregnant women, new mothers and children up to age 5 receive free government services at public clinics, but others must pay for services such as consultations, diagnostic tests and medicines. Most people prefer private healthcare services but few are able to afford the provider fees and transportation costs.

In an effort to limit the impact of health costs, market research conducted with CRECER clients in 2006 revealed that they generally self-treat or seek the services of traditional healers. If these are not effective, they visit local health centers or pharmacies from which they can buy medicines to treat themselves. Transportation expenses, productive time lost during travel and long wait times to see providers all add to the cost burden, especially for rural families. Without access to appropriate treatment, common illnesses often become serious and these, along with high-impact diseases such as cancer and gallbladder disease and accidents, pose serious health and financial risks for CRECER clients.

When problems arise, clients need to pay cash (generally prior to treatment) for medical expenses and related transportation. To meet health expenses, CRECER clients borrow money from family

[9] Section references work done by Marcia Metcalfe: Metcalfe, M. 2006. "Bolivia Health Economy Profile." Freedom from Hunger. Davis, CA.

members, friends and neighbors, or sell valuable assets such as livestock or crops—often far below market value. Women also look to their microenterprise earnings or capital, reducing liquidity and business capacity. A last alternative is to withdraw savings or to solicit internal loans from their credit groups. In the absence of sufficient funds, clients delay treatment for themselves and their families and hope things will improve.

CRECER *Saludable* Products and Services

Three fundamental objectives for an effective health program are to improve the health of the target population, respond to people's expectations regarding access to and quality of health care, and provide financial protection against the cost of ill health. With this in mind, the CRECER *Saludable* package was designed to address these objectives with four complementary health protection products: 1) health education, particularly on chronic illnesses and how to plan for health expenses; 2) health loans; 3) linkages to health care through *jornadas*; and 4) linkages to health care through direct negotiations with local health providers, particularly for discounted prices on health services.

Information from in-depth market research was used to design an integrated package of health protection services to address clients' most important health and related financial challenges. CRECER clients expressed a need for access to routine primary care services such as general check-ups and diagnostic services. Of key importance was a need for trustworthy, high-quality services provided in a respectful, convenient and culturally sensitive manner. Contractual linkages with private healthcare providers enable CRECER to bring basic health services to members via *jornadas* or via discounted rate agreements with local health providers, in rural communities. For a small, all-inclusive fee, the *jornadas* offer general check-ups; diagnostic services such as Pap tests; gallbladder scans; screening for hypertension and diabetes; and referrals for follow-up care as needed. As an integral part of regular credit group meetings, health education sessions encourage women to participate in the *jornadas* and to receive any recommended follow-up care, help them plan ahead for family health expenses, equip them with information about minimum healthcare standards and encourage them to adopt healthy habits to prevent disease.

Finally, CRECER's health loans enable members who encounter major medical problems to pay for the care they need and repay over time on a rate and time schedule they can afford without compromising their business assets. During the same time period as the MAHP initiative, CRECER also began offering an "opportunity credit" loan that offered smaller loan amounts than the health loan. The opportunity credit product is not included in this evaluation but we will discuss the relationships between the opportunity credit and the health loans later in this report.

Table 2 presents general institutional indicators for tracking the progress made by CRECER using MAHP packages and services. The table shows the numbers from 2007 through the end of the project in December 2009.

Table 2: CRECER *Saludable* Outreach			
	December 2007	December 2008	December 2009
People with access to full CRECER *Saludable* package [10]	28,846	27,581	26,296
Number of active borrowers across all of CRECER	98,202	94,713	102,212
Number of *Credit with Education* members (in pilot region)	28,846	27,581	26,296
Number of *Jornadas* delivered (per year)	17	697	523
Number of *Jornada* participants (per year)	549	14,837	8,514
Number of clients with individual health loans (per year)	31	177	48
Use of health loan proceeds by borrower	Major surgery, dental and medicines	Ophthalmology, surgery, dental treatment, prosthesis and general treatment	Ophthalmology, surgery, dental treatment, prosthesis and general treatment

CRECER *Saludable's* Research and Evaluation Goals and Activities

A key component of the MAHP initiative is evaluation research to better understand the impacts that integrated microfinance and health protection services have on MFIs and their clients. The evaluation activities for CRECER include both quantitative and qualitative data across all of the CRECER *Saludable* package components. Research design and data collection for client-level and institutional-level indicators began in 2007 and continued through March 2010.

For CRECER, as with all five MAHP partners, the evaluations draw on data collected from individual client interviews, focus-group discussions (FGDs) and MAHP institutional indicators to examine two primary questions:

- Does the provision of integrated microfinance and health protection services by an MFI have a positive impact on client health and financial status?

- Does this provision of services result in stronger institutional performance as measured by growth rate, client loyalty and retention, repayment rates, demand for and effective use of MFI services and overall competitive position?

[10] The overall outreach for the CRECER *Saludable* package dropped during the three-year period. Because there is a direct correlation between those who have "access" to CRECER *Saludable* and the total population for the pilot area, the drop in numbers reflects the overall drop in clients in the pilot area due to two possible factors: 1) The La Paz regional office split into two offices—La Paz and El Alto—which meant less focus on generating client growth during restructuring and 2) Activities as required by the Bolivian government for transitioning to a regulated microfinance organization.

Seven key components of the CRECER *Saludable* evaluation plan were designed to answer the two questions listed above:

1. Economic and Health surveys with a statistically representative sample (baseline and end line as well as monthly interviews with a subset of clients in the original sample)
2. Health Loan Use
3. *Jornada* Use
4. Client Satisfaction, Client Exit, Competitors Analysis
5. Client Impact Stories
6. Healthy Habits Mini-Survey
7. Institutional Assessment

KEY RESULTS

This section provides descriptions of the methods used and the results for each of the seven components listed above.

Economic and Health Survey

This survey was undertaken to answer the following question: What impact does participation in microfinance and education and health services have on family health, health costs, productivity, food security, business outputs and outcomes? We hypothesized that the longer a client was in the microfinance program, the client and family would experience fewer financial shocks, have more income smoothing and experience higher business productivity and outputs, and through participation in CRECER *Saludable*, they would have a lower risk of health shocks (they would seek more preventive care as well as seek curative care more promptly because of having improved financial means to cover health expenses and access to more direct medical exams and services).

Methods

The full impact survey consisted of two separate modules: a financial module that included questions about the client's loan and savings history with CRECER, demographic information, business activity data, and household income and expenditures; a separate health module that included food security questions, a food diversity scale, and data on illnesses experienced in the family and subsequent treatments and costs. Both parts were implemented on the same client population at two points in time: a baseline study conducted in 2007 (n=240) and a follow-up survey conducted in 2009 (n=247); both samples were randomly selected from all clients in the study region. Interviews were conducted with clients in the La Paz/El Alto CRECER program areas (in CRECER's local operating units L-6 and L-8), which were treated as one entity in the analysis and in Viacha (part of CRECER *Saludable* program area) and Batalles (comparison area in which CRECER *Saludable* was not implemented). We did not have a "control" community in this study; instead, we have two regions that are similar in most obvious respects in which we introduced the CRECER *Saludable* program (Viacha) and in which we did not (Batallas). From a strict statistical perspective, this means we cannot directly impute changes (positive or negative) directly to CRECER *Saludable*. We compensated by using a variety of methods, which serve to triangulate each other; similar findings from distinct methods corroborate emerging findings. In addition to these "bookend" surveys, a monthly survey was conducted with a subset of the clients (n=40) to follow this group

over time to help understand monthly fluctuations in key variables in both the economic and health surveys. The survey used for the monthly interviews was a shortened version of the full study instruments and focused on data that was likely to fluctuate on a month-to-month basis such as household expenses, business activity and health expenditures. The data from the monthly economic survey will not be discussed at length in this report because it is still undergoing analysis, but some of the key findings from the monthly health survey will be highlighted here.

Freedom from Hunger partnered with Professor John Brett of the University of Colorado Denver to design and implement the study and analyze the data. EMCOM in Bolivia collected data for the baseline, Agrodata collected data for the follow-up. Monthly interviews were conducted by Professor Brett, his students, and local research assistants. Analysis was conducted using SPSS.

Key Results

The results in this section will be described in three separate sections: Economic Behaviors, Health Behaviors, and Food Security. Food security was a theme studied in depth because of its implications for both Freedom from Hunger and CRECER's missions. It is worth noting here that macro environmental forces present in Bolivia between the baseline and end line period may have affected client- and institutional-level behaviors. In 2007–08, Bolivia experienced a food crisis that was worsened by widespread flooding, followed shortly thereafter by the global financial crisis. Data presented here should be viewed with that context in mind. Two client case studies are provided in Appendix D.

Economic Behaviors

The economic data (Appendix A) provides a fairly complex, and somewhat counter-intuitive, view of CRECER clients. In 2009 clients experienced an *increase in income* (2688 Bs) compared to 2007 (2214, p=0.003), and more clients (69.6%) *had personal savings*—non-obligatory savings, such as that held with CRECER—compared to 2007 (56.7%, p=0.006). Conversely, in 2009, clients (46.2%) *had more than one loan in addition to their CRECER loan* compared to 2007 (33.8%, p=0.005). More clients (70.4%) *used their loan for expenses other than for business (primarily food)* compared to 2007 (35%, p<0.001). The client satisfaction study discussed later also revealed that 74 percent of clients reported not investing all loan funds in their businesses. About the same number of clients (23.9%) *were unable to make a loan payment* as in 2007 (20.4%, p=0.357).

More clients were also found to be making a profit in 2009 (72.9%) compared to 2007 (67.5%, p<.001). The monthly data collected on business profitability suggest that, in general, clients are over-estimating their profit every month of the year. In actuality, clients are losing money, and while an improvement in profit between 2007 and 2009 might be real, it might also be an inaccurate estimate by the client. The over-estimation of profit could also be explained by clients and the population using various cash transfers and subsidies provided by the Bolivian government during the study period to lessen the effects of the food and financial crisis on the Bolivian population.

Client over-indebtedness is a concern of CRECER given that between 30 and 50 percent of its clients are also clients of Pro Mujer, one of CRECER's closest competitors, or from one of its other MFI competitors. The use of multiple loans by many clients, but the inability to repay the loans by only a few clients, would suggest that there is a risk of over-indebtedness for some clients due to outstanding loans from multiple institutions. For others it may indicate a movement from informal to more formal sources of financing. It might also suggest that the loan products provided by

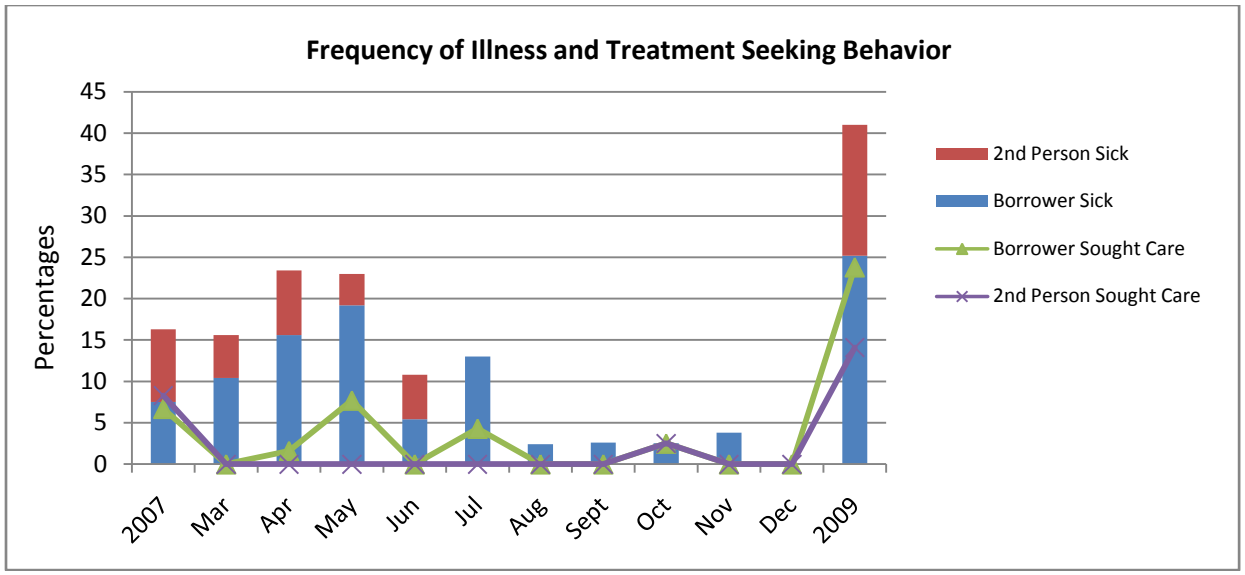
institutions such as CRECER and Pro Mujer are either too small to meet the credit needs of their clients or do not provide enough flexibility in their use, thus forcing clients to seek other types of loans from other financial providers.

The data appears to suggest that as a population, this group of clients had experienced significant improvement in their financial status. At the same time, it also appears they are using more credit to support their varied financial needs. CRECER clients reported having pride in "not having to borrow from family and friends;" they like having access to formal credit and mentioned that the use of their multiple loans were for reasons such as their business, improving their household and purchasing land.

Health Behaviors

When respondents were asked about illnesses experienced in the family, approximately 30 percent of households in 2009 indicated someone in their household suffered from a chronic illness. This percentage was 38 percent in 2007 but the difference is not significant (Appendix A). More individuals indicated experiencing illness in 2009 (25.2%) than in 2007 (7.5%); however, the monthly data demonstrates a fairly consistent rate of illness with 2007 data, suggesting a consistent rate of illness between 2007 and 2009 (Figure 1). The difference between the number of people reporting being sick in 2007 was not significantly different from 2009. The perception of increased illness in the 2009 end line survey (Appendix B) may be due to an "implementation effect" where respondents are more aware or paying more attention to their health because of their participation in the CRECER *Saludable* program: therefore, they are more accurate in their reporting of illness.[11]

Figure 1



When we compare the clients who participated in both the 2007 and 2009 survey (n=93), the average cost per episode of care in 2007 was 263.31 Bs (range 0-3040 Bs). See Appendix B for data table. The average cost per episode for seeking health care in 2009 was 1006.82 Bs. If you compare

[11] O'Donnell, O. 2007. "Access to health care in developing countries: breaking down demand side barriers." *Cad Saude Publica.* 2007 Dec; 23(12):2820-34. <http://www.scielosp.org/pdf/csp/v23n12/02.pdf > (June 24, 2010)

the cost in 2007 to the average monthly income of a CRECER client in 2007 (2214 Bs), it would have cost the average CRECER household 12 percent of their monthly income during any month when the client or a family member sought treatment. When you compare the cost in 2009 to the average monthly income of a CRECER client in 2009 (2688 Bs), it cost the household 37 percent of their monthly household income when the client or a family member sought treatment. If the CRECER client was on the lower end of the scale (160 Bs), the treatment expense would have been more than twice the amount of money they make in a month. If the CRECER client was on the upper end of the income scale (16000 Bs), this would have accounted for approximately 5 percent of their monthly income.

Most families reported being able to pay for the cost of treatment in both 2007 and 2009 using mostly personal and a variety of other funds. One person used a CRECER health loan in 2007. More respondents in 2009 indicate they used some of their commercial loan to pay for health and other expenses, compared to what they reported in 2007. The latter could be attributed to respondents being less inhibited about sharing the reality of their loan use, or as a result of the economic crisis, more people were forced to use their loans for other needs.

When examining the data for loss of days at work there was little change between the baseline and the end line data. The average number of sick days reported by respondents was nine in 2007 and 13 in 2009. Of the 31 out of 247 clients who participated in the 2009 end line survey and indicated that they were sick, 58.1 percent lost 0 days at work, 19.4 percent lost 1–3 days of work, 9.7 percent lost 6+ days, 9.7 percent did not know. The 2009 reported data was not significantly different from the 2007 data.

With respect to treatment there is some indication that there was an increase in respondents self-managing their care; i.e., making more use of pharmacies and using more traditional medicine. More respondents sought preventive care in 2009 than in 2007. Although this is not statistically significant at the standard used by most social sciences of $p<0.05$, it is significant at $p<0.10$, thus indicating a strong trend. There is definitely more preventive treatment sought for a third family member (likely a child) in 2009 than in 2007. While there is indication of more preventive care-seeking behavior in 2009 than in 2007 (10 percent compared to 15 percent, respectively, $p<0.10$), there is also indication that more people are not able to pay for preventive care in 2009 compared to 2007. The source of funds to pay for preventive care varies; most rely on personal funds and only one family in each year used a CRECER health loan.

About 64 percent of clients indicate they have some type of insurance (including health-related or credit-related insurance and other) but all clients should report having some sort of insurance because CRECER clients are required to have the credit life insurance. This suggests that not all clients understand insurance or acknowledge that they have it.

While there was a perception of increased family illness in 2009 by respondents compared to 2007, there was little significant difference in the actual incidence of illnesses reported in 2009 compared to 2007. Likewise, the average cost of treatment and the average number of days lost at work were not significantly different in 2009 compared to 2007.

Food Security

The degree of household food insecurity is striking in Bolivia, and surprisingly high among longer-term clients of CRECER. Using the Food Security Survey,[12] we examine, "Why food insecurity does not decrease as clients are with CRECER longer," in order to gain insight into this issue.

In 2009, 66.8 percent of clients were food-secure compared to 46.3 percent in 2007 (sig. dif at <.001), see Appendix A. One part of the explanation for the increase in food security in 2009 is that people purchased more food by diverting more of their loan funds to purchasing food. Another part of the explanation lies in the very active government intervention in basic food provision through providing food subsidies during the food and financial crisis and placing an embargo on exports of certain high value but basic foods (chickens, cooking oil) to keep prices down. Thus, the overall food situation in the country did not worsen as badly as it might have. It appears that people who receive "*beneficios*" or cash benefits (e.g., retirement, school child subsidies) from the government are more food-secure than those who do not.

When assessing the 40 monthly household surveys for which we have at least 6 months of data, we see that food security fluctuates, sometimes dramatically, on a monthly basis (see Appendix C, Table 1). Examining only the 2009 and 2007 data would suggest that there is overall "improvement" from one year to the next; however, this is somewhat tempered when we consider that nearly all of the 40 participants dipped at least once, and often more than once, into food insecurity during the year. Repeated testing gives us confidence that the scale we used accurately measures food security.[13] In a regression analysis, nothing emerged that explained why a family was food-secure or -insecure; additional research is under way to determine the factors that influence food security at the Bolivian household level. Much like the explanations about financial behaviors in the book, *Portfolio's of the Poor,*[14] if we only assess food security at one or two different times, it is highly likely that we will miss important fluctuations that occur and might under- or overestimate food security at any given time. Food security appears to be much more complex than a snapshot measure suggests. At the time the survey was conducted, participants could have been "feeling better" about a very challenging situation and therefore claiming a less difficult situation. Or, based on personal experiences and other enabling environmental factors, the government of Bolivia provided large amounts of resources directly to the population accompanied by propaganda about what they were doing to improve the lives of the population. Over time, these messages may have influenced the attitudes of the poor resulting in a perception of improvement.

Using 2007 food security data alone, when we compared "new clients" to "mature clients" (Appendix C, Table 2), choosing both 6- and 12-month cutoffs to represent a "new client," we find that when comparing clients who have been in the program for less than a year compared to those in the program over a year, there does not appear to be any improvement for those who have been with the program longer. For both "new" and "mature" clients in this category, there are more food-insecure than food-secure clients. When we compare clients who have been in the program for less than 6 months, they are statistically significantly more likely to be food-secure (70.4%) than clients

[12] The food-security survey used by Freedom from Hunger comes from the United States Department of Agriculture and was adapted to the developing world context. The survey, which serves as a scale, has 17 questions that range from worrying about not having food due to lack of money to going an entire day without eating because there is no money to purchase food.

[13] Melgar-Quinonez H.R., Zubieta A.C., MkNelly B., et al. "Household food insecurity and food expenditure in Bolivia, Burkina Faso, and the Philippines." *J Nutr* 2006;136:1431S–7S.

[14] Collins, D. et al. 2009. *Portfolios of the Poor.* Princeton, NY: Princeton University Press.

who have been in the program for more than 6 months (61.8%). Intuitively, it would seem that food insecurity would decrease the longer the relationship between a client and the MFI. However, our data suggests the case may be otherwise, even though, as indicated above, there are no factors that easily explain this.

Food is one of the few points of flexibility the poor have when dealing with income pressures and expenditure flows. Families may reduce quantity and/or quantity of food in order to use money for more fixed, non-negotiable expenses (school fees, water/electricity bills). It is important to understand that the relationship between food and income is not clear. More money through income generation or from loans does not necessarily equal more food, especially if the household is experiencing severe financial shocks generated by chronic illnesses or loss of agricultural production, for example. Also, even if the quantity of food increases with added income, the quality and diversity of the food may not change, in part because participants appear to have a traditional sense of food and diet. In our various regression models, few variables, besides whether the client was categorized as urban or rural, emerged as determinants of food security, suggesting there are multiple forces and factors that influence food security at the household level. We are engaging in additional analyses in an attempt to untangle these complex but very important relationships.

Health Loan Use

In March 2010, the final research component of CRECER's evaluation plan was completed to study the influence and possible impact that access to a health loan could have on CRECER clients. The study was undertaken by Guillermo Monje and team from the research firm PRIME. The study examined whether access to health loans changed the behavior of clients in terms of

- how clients used their primary loans and obligatory savings;
- when clients sought medical care (are they seeking early treatment);
- where clients sought medical care (are they seeking quality medical care); and
- whether client medical expenses were being reduced (are they seeking preventive care, better quality care and early treatment).

The questionnaire was designed to be partially quantitative and partially qualitative. There were three separate samples of clients interviewed: 1) Clients who had access and used the health loan "health loan users" (n=41); 2) Clients who had access to a health loan but did not use one "health loan non-users" (n=27); and 3) Clients who had no access to the health loans "health loan comparisons" (n=21). The purpose of this division was to determine whether health loan use changed a client's health-seeking behavior, whether the knowledge of having access to a health loan changed health-seeking behavior, and whether having no access would serve as a "comparison" group for behaviors that exist when no such product or financial "safety net" exists. See Appendix E.

Key Results

Of the total sample (n=89), 53.9 percent feel they take good care of their health. Health loan users were slightly less likely to say they take good care of their health compared to health loan non-users and health loan comparisons. Of the total sample, slightly more than one-half of the clients visit one doctor on a regular basis, 24 percent visit two doctors regularly, 16 percent visit no doctors regularly, and seven percent visit three doctors regularly. There appears to be no clear difference among the three sample groups.

Compared to the entire population in the economic and health survey in which 15 percent sought preventive care in 2009 (n=247), 36 percent of the health loan study population (n=89) had sought out preventive services in the past year. Similar numbers sought preventive care among the three groups. If the last two groups are averaged together into "non-users of health loans," the averages for seeking preventive care are practically the same for users and non-users of health loans (34 and 36%, respectively), suggesting that there is no correlation between health loan use and preventive care-seeking behavior. There were no real differences between urban and rural clients for those who sought preventive services, meaning the same percentage of urban and rural clients sought preventive care and thus differences in access to services did not appear to be important factors for seeking preventive care.

To understand some basic healthcare behaviors, of the clients who were asked whether in the last year they had or had not sought the following services:

- 45 percent needed dental services but did not go to the dentist (more health loan comparisons did not go compared to those who had access to the health loan)
- 28 percent had a health problem but did not go to the doctor
- 23 percent did not take the needed dose of a medication
- 21 percent did not follow the treatment as directed by doctor
- 21 percent did not get an annual physical
- 18 percent did not purchase the medicines as directed
- 15 percent did not follow through with an exam (health loan users seemed no less likely than other clients to not follow through with medical plans/treatments).

Of the total sample, 52 percent did not seek medical attention in the past year due to the cost; the health loan comparison group was more likely to not seek treatment due to cost compared to those who had access to the health loan.

When clients were asked about the general health expenditures for the last three months, more than half spent 100 Bs and almost 10 percent spent 1000 Bs or more. The 10 percent who spent 1000 Bs or more were mostly health loan users. The health loan users spent more on average (1,062 Bs) with a minimum cost of 40 Bs and a maximum cost of 7,500 Bs. Clients in urban areas spent quite a bit more on average compared to clients in rural areas, 790 Bs (range of 5-7500 Bs) compared to 177 Bs (range of 7-600 Bs), respectively.

In addition to understanding health expenditures, clients were asked about their obligatory and voluntary savings and their participation in "merry-go-rounds" (rotating saving credit associations), known as *Pasanukus* in Bolivia. Of the total sample, 73 percent had voluntary savings at home, but none of the three sample categories were more likely to have voluntary savings. When asked what their savings goal in general was, 18 percent said health emergencies. Health loan comparison clients were not very likely to save for health emergencies compared to health loan users and non-users. One reason the comparison group reported a lower percentage for saving is that the health loan users and non-users received education during the program period about the importance of saving for health, while the comparison group was not likely to have had access to the education.

Sixteen percent of the total sample belonged to a *Pasanaku*. Health loan users were the least likely to belong to a *Pasanaku* (at 5 percent compared to 26 percent, and 24 percent health loan non-users

and comparison clients and the difference between the health loan users and both non-user groups was statistically different at $p<0.01$). This might suggest that savings held with *Pasanakus* is an important source of health financing and when clients have no *Pasanaku* resources, they may be more likely to take a health loan. This area should be studied more in-depth in the future to understand client preferences in using voluntary savings at home as well as *Pasanaku* funds for financing health expenses instead of using health loans.

Thirty-nine percent of clients used their obligatory savings for health expenses. Health loan users and non-users appear slightly more likely to use their obligatory savings than health loan comparison clients. As mentioned earlier, this active use of obligatory savings by health loan users and non-users may have been a result of having participated in health education about saving for health expenses. However, only 16 percent of the total sample indicated they saved outside of CRECER specifically for health. Fewer health loan users compared to non-users and comparison clients used savings specifically for health. This contradiction might suggest that although health loan users and non-users are more likely to use obligatory savings for health expenses, they are not saving more actively for their health through voluntary savings at home or with *Pasanakus*. However, a small percentage of health loan users (14.6%) indicated they started saving for health for the first time in the last year.

Although clients were not saving much for health, 25 percent indicated some other family member saved to cover health expenses. Health loan users and non-users had more additional savings saved by family members than health loan comparison client family members did. Thirty-five percent in total indicated they had used CRECER's internal loan for health expenses. All three groups looked similar in their use of the internal loan for health expenses.

One important goal of the health loan-use study was to determine whether having access to or using health loans changes the way clients use their microenterprise loans. When asked how they used their *first* microenterprise loan (through use of an open-ended question), 16 percent indicated they used their loan for food, 15 percent for school fees and 8 percent for health. When examining the percentage of health loan users who used their first loan for health expenses, this was 17 percent. No one in the other two groups admitted to using their first microenterprise loan for health. When asked how they spent their *current* microenterprise loan, 14 percent said for food, 15 percent for school fees and only 3.4 percent for health expenses. If we look again at just health loan users, only 4.9 percent of them used their current loan for health expenses (compared to 17 percent for the first loan for health). The decrease in use of microenterprise loan for health expenses suggests that those who used a health loan were using their microenterprise loan less for health expenses. One client shared: *"Yes, [the health loan] helped me a lot with my health, the expenses I would have had to take from my business, and then it would have reduced my capital."* Another client indicated that she *"feels calmer, because [without access to the health loan] I would have had to take money from my husband's business and his salary."*

When asking clients directly (through use of a closed question), however, whether they have ever used a CRECER microenterprise loan for health expenses, 37 percent of the total sample said "yes." All three samples looked fairly similar to the average for the total sample.

The average health loan size was 732 Bs; two people took out a health loan for less than 100 Bs. The average reported in this health loan-use study is almost twice the size of the average loan size (400 Bs) reported by CRECER for all health loans during the four-year program period. This is likely explained by the fact that 10 percent of this sample had loans that were 1500 Bs or more. The

majority took out loans for 100–499 Bs, 24 percent took out loans for 500–999 Bs. The remaining 24 percent took out loans for 1000–1499 Bs.

Twenty-nine percent of clients took loans out for aesthetic dental procedures, 27 percent for surgery, 17 percent for preventive dental (such as fluoride treatments) or curative dental care, and the remaining for gall bladder procedures, fracture/broken bones, breathing difficulty, tumor, a cesarean section, convulsions, back pains, kidney pain, diabetes, an accident and a hip replacement. Less than one-half (37%) indicated the loan covered all of their medical expenses; and most (80%) of the unmet costs were for medicines. Other costs not covered were follow-up exams, part of the surgery, emergency transport, hospitalization, physical therapy, special tests, public transport, food and medical equipment.

Over one-half covered unmet medical costs by borrowing money from a family member and the remaining covered unmet medical costs by using business earnings, savings at home, savings with other family members and taking out a loan from another institution, using their microenterprise loan with CRECER and other earnings.

If they had not had the health loan, almost an equal number of clients would have borrowed money from friends or family, postponed treatment or sold an asset. The remaining would have taken credit from another institution, not followed through with treatment at all, opted for less quality treatment, used savings, taken a commercial loan, or mortgaged their house. Of those taking a health loan, 100 percent would recommend it to a family member.

Jornada Use

Much like the health loan-use study, this study was conducted to look more deeply into behaviors as a result of having access to or use of *jornada* services. This study was conducted concurrently with the health loan use study in March 2010 and the data collection and analysis was led by PRIME. The study examined whether access to *jornadas*:

- encouraged clients who had never sought medical care, a specific exam or treatment (for example, a Pap smear or blood pressure screening) to participate in the *jornada* services;
- improved confidence in use of medical services because clients could go as a group and seek the services or improved confidence if the services were brought directly to them (thereby reducing opportunity costs in time and money for seeking services elsewhere);
- detected chronic or life-threatening illnesses for which clients could seek treatment outside of the *jornada*;
- improved client confidence in seeking prompt medical care from providers outside of the *jornadas*; and
- increased used of preventive services, in general.

Finally, the study assessed client satisfaction with the *jornadas* and had clients compare them to other services in terms of cost and treatment by the provider.

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As before, the questionnaire was partially quantitative and partially qualitative. There were three separate samples of clients interviewed: 1) Clients who had participated in the *jornada*—"*jornada* participants" (n=41); 2) Clients had had access to a *jornada* but had not participated—"*jornada* non-

participants" (n=22); and 3) Clients who had no access to the *jornadas*—"*jornada* comparisons" (n=20). See results in Appendix F.

Key Results

Of the total sample (n=83), 53 percent of the clients reported they take good care of their health. When broken down by participant category, *jornada* participants are slightly more likely to say they take good care of their health compared to non-participants and *jornada* comparison clients. Because of the overall sample sizes, running tests of statistical significance were not possible, thus, results are only comparing averages directly.

Twenty-four percent of *jornada* participants had never been to a doctor before seeking out *jornada* services. Only 32 percent indicated they had sought out the same service they accessed previously at the *jornada*. When they do seek treatment, almost equal numbers go to the hospital and the health center.

Fifty-seven percent of the entire sample mentioned having been diagnosed with some sort of chronic illness. A quarter of them mentioned gall bladder problems, 8 percent had high blood pressure and 7 percent had digestive problems.

More *jornada* participants reported having various chronic illnesses compared to the other two groups. This does not mean on average they had more chronic illnesses, but that there is a wider distribution of types of chronic illnesses. For example, *jornada* non-participants and comparison clients did not mention having cancer, diabetes, high blood pressure, low blood pressure or high cholesterol whereas those who accessed the *jornadas* did. Given the type of *jornadas* provided, this suggests that either these illnesses were detected at the *jornada* for the first time or that the jornadas attract people who already suffer from chronic illnesses. Forty-seven percent (47%) of all clients mentioned someone else in their family having a chronic illness, such as gall bladder illnesses, diabetes and kidney problems.

Twenty-three percent of all CRECER clients interviewed had sought out preventive care treatments. *Jornada* participants were no more likely to mention seeking out preventive care compared to the other two groups. Neither urban nor rural clients were more likely to seek preventive care. Most had sought preventive care mainly for medical checkups, to remain healthy, for prevention, and because they were afraid of getting sick. For those who did not seek out preventive care, the majority indicated it was because they felt healthy, there was a lack of money, lack of time, fear of male doctors, they disliked going to the doctor, and were afraid of discovering they were really sick. Although the question about seeking preventive care asked the client whether they went to the doctor when they were not sick so that they could stay healthy, the fact that the *jornada* participants did not acknowledge the *jornada* services as preventive treatment suggests that they did not see this as a preventive measure for protecting their health.

> *"We are not accustomed to visiting doctors and it makes us happy that the [jornada] nurse visits us."*
>
> *"Thanks to this test [colposcopy] from the jornada, they can detect cancer in you in time."*
>
> *"Yes, it is very likely I will visit [the jornada doctor] again because we have become friends with the doctors. If we need them, we will go to them."*—Jornada participants

When clients participated in the *jornadas*, the majority participated in gynecological services or in services to detect other chronic illnesses, such as gall bladder disease and diabetes. Bolivia has the second highest rate after Haiti of female cancers, such as cervical and uterine cancers, in the Western Hemisphere. Cervical cancer ranks as the most frequent cancer among women in Bolivia and is most frequent among women between 15 and 44 years of age. Most of the cervical cancers in Bolivia have been linked to the human papillomavirus (HPV). Approximately 13.2 percent of the general population in this part of the world is estimated to carry cervical HPV infection at any given time. Bolivia has a rate of approximately 3.9 percent of women who will get cervical cancer in their lifetime. Fifty-five out of 100,000 women each year are diagnosed with cervical cancer.[15] Between 5 and 6 percent of the adult Bolivian population suffers from diabetes[16] and Bolivia has one of the highest rates of gallbladder disease in Latin America.

Most of the *jornada* participants spent nothing or less than 49 Bs. ($7) on accessing the *jornada* services and most felt this was a fair price. Sixty percent would have paid more money for the service they accessed (anywhere between 5 and 100 Bs more). Most were satisfied with the service they got because they felt they received good attention, good explanations, and the doctors responded to their doubts. For those who weren't satisfied, they either indicated they never got their results, did not believed their results, did not feel the doctor explained things well enough, or were sent to another doctor. All felt they had been treated with respect by the doctor and almost all indicated they would visit the same doctor from the *jornada* again. The *jornada* participants most valued the medical attention followed by the fact that the service was brought to them in their groups.

Client Satisfaction, Client Exit, Competitors Analysis

The client satisfaction, client exit and competitors analysis were three separate studies; there were also components of client satisfaction and client exit in the economic and health surveys and the health loan and *jornada* use studies that will be referenced and cross-referenced here.

Client Satisfaction

The client satisfaction study was undertaken by PRIME across all of the regions served by CRECER in Bolivia. In addition to the national level study, more intensive work was conducted in the MAHP region in order to specifically study satisfaction with the CRECER *Saludable* health products and services. Approximately 1,870 CRECER clients and ex-clients were interviewed through an FGD format or individual interviews.

Overall, clients appear to be satisfied with CRECER, but are dissatisfied with recent changes in internal loan policies, minimal group membership (which forces some groups to add other members to their group that they would not ordinarily add) and loan size maximums that are too low for some. Some of the changes instituted by CRECER were in response to the regulatory process they were undergoing. Clients appear dissatisfied with the promotion of new products: health loans, *jornadas*, health days, technical trainings, workshops and the opportunity credit. Clients also voiced

[15] "Human Papillomavirus and Related Cancers Summary Report Update: Bolivia." January 29, 2010. HPV Information Center. World Health Organization. Available at: <http://apps.who.int/hpvcentre/statistics/dynamic/ico/country_pdf/BOL.pdf?CFID=3941786&CFTOKEN=65819176) > (June 24, 2010)

[16] "La Diabetes en las Américas." 2001. *Boletín Epidemiológico,* Vol. 22 No. 2, June 2001. <http://www.paho.org/spanish/sha/be_v22n2-diabetes.htm> (June 24, 2010)

dissatisfaction with perceived high interest rates and dissatisfaction when the group loan guarantee requires clients to pay for others who are late, which also strains their own ability for repayment.

Clients appear to really appreciate any form of "saving" with CRECER, whether it is through their obligatory savings (of which 74 percent of clients are satisfied with the requirement to have an obligatory savings during the loan period) or through the earnings they gain from the internal loan managed by the group. They also mentioned appreciating the education (health, business and financial) provided by CRECER credit officers.

The 2009 economic and health impact survey asked respondents (n=247) about the likelihood of continuing as a client in CRECER and whether they would recommend CRECER to family and friends. Eighty-one percent of clients are either somewhat or very likely to continue being a member of CRECER. Sixty-six percent of clients are very likely to continue being a member of CRECER and a majority (88%) were either somewhat or very likely to highly recommend CRECER to family and friends, with 62 percent of them being very likely to recommend CRECER. CRECER *Saludable* clients compared to comparison clients were slightly more "very likely" and "somewhat to very likely" to continue being a client of as well as recommend CRECER to family and friends (but this difference was not statistically significant).

Three additional important questions help us understand satisfaction with CRECER: why they join, why they stay and why they leave. The two final questions are answered in the client exit and retention section. However, it is important to analyze them together so that we can understand the role that the nonfinancial services of health education and the CRECER *Saludable* products play in helping CRECER recruit and retain clients.

In the 2009 economic and health surveys (n=247), clients were asked to rank the reasons why they joined. The first answer that people gave indicated they joined CRECER for the microenterprise loan. However, when you add up all reasons given, 28 percent said they joined because of "other financial services, such as savings and insurance;" 27 percent said because of access to capital—the loan; 11 percent indicated the group solidarity; and 8.4 percent said it was due to the easier guarantee. Four percent joined because of the education. Two people said they joined because of the health services and one person because of the health loan. Although there was no difference in responses between new and mature clients, and CRECER *Saludable* clients and non-clients, having access to other nonfinancial services seems to matter more for urban clients than for rural clients.

Looking at the health loan use survey (n=83), again, most clients joined CRECER for access to the microenterprise loan (63%), savings (44%). Other reasons for joining were group solidarity, family recommendations (29%) and the education (3.4%). Thus, as would be expected, most join for the microenterprise loan, but even access to an obligatory savings is an important reason why women join in addition to human connections and education.

Client Exit and Retention

Data from the client satisfaction study conducted by PRIME was also used to understand why clients leave (n=131). In addition to the individual client exit survey, Innovations for Poverty Action (IPA) assisted in using CRECER's existing management information system (MIS) to understand

more about client retention. Chuck Waterfield's[17] measure of client retention was used as well. Clients were similarly asked in the health loan-use study (n=83) their reasons for staying with CRECER.

Although most clients *join* CRECER for access to the microenterprise loan, for savings, for group solidarity and family recommendations and education, according to participants in the health loan use survey (n=81), most *stay* for the savings (38%), for the group solidarity (36%), for the credit (29%) and for the education (23%). In addition, 5.6 percent indicate they stay for the "opportunity credit," 2.2 percent for the *jornadas* (this was 3 percent for those who at least had access to the health loans), and 2.2 percent for micro-insurance.

> "[I stay because] I like the family health education, the group credit and the custom of being friends."
> "Yes, I believe I would return again for the health education, the activities and I plan on returning the next cycle." - Health Loan clients

In seeking to understand why they remain, an analysis was conducted on what percentage of clients are retained by CRECER and whether there was any visible difference between clients in areas that had access to the health protection services compared to those without access to those services (if we know there are some who have indicated they stay for services beyond the typical *Credit with Education* service). Using Waterfield's retention equation, the CRECER *Saludable* branches consistently held a higher retention rate than the non-CRECER *Saludable* branches. If we compare 2006 to 2008 data, we see that for the average of the two CRECER *Saludable* program years, there was a .08 percent increase in the retention rate; however, if you just compare the retention rate for 2006 to 2008, we see that the retention rate practically doubles at 4.81 percent (See Table 3). Using IPA's assistance to calculate the retention rate using existing MIS data,[18] we took the percentage of clients who could and did renew their loan at the end of the period and divided this by the total number of clients at any period during that year. With this measurement, the CRECER *Saludable* regions went from 2.9 percent higher to 6.4 percent higher, so retention went up an average of 3.5 percent.

Table 3: Client Retention Rates

	IPA Method			Waterfield Method		
	2006	**2007**	**2008**	**2006**	**2007**	**2008**
CRECER *Saludable* program area	92.39%	93.53%	87.07%	76.19%	70.87%	73.30%
Comparison area	89.47%	87.46%	80.33%	71.35%	70.76%	63.65%
Differences between program and comparison area	2.92%	6.08%	6.74%	4.84%	0.11%	9.65%

[17] Total number of clients at end of period ÷ (total number of clients at beginning of period + new clients); Waterfield, C. 2006. "The Challenges of Measuring Client Retention." *The Practitioner Learning Program: Putting Client Assessment to Work, Technical Note #2*. The SEEP Network. Washington, DC. http://www.microfinancegateway.org/gm/document-1.9.26453/34248_file_2FINALClient_Retention_1_.pdf> (June24, 2010)

[18] The methodology used by IPA is slightly more complicated in that it tracks clients over time and allows for some "resting" between loan cycles and literally follows a client through loan cycles to see whether they "stay" versus having a blunt measure at one point in time to see the number of clients retained.

Ex-CRECER clients reported leaving CRECER mainly due to policies and procedure issues with CRECER. The four main reasons mentioned:

1. Being reported to the Credit Bureau
2. Changes in the norms of how CRECER does business
3. Loan sizes are too small
4. They do not like participating in the meetings

Elaborating on these reasons, most indicated they liked CRECER as an institution but the products provided by CRECER "were just not for them." Because of our interest in whether clients leave an MFI due to health reasons, we assessed how many left for "personal reasons." Twenty-six percent of ex-CRECER clients left for personal reasons; of those, 17 percent left because a family member was sick or had died and 14 percent left because they were sick. Of all dropouts, 8 percent left because either they were sick or someone in their family was sick or had died. Twelve percent indicated they were simply "resting" between loan cycles with CRECER.

In addition to interviewing clients who had left, those who were late in their loan repayment were also interviewed to understand why they were having difficulty with loan payment. The principal reason for being late with payments was they gave their loan money to another person (and this is mainly with clients having three loan cycles or less with CRECER). The second reason for late payments was the illness or death of a family member (46%, n=82). Thus, health reasons are not primary motives, but fairly important reasons for late repayment or drop-out for CRECER clients.

Competitors Analysis

The competitors analysis at CRECER was particularly important among the five MAHP partners because of the level of competition faced in Bolivia. The number of MFIs has practically doubled since the year 2000 and since MFIs in Bolivia now use the credit bureau, some MFIs and banks are able to target and market directly to clients with high repayment and credit scores. In addition, because CRECER is going through a regulatory process—which means they must comply with new regulations established by the government that requires them to bring their financial services in line with regulated banks, such as more transparency, uniform reporting, and improved data systems—they will face even greater competition as they compete with formal banks and larger institutions. In the competitors analysis, we first conducted an internal study with CRECER staff to understand who they perceive to be their greatest competitors and to understand what they know about their competitors followed by an external study with clients to better understand how much clients know about the competitors and how CRECER fits into the competitive environment.

This study revealed that CRECER is well-known for its health programs, even more so because, apart from Pro Mujer, the competition in health with other MFIs is limited. However, when CRECER clients need a loan for health, they have gone to banks like BancoSol, Banco los Andes, and PRODEM because "*they give us rapid credit."* This is not a strike against CRECER as a majority of clients who took loans out for health with competing financial institutions appear to have been provided the loans prior to joining CRECER *Saludable*; this statement refers to the relative ease with which one can get an individual loan if qualified. CRECER clients have confidence in CRECER and would like more services in health. Some groups expressed the hope that CRECER would build a clinic or hospital. From PRIME's study, 50 percent clients seem to like the education, the other 50 percent do not (in some cases, this meant they wanted more education, more interesting education, different topics). Some want more education in health and consider themselves "CRECER fanatics." It appears that the more mature clients like the education better than the younger generation of

entering clients. This may reflect the relative maturity of the microfinance market in Bolivia: as the market becomes ever more saturated with options, it is easier to access credit without the stricter requirements of shared liability models and the "hassle" of education.

Savings options are very important to CRECER clients. Some mention they joined CRECER for the obligatory savings and this is an important reason for their membership. Some would like the ability to leave their savings in an account rather than having it returned in bulk at the end of each credit cycle. Two things were mentioned repeatedly that clients do not like about CRECER: 1) clients are very disappointed about the restrictions put on the internal loan account (imposed by the regulatory process in which they are engaged), not necessarily because it restricts access to credit, but because it limits the amount of interest generated through internal loans, which is shared among the group at the end of each cycle. 2) They do not understand the 1 percent administrative commission on loans assessed by the national office. Because their primary relationship with CRECER is with their local credit officer, they have limited understanding of CRECER as a large entity with substantive costs.

Although Pro Mujer is starting to have a more significant presence in the rural areas, there is still very little. There is growing competition, especially in urban areas, with PRODEM, EcoFuturo and Diaconia, which are in many cases offering more flexible financial products. For example, Diaconia holds meetings the same day each month in lieu of meeting 14 days or 28 days. For some, this is really useful because they do not have to calculate and remember the next meeting date. If clients cannot make a payment at the meeting, they can make payments at any branch at a later time, although that incurs a penalty; for some the flexibility in repayment was worth the extra cost.

The competition in the urban and peri-urban areas is significant. Many CRECER clients are not only familiar with the competitors, but have loans with them as well. The economic and health survey data suggest that approximately 54 percent of CRECER clients have loans with other financial institutions. CRECER clients are very impressed with the competitors who often have nice brochures and billboards. In tandem, many CRECER clients expressed concern that CRECER "is hidden" and there are even rumors that CRECER might not really exist, largely because most offices did not have large signs the way the competitors do. Because of this study, CRECER launched a more visible marketing and branding campaign.

When discussing the competition, CRECER clients mentioned that they like grace periods provided by some competitors, even when the grace period has a penalty, because it offers them more flexibility. Some like the competition because they can access their money with no further involvement with the lender.

CRECER is most well-known for reaching rural areas as well as for providing integrated services; these two components are likely CRECER's primary competitive advantage when facing regulation as well as growing competition in the urban areas.

Impact Stories

This study was undertaken to understand a cross-section of clients' life hopes and aspirations, perceptions of health and well-being, and generational change. In addition, the study was designed to help us understand better how the program has met the participant's expectations and their overall experience in the MAHP program. Twenty-four impact stories were collected in urban, peri-urban, and rural areas of Viacha, Copacabana, Achacachi, El Alto, La Paz and Los Yungas.

Professor John Brett of the University of Colorado, Denver and graduate student assistant, Stephanie Cole collected the data using a standardized Freedom from Hunger Impact Story questionnaire that had been adapted to incorporate several more health-specific questions. They wrote up all the stories regarding their conversations with the CRECER clients. For an example of a full impact story, see Appendix G.

Key Results

When asked to describe the meaning of "a good life," most clients in the study described "well-being" or "the good-life" as having a good family life, good food, good health and steady income. In general, the clients felt they did not lack for anything of importance, but their overall life stories demonstrate lives of privation, difficulties and often major, ongoing problems: major illness or death of a family member at an early age, robberies and abandonment.

When asked how they describe "good health," many mention the ability to work and being free of illness. Routine illnesses do not appear to generate significant concern, but disabling ones that prevent them from working, do.

"Good health starts with good nutrition. If one isn't well nourished, that's how one gets sick. We are in good health, but I worry a lot about my mother and some about my daughter."—Jeanette Paco Jerastegui

An important influence on people's lives has been the very significant structural changes that have occurred in the last 30 years or so. Many of the women were born during or lived through a very repressive dictatorship, hyper-inflation and a dominant society that actively denied basic necessities to the majority indigenous population and to women. Major and significant changes since then include better education, much better access to basic if limited health care, much improvement in electricity, transportation and telecommunications infrastructures.

"There is a wider availability of healthcare options now compared to my mother's time, which makes it easier to go to the doctor or the hospital. Before, the only options were 'natural cures' and there weren't pharmacies or medical personnel in most communities."—Ines Coarte

These political, social and generational changes have had a huge, although imperfect and uneven, impact on people's lives. Programs such as CRECER appear to build on these factors by providing an extra boost over and above what might have been the case if there were only structural changes. Similarly, the ability of women to participate more broadly in society has changed dramatically. In a sense, these broad societal and infrastructure changes provide a base upon which programs such as CRECER can build. CRECER clients are also quite proud of the fact they no longer have to borrow from friends or family: *"CRECER helped me when my daughter was sick. I am proud I never had to ask friends or family for money, only CRECER."* —Elsa Mayta Vargas

Education is recognized as one of the most essential elements in children doing better than their parents. This theme emerged very strongly: women recognize that one of the few ways their children will have a more secure future is by becoming professionals of some sort and education is seen as an essential element in this process. There is a deep commitment and parental sacrifice to ensure their children getting training and jobs as professionals and a lot of emphasis on doing well in school.

"I need to work and save so that my daughter will have a better life."—Jeanette Paco Jerastegui

There is a sense from the clients that CRECER could help women further: with more in-depth medical care (because they trust CRECER in ways they do not trust others); with assisting clients on how to better market their goods; and helping them improve and grow their personal savings.

"I have learned a lot about saving money, about diabetes and cancer, nutrition and money management. CRECER loans to poor people. CRECER is good. If a woman gets sick, she can join and get a health loan. People are not always well and a health loan is a good thing. I have taken a health loan."—Martha Patricia Bautista Torrico

Savings was a topic highlighted in several studies across CRECER that showed much promise as it becomes a regulated institution and can begin taking voluntary savings. Although savings are obligatory for participating in CRECER's village-banking microfinance program, CRECER by law cannot collect deposits. As CRECER becomes capable of collecting savings deposits, they will be in a promising position to expand a service that appears to be extremely valued by CRECER clients.

"CRECER is the place I learned how to save money and be responsible with my money. Before, I was completely unable to save even a small amount and did not know how to properly administer my money. What I most like about CRECER is becoming responsible with my money, learning about health and eating well, and a wealth of other knowledge that I would have never learned elsewhere."—Hortencia.

Clients also highly value the solidarity they have with other women through their participation in CRECER. This value emerged most robustly among women who had been together for many years but was recognized by women who were relatively recent entrants as well.

Healthy Habits Mini-Survey

CRECER staff members undertook a mini-survey of clients who had participated in the "Healthy Habits" module that was developed under the MAHP initiative with Freedom from Hunger to address chronic illnesses such as high blood pressure, diabetes, etc. The purpose of the mini-survey (consisting of 12 short questions) was to measure changes in knowledge, attitude and practice pre- and post-implementation of the Healthy Habits education module. The pre-test was conducted in January 2009 and the post-test in July 2009 with clients in El Alto and La Paz. In El Alto, 54 clients were interviewed in the pre-test, 120 in the post-test. In La Paz, 19 clients were interviewed in the pre-test and 38 in the post-test. All samples were convenience samples.

Out of the 12 questions posed in the Healthy Habits mini-survey, all but two indicators saw clear improvement from the pre- to the post-test (See Appendix H). Clients did not report seeking out preventive care any more often in the post-test (49%) than they did in the pre-test (48%). It is important to note that the question about preventive care was asked differently in this survey compared to the others. The mini-survey asked whether "they sought preventive care in the past 6 months" and the other surveys mentioned in this report asked whether they had "visited a doctor when they were not sick in order to stay healthy." In either case, the results in this report suggest that the way this particular question is asked likely influences how people interpret the use of preventive care services. Although there was not a visible change, the percentage of clients who reported seeking out preventive care in this survey was still higher than those who reported seeking preventive care in the economic and health survey. The second indicator for which there was no improvement was in regards to knowledge about high blood pressure. Fewer people at the post-test knew causes of high blood pressure (7%) compared to the pre-test (19%). This might have to do with the fact there were more people included in the post-test, who might not have ultimately

received the education or it could simply be due to the ineffectiveness of the session that included blood pressure.

The remaining indicators showed improvements between the pre- and post-test. More clients knew about the risks and causes of diabetes (such as drinking soft drinks, consuming foods with a lot of sugar or fat, and not exercising); more clients after the education knew at least two causes of cancer and knew that it could show up anywhere in the body; more are eating fruit at the post-test and more know the foods they should consume in small quantities—there was a particularly large jump in those who knew they should consume soft drinks in small quantities. There were also more clients who knew the maximum amount of sugar, salt and fat they should consume each day. When asked about the five healthy habits one should have, more at the post-test could list all five habits (9 percent at pre-test and 39 percent at post-test) and more mentioned putting those habits into practice (6 percent at pre-test and 11 percent at post-test). These two results suggest that although more people know what they should put into practice, they are still challenged in changing their behavior.

These results suggest that the Healthy Habits education was well-received and that knowledge and behavior change was possible as a result of participating in the education; however, there is still much room for improvement, particularly among the knowledge indicators.

Institutional Assessment

The institutional assessment section includes high-level details from the cost-benefit analysis conducted by Myka Reinsch and team,[19] an assessment of staff satisfaction and a description of the enabling environment.

Cost-Benefit Analysis

Although CRECER offered health loans and *jornadas* and the majority of this paper has focused on both, Freedom from Hunger conducted the cost-benefit analysis solely on the *jornadas* to compare the economic benefits of client health and financial well-being with the costs of implementing the *jornadas* to determine how the *jornadas* influenced institutional performance in terms of expenses, revenues and other nonfinancial benefits and costs to CRECER.

The costing activity was done using a combination of activity-based and allocation methods. Where direct, tangible costs were incurred, we used CRECER's financial records and internal expense reports. We emphasized the cost of operating and growing the service, rather than the upfront investment required for its development and launch. Because the health days do not generate any direct revenue for CRECER, we reported only on direct expenses—including an allocation of salaries for those staff who are directly involved in the service—rather than adding general overhead allocations. We based much of our analysis on 2008 data.

A true cost-benefit analysis, though, goes beyond financial data and profit to examine indirect nonfinancial costs and benefits that can be quantitatively estimated and rolled into the analysis of financial gain or loss. We adopted the vantage point of the MFI itself and looked in particular for

[19] Reinsch, M, Chandler, C., Rotemberg, M, Ruaz, F. 2010. "Costs and Benefits of 'Health Days' for Microfinance Clients: CRECER's Experience with Mobile Health Providers in Bolivia." Freedom from Hunger. Davis, CA.

impacts related to the health protection package that might not be captured in the financials but that could ultimately enhance CRECER's business bottom line.

Results

Jornadas entail MFI-brokered and -facilitated visits by healthcare providers to CRECER branches or client communities, where clients may opt to come and pay a reasonable (unsubsidized) fee to public or private providers for quality diagnostic and primary healthcare services. CRECER arranges, promotes and manages the *jornadas* but does not collect any direct revenue from the events. Thus this is a non-income-generating product.

We estimate the costs to CRECER of offering *jornadas* to clients in the largely rural and semi-rural areas of El Alto and La Paz regions. We conclude the following:

- CRECER spent about $13,073 on 697 *jornadas* with over 14,800 participants in 2008.[20]
- This amounts to about $.88 per participant for the year and about $.51 per client with access to the service (about 58 percent of clients with access actually chose to participate).
- CRECER spent about $.40 per client with access to *jornadas* in 2009, and the service is projected to continue costing about the same amount in the coming years.

We then analyze the indirect benefits to CRECER from providing these services and estimate their potential impact on the MFI's financial bottom line. We show the following:

- Some evidence points to the creation of more new credit groups (and thus higher client growth) in branches that provide *jornadas* because friends and relatives who participate in or learn of the *jornadas* are inspired to join CRECER. Based on 2008 statistics, if *jornadas* resulted in even a .43 percent uptick in CRECER clientele, or stated more practically, if just nine new credit groups were formed in that year as a result of *jornadas* (in an area covering 25,000 clients and more than 2,000 groups), then the total cost of the *jornadas* for that year would be covered by increased revenues from additional clients. If *jornadas* lead to client growth that exceeds .43 percent in the coming years, then CRECER's *jornadas* could have a net financial benefit for CRECER.

- There may also be enhanced client retention rates in the branches offering the health protection package. A comparatively higher retention rate of 4 percent (as mentioned in the client retention section of this paper) would lead to more than $30,000 in net profit across just two regions in a single year that CRECER might not have earned had health protection products not engendered client loyalty—easily covering the costs of providing the service.

Staff Satisfaction

All staff members (n=60) in the El Alto and La Paz regional offices participated in an individual survey regarding their perceptions about how the provision of the new health protection services supported CRECER's mission, whether they were adequately prepared to deliver the new services, and any increased workload. They were also asked to provide their thoughts on what worked well and did not work and their recommendations to CRECER before rolling these products out to clients in other areas of Bolivia.

[20] The exchange rate used is 7 Bolivianos to US$1, based on December 2009.

Results

The staff seemed very supportive of CRECER *Saludable* products, and the field agents communicated that they saw firsthand how these health protection products influenced the lives of their clients. Staff appreciate CRECER's social mission and also seemed to exhibit buy-in in terms of CRECER's vision and mission. There was mention that some of the products, namely the health loan, were seen as "outside" of CRECER's regular package, which seemed to have caused some confusion and resulted in slow uptake.

Staff reported noticing an increased workload after adding the health loan and *jornada*, and then follow-up and promotion of these. Some staff reported needing extra time to follow up with those who did not repay their health loans. However, staff said that it was worth their additional time and effort because it helped accomplish CRECER's mission and their social responsibility, and it was an effective way to promote the institution.

"CRECER is not only about giving loans; it cares for the well-being of the family—their health, financial and social well-being."

"CRECER's clients are compliant because CRECER brings them health products and services that no other institutions have."

Many staff members were grateful for the CRECER *Saludable* products as they said that clients were not accustomed to visiting health providers and that clients originally only saw the need to "cure" instead of "prevent" illnesses. Staff stated that they have seen changes in client behavior as it pertains to health and saw the benefits of these complementary products that build on each other.

Staff provided helpful feedback in terms of how the program can and should be improved: shorter turn-around time for health loans as these are most often used in emergencies; linkages with health providers should be more formal or "serious"; more games should be included in the education; lower the prices for services offered during *jornadas*; more partnerships with public health providers, particularly in rural areas; and that CRECER needs to better promote these health products and services.

Particularly after observing changes in client attitudes and behaviors, staff members seemed to better see how they are positioned to help families. Staff members noted that they understand they are not only helping clients financially, but also helping them take care of themselves and their families—and they see this as an important responsibility and part of their job. Staff mentioned several times that clients now feel less timid and afraid to visit public health centers. Staff saw the benefits of these products in their own lives as well, and one said, "*…it [learning about health and how to access services] has made me reflect on my own life and family and for that I am appreciative*."

Enabling Environment

CRECER staff unanimously agreed that the government's mandatory regulation has significantly and, likely adversely, affected CRECER *Saludable* implementation, rollout, outreach and results. Staff noted that the government is now more "active in everything" and there are new actors involved in the microfinance arena. CRECER's strategic focus has been on how to incorporate the new regulatory norms into practice. The Bolivian government's decision to regulate banks and MFIs has

created more competition in an already intense microfinance market in Bolivia. Community banks are now offering loans to "poor women" with lower interest rates as a result of regulation.

Though clients felt differently, CRECER staff generally did not think that the food crisis significantly affected their clients. Staff said that as a result of government regulating food prices, the food crisis was felt less in Bolivia than in other countries. The sentiment was similar in terms of the financial crisis; that clients might have been slightly affected, but certainly not devastated by it—"at least less affected than those in other countries." Staff reported that politics, economics and culture all were barriers to improving health.

It was mentioned that the government, in an effort to decrease the infant and maternal mortality rate (among the highest in the Latin America/ Caribbean region), is now providing pregnant women with a cash incentive to receive prenatal controls upon visiting a health provider. It was mentioned that chronic disease is a significant issue for many clients, but that incidence has stayed at the same level over the past few years. H1N1, or the "Swine Flu," affected the general population as well as many CRECER clients, but staff felt that both the Bolivian government and CRECER reacted swiftly and efficiently to manage the outbreak. The government is reportedly trying to model Bolivia's health system after Cuba's system, and making a laudable effort at mixing Western medicine with traditional medicine. This year, Bolivia even opened a "traditional medicine" medical school.

It is generally agreed that internal changes within CRECER over the past several years significantly compromised and adversely impacted the CRECER *Saludable* program. Much institutional knowledge was lost during this time, due to staff losses and changes, which made it difficult for the project to gain momentum or consistency.

ANALYSIS

This section synthesizes key results from the client-level and institutional assessment research activities to provide a more holistic understanding of the performance and reception of these health protection products and services. We are cautious not to overstate the meaning of the data but attempt to use it to provide insight into understanding how the clients use the products and services and their general satisfaction with them.

Multiple studies were conducted at CRECER over the four-year grant period, which is, on one hand, exciting and provides multiple and triangulated views into the lives of the clients on both economic and health fronts. On the other hand, the different data-collection processes and timing of studies create a challenge for drawing clear conclusions. Some of the evaluation activities were considered "evaluation free," or did not specifically evaluate CRECER *Saludable* program objectives, such as the impact stories and the economic and health surveys and were used to provide important clues to the benefits of participating in a program that provides multiple health protection services: health education, linkages and direct referrals to health providers, and health financing. While there are important findings from both studies, they do not directly evaluate specific health outcomes to determine whether CRECER *Saludable* was a success. Although the intent from the outset was to clearly define a CRECER *Saludable* "target" and comparison areas, in practice this did not happen. In some cases, this was challenging as it acknowledged that it was easier to begin offering the health loan in more urban and peri-urban areas of both the comparison and target areas. Consequently,

comparing a treatment versus comparable area became less meaningful and we resorted to making comparisons between two points in time using the same sample population.

In order to evaluate the value of the health loans and the *jornadas*, studies were designed to look into the benefit of these products, including the client satisfaction data and the health loan and *jornada* use studies. With these studies, we can more directly understand the benefits of access to and participation in these two products. Because we had multiple evaluation activities, this section will work to synthesize this data so we can better understand impacts that cannot be linked directly to one of the products, but are representative of participation in CRECER in general and to better understand benefits directly related to the health loan and the *jornadas*.

Health Loans

CRECER initially struggled with the design and the implementation of the health loan. They had some experience with offering an individualized loan shortly prior to the health loan; however, the scale of this loan was not significant nor was there much experience among credit officers in offering individual loans outside the context of village banking. Thus, any studies begun early in 2006 or 2007 to detect changes in health behaviors, particularly relating to access to or use of the health loan to cover medical expenses, were unable to detect any change because so few clients took up the health loan during the main evaluation period and because marketing of the health loan was inconsistent both internally and externally. At one point, provision of the health loan was stopped (for more than three months) while CRECER assessed product design and reasons behind repayment problems. The health loan suffered from a high portfolio-at-risk (PAR) for the last two years of the initiative (up to 47%), but was slowly improving at the time of this report. Most of the loans at risk had been offered before CRECER paused in offering this loan to its clients in order to assess the growing PAR. CRECER discovered that most of the health loans at risk of non-repayment were made to clients already in arrears with their microenterprise loan. An important correction to this situation was made by ensuring there was more internal verification and communication between the credit officers who worked directly with the clients and the individual loan officers who made the health loans. Because new health loan clients were on time with their payments and although the discontinuation of the health loans during a lengthy period likely resulted in slower growth, CRECER benefited from the time period to assess and adjust the health loan product in order to make it a more viable product for CRECER and its clients.

Ultimately, if CRECER had the opportunity to start over with the health loan product, they would have chosen to initially offer it in a more urban setting in order to work out the logistics related to the product offering prior to targeting its more rural clients (where most of the original CRECER *Saludable* clients were located). Thus, the initial and formal marketing of this product in 2007 was hampered by poor internal marketing and communication about the product among various field staff members and the confusion of the product being pulled from the market for a lengthy period in 2008 and then re-introduced to the market.

In addition to the discontinuation of the health loan during the three-month period, it was later found that the health loan was competing with a fairly popular loan called the "opportunity credit" or *credito oportuno*, which made it more challenging to detect the effects of the health loan. Many of CRECER's clients requested the *credito oportuno*—a smaller loan with a higher interest rate—because it was a bit more flexible and could also be used for general consumption. While the *credito oportuno* provided competition for the health loan product, it also complemented the health loan because

clients who did not need a large health loan could take the *credito oportuno* and use it for less costly medical needs (such as pay for services at the *jornadas*, seek out follow-up exams, etc.).

The client satisfaction study revealed dissatisfaction with the promotion of the health loan product, but overall, clients voiced great satisfaction with knowing this product was available to them if ever needed. The terms of the loan and CRECER's direct payment of the health expenses to the providers (versus providing the loan directly to the client) was also appreciated because it ensured that the client completed their medical treatment and helped ensure the loan was used for its intended purpose. Results from the health loan-use study suggest that the health loan clients might have had fewer financial resources to draw upon to cover medical expenses (for example, having fewer "savings" with *Pasanukas* and they were slightly less likely to report having savings at home specifically for health) but recognized the role that their voluntary and obligatory savings played in covering their medical expenses.

The original hypotheses of the health loan were that clients would use their microenterprise loans less for health expenses and that they would not have to borrow from friends or family as frequently or to sell important assets to cover health expenses. The health loan-use study suggests that those who used the health loan were indeed less likely to use their current microenterprise loan for health expenditures compared to how they used their first microenterprise loan. The sample size is small, but this is a promising finding. The health loan client also indicated that if the health loan had not been available, the client would have had to resort to borrowing from family or friends, selling an asset or forgoing treatment altogether. Thus, the 41health loan clients who participated in the health loan-use study reported that the health loan helped them avoid these less optimal mechanisms for covering their expenses.

Interestingly, almost one-half of the health loan use clients reported using their health loan for dental treatment, which is one of the services provided at the *jornadas* where general check-ups and fluoride treatments were provided. This demonstrates the linkage between the types of services provided at the *jornadas* and the health loans. Between 2 and 7 percent of the total *jornada* participants from 2007–2009 participated in dental-focused *jornadas*, suggesting that demand was generated at the *jornada* to seek further dental treatment, including aesthetic dental treatments in addition to routine treatment.

The health loan had a somewhat challenging start; however, by the end of 2009, 256 clients were able to seek needed and desired medical treatment. If we had similar loan data from the *credito oportuno*, we'd likely be able to detect a higher percentage of clients using a loan specifically for health needs, and the impact of loan use for health would likely be more comprehensive.

Jornadas

Prior to the MAHP initiative and the establishment of an official program under CRECER *Saludable*, CRECER had been offering linkages to health providers in some of its regions through referrals by credit officers to community health centers and community health fairs or *ferias*. Clients had access to medical visits at a discounted rate for some services such as family planning, reproductive health, and pediatric care. In addition to these linkages, CRECER organized health fairs for credit groups as well as for entire communities to discuss major health issues and in some cases, to receive direct medical care from local public health providers, such as pap smears and vaccinations. Although

clients who participated in these linkages were primarily satisfied[21], in some cases, the care was not thorough (some women did not receive test results for the pap smears) or the coverage or outreach of these linkages was limited and did not include all credit groups. During the four-year initiative, CRECER worked to systematize the processes to create organized linkages to health providers through *jornadas*, increase the number of formal linkages to health providers, and improve the services for their clients. By the end of December 2009, nearly 24,000 CRECER clients and their family members received medical assessment or treatment because of *jornadas*. Most *jornadas* focused on preventive medicine such as screenings, annual exams and vaccinations. An important outcome from the *jornada* use study is that as clients are exposed to *jornadas*, their level of health care-seeking behavior increases. Twenty-four percent of clients who participated in the *jornada* use study indicated they had never sought medical treatment of any kind before participating in the *jornada*. Although we cannot clearly link the improved preventive care-seeking behaviors found in the economic and health survey to the *jornadas,* health education, or to the health loans, this finding suggests that improved preventive care is very possible and could be associated to CRECER creating more demand for and then linking their clients to these services.

Clients also mentioned that having access to the *jornada* services contributed to their desire to remain a CRECER client, suggesting that the *jornadas* are contributing to client retention and providing CRECER with a competitive advantage as few MFIs, besides Pro Mujer, provide this type of service to their clients. More time and research are needed to truly understand the long-term health impacts that result from access to health loans and/or *jornadas*, as well as the long-term institutional benefits.

On a broader scale, by providing *jornada* services and financing medical treatment through health loans, CRECER has established a structure and set of processes that are helping to improve and strengthen local health systems by raising public awareness, encouraging treatment on important health issues, holding providers to higher service standards. CRECER has an opportunity to further strengthen local and regional health resources and systems and add considerable value for clients and communities by focusing the *jornada* services on priority diseases and key community health concerns. For example, almost half of all CRECER clients reported having or someone in their family having a chronic illness. Instead of offering a wide range of health services, CRECER might be best positioned to address the illnesses that most affect its clients, such as gynecological diseases, gall bladder disease or diabetes, set specific improvement targets, and address these in a more comprehensive way, from detection to treatment.

Food Security

Assessments on food security, a key impact measure for Freedom from Hunger and an important assumption for microfinance in general, reveal improved food security between 2007 and 2009. However, monthly data reveals many fluctuations in food security status—suggesting the "bookend" surveys could be under- or over-calculating food security. However, it is very likely that there were more food-secure households in 2009 as Bolivians, like many around the world, were suffering from the food and economic crises during 2007 and 2008 and conditions were improving towards 2009.

Although research is ongoing to understand more about factors that would explain household food security, as initial research revealed that few obvious factors, such as improved revenue, were linked to improved food security, it is currently hypothesized that food, like cash, is one of few fungible

[21] CRECER Impact Evaluation. 2003. FINRURAL.

levers a poor family might have. Loan payments have to be made. Business costs have to be covered. But food quality and/or quantity can be reduced to accommodate these expenses more easily than other "expenses." Food may be the only place the family can "skimp" when facing many fixed costs or large investments (such as home improvement, a health crisis, etc.) such that improvement in family income may not immediately, or in the long run, result in improved and consistent family food security.

Microfinance in Bolivia

As mentioned earlier, CRECER appears to have an important competitive advantage amongst MFIs in Bolivia in part because of offering health protection services and in part because of its experience in providing products and services to the rural poor. Despite the competitive advantage, CRECER still faces growing competition with its financial products, particularly in the more urban and peri-urban areas. CRECER clients seem to be very influenced by competitors' glossy, flashy and very aggressive marketing techniques as well as affected by CRECER's requirement to regulate, which has resulted in some client dissatisfaction. Regulation in general has impeded CRECER's ability to really focus on "innovation" during a time of serious transition and will continue to challenge CRECER as it competes with even larger financial institutions after becoming a regulated MFI. Consequently, more is required in marketing not only CRECER's basic services, but also its newer products and services, such as the *jornadas* and the new individual loan products.

Given that many microfinance clients in Bolivia are members of multiple institutions, a "new" client might not be new to microfinance. Thus, when looking to monitor impact based on "new" versus "mature" clients it is important to assess "new to CRECER" and "mature to CRECER" and not necessarily "new to microfinance or integrated services." In this way, the marginal benefit CRECER provides would be measured in terms of client loyalty, health and group solidarity for example, compared to microfinance participation in general. Data would also need to be collected on prior experiences with microfinance to CRECER to really help categorize clients. This might also mean reaching a younger generation of potential clients before they join the formal financial market to make "new client" and "mature client" comparisons.

CONCLUSION

Before the end of 2009, CRECER announced its intent and commitment to scale *jornadas* and health loans across all eight regions of Bolivia where CRECER currently provides its basic *Credit with Education* services. When CRECER fully scales and further systematizes the implementation of the *jornadas* and health loans, more than 100,000 clients and their families will have important linkages to healthcare providers and services as well as to health financing tools to cover large health expenses with use of the health loan, and small health expenses with use of the *credito oportuno*.

One of the key challenges at CRECER, and among most of the MAHP partners, was promotion and marketing of the health protection services. CRECER's original research plan included a randomized control trial to test out which marketing materials and approaches (such as using materials that had underlying themes of hope and one of fear and curative and preventive care messages) would be most effective in promoting uptake of the health loan and which marketing materials would most influence the actual use of the loan; however, this research activity was cancelled when it became apparent that promotional challenges resulting in a lack of uptake of the

health loan considerably reduced the sample of clients we would be able to include in the study. Given that marketing and promotion was a challenge for most of the MAHP partners, more research and effort is needed to understand how to most effectively promote health protection services to microfinance clients. For many of Freedom from Hunger's partners who offer integrated village-banking microfinance and education, word-of-mouth marketing has been the most effective because outreach was most often in rural communities and this was the best method for growing a *Credit with Education* product; however, this is changing as new financial service providers enter the market. Consequently, more is required in marketing not only CRECER's basic services, but also its newer products and services—those that CRECER describes as giving them a competitive advantage—such as the *jornadas* and the new individual loan products.

Additionally, more time and research are needed to truly understand the long-term impacts on access and use of health services and health status (for example, is the improved use of preventive care actually as a result of having access to the health loans or the *jornadas*, and does it lead to earlier treatment and reduced impact of disease?) and the long-term institutional benefits (for example, will the offer of *jornadas* and health loans actually contribute to visible client retention and client growth). Yet, CRECER's health loan products and the *jornadas*, as well as their health education, are promising strategies for both clients and the institution to improve client health and the institutional financial and social bottom-line.

APPENDICES

Appendix A: Economic and Health Survey—Borrower Profile

	2007 (N = 240)				2009 (N=247)				
Characteristic	**N**	**%**	**Range**	**Mean**	**N**	**%**	**Range**	**Mean**	**p value***
Gender									
Female	229	95.4%			234	94.7%			0.730
Male	11	4.6%			13	5.3%			
Age			17 - 76	39.79±12.93			18-77	41.13±12.97	0.450
Marital status									
Married	189	78.8%			184	74.5%			0.502
Separated/divorced	16	6.7%			16	6.5%			
Widow/er	21	8.8%			24	9.7%			
Never married	14	5.8%			23	9.3%			
Household size			1 - 15	5.04±2.29			1 - 13	4.50±1.83	0.164
Household composition									
HH with Children 0-4	102	42.5%			97	39.3%			0.206
HH with Children 5-10	133	55.4%			118	47.8%			0.075
HH with Children 11-14	108	45.0%			98	39.7%			0.054
HH with Children 15-20	125	48.8%			99	40.1%			0.018
Children working in business									
HH with <10 years olds working	46	19.2%	0 - 5		36	14.6%	0-5		0.066
HH with 11 – 17 years olds working	83	35.6%	0 - 4		91	36.8%	0-5		0.891
Economically active persons in HH			1 - 7	2.22±0.96			1 - 6	2.19±0.968	0.308
HH with chronic illness	92	38.3%	0-4		73	29.6%	0-3		0.269
Urban	155	64.6%			124	50.2%			0.001
Rural	85	35.4%			123	49.8%			
Have access to land to plant	157	65.4%			141	57.1%			0.059
Cultivate crops/breed animals for food	163	67.4%			141	57.1%			0.014
CRECER loan									
Years in CRECER program			0.17 – 5.5 yr	2.27±1.47			0.17-18 yr	3.19±2.97	<0.001
Type of business loan									
Commercial	106	44.2%			123	49.8%			0.008
Manufacturing	46	19.2%			29	11.7%			
Service	13	5.4%			21	8.5%			
Agriculture	43	17.9%			33	13.4%			
Other business type	16	6.7%			9	3.6%			
Loan not used for business	16	6.7%			32	13.0%			
Business cycle									
Daily (reference)	73	30.4%			75	30.4%			
Weekly	102	42.5%			79	32.0%			
Every two weeks	21	8.8%			25	10.1%			0.019
Monthly	20	8.3%			31	12.6%			
Other	13	5.4%			29	11.7%			
Use loan for other expenses	84	35.0%	0-8 uses		174	70.4%	0-8 uses		<0.001
More than one loan	81	33.8%			114	46.2%			0.005
Ever unable to make loan payment	49	20.4%			59	23.9%			0.357
Total household income (monthly)			200-18000B	2214±1820			160-16000B	2688±2364	0.003

Appendix A: Economic and Health Survey—Borrower Profile (continued)

	2007 (N = 240)				2009 (N=247)				
Characteristic	**N**	**%**	**Range**	**Mean**	**N**	**%**	**Range**	**Mean**	**p value***
Have personal savings	136	56.7%			172	69.6%			0.006
Made profit in business	240	67.5%			247	72.9%			<0.001
Food security									
Food secure (reference)	111	46.3%			165	66.8%			
Food insecure without hunger	45	18.8%			32	13.0%			<0.001
Food secure with hunger	84	35.0%			50	20.2%			

Appendix B: Health Survey Outcomes

Indicator	2007 (N=240)	2009 (n=247)
Client-level Statistics		
Number and % clients that were sick or injured in past 30 days	18 (7.5%)	67 (25.2%)
Average days client was sick or injured	9.2	12.5
Client sought care outside of the home	19.2%	23.8%
# clients & average expenses (in Bolivianos-Bs) for clients' illnesses	15 (573Bs)	59 (602Bs)
Days of work lost	**(n=5)**	**(n=31)**
0 days	2 (40.0%)	18 (58.1%)
1-3 days	2(40.0%)	6 (19.4%)
6+ days	1 (20.0%)	3 (9.7%)
Don't know	0	3 (9.7%)
# and % clients seeking preventive care	24 (10%)	36 (14.6%)*
# and % clients able to pay for preventive care treatment	23 (95.8%)	31 (86.1%)
Someone in family has some sort of insurance	26.3%	64.4%
Other Family Members Mentioned		
Number and % person 2 (P2)that was sick or injured in past 30 days	21 (8.8%)	42 (15.8%)
Average days P2 sick or injured	10.9	10.7
Care outside of home was sought for P2	7.7%	14.7%
# persons & average expenses for P2	20 (243Bs)	35 (257Bs)
# and % P2 seeking preventive care	24 (10%)	13 (5.3%)*
# and % P3 seeking preventive care	4 (1.5%)	21 (8.5%)**
# and % P2 able to pay for preventive care treatment	24 (100%)	9 (69.2%

* statistically significant at $p<0.10$
**statistically significant at $p<0.001$

Appendix B: Health Survey Outcomes (continued)

Indicator	2007 (N=240)	2009 (n=247)
MATCHED RESPONDENTS	**(n=93)**	**(n=93)**
# and % clients sick in past 30 days	7 (7.5%)	23 (24.7%)
Average # days client sick	8.71±10.45	12.91±12.56
# and % P2 sick in past 30 days	7(7.5%)	15 (16.1%)
Average # days P2 sick	7.00±5.73	12.08±13.05
Average Household Cost per Episode	263.31 Bs. ±834.87	1006.82 Bs. ± 2615.98
Household Cost Range per Episode	0-3040	5-10755
Days of work lost for Client		
0 days	50%	44.7%
1-3 days	14.3%	10.5%
4-5 days	0	2.6%
6+ days	21.4%	28.9%
Don't know	14.3%	13.2%
Where sought treatment		
Hospital	28.6%	33.3%
Pharmacy	0	11.1%
Health Center	42.9%	16.7%
Mobile clinic	7.1%	0
Private facility	14.3%	22.2%
Traditional Medicine	0	11.1%
Curandero	0	5.6%
Other (Caja Nacional de Salud)	7.1%	0
Client sought preventive care in last 30 days	11%	11%
P2 sought preventive care in last 30 days	7.5%	5.3%
P3 sought preventive care in last 30 days	1%	7.5%
Household able to pay for preventive care	100%	81.8%

* statistically significant at $p<0.10$
**statistically significant at $p<0.001$

Appendix C: Food Security Data

Table1 below provides the sample size for each survey as well as percent of clients who experienced food security or were food insecure with or without hunger.

Table 1: Monthly Food Security Data												
Status	**2007 (240)**	**March (30)**	**April (33)**	**May (36)**	**June (32)**	**July (27)**	**Aug. (31)**	**Sept. (34)**	**Oct. (33)**	**Nov. (33)**	**Dec. (30)**	**2009 (247)**
Food-secure	46.3	33	39.4	44.4	40.6	44	54.8	47	51.5	54.5	40	66.8
Food-insecure without hunger	18.8	30	21.2	30.6	37.5	30	19.4	26.5	15.2	27.3	26.7	13
Food-insecure with hunger	35	36.7	39.4	25	21.9	26	25.8	26.5	33.3	18.2	33.3	20.2

Table 2 provides a comparison of food security levels for "incoming" (less than 1 year of participation) CRECER clients and "mature" (more than 1 year of participation) and using a cut-off of 6 months to determine whether a client was considered "incoming" or "mature."

Table 2: Food Security comparisons of new and mature CRECER clients			
	Food-Secure	**Food-Insecure without Hunger**	**Food-Insecure with Hunger**
Incoming clients (< 1 year)	36.0%	17.4%	46.5%
Mature (> 1 year)	33.9%	19.4%	46.7%
Incoming clients (< 6 mos.)	70.4%*	22.2%	7.4%
Mature clients (> 6 mos.)	61.8%	18.4%	19.8%

*statistically significant association ($p<0.10$) between incoming and mature clients and food security data

Appendix D: Economic and Health Study Case Studies[22]

Case Study: Maria

In 2007 when this study began Maria had been a member of CRECER for three years. She is in her late fifties, lives in her own home in El Alto with her husband and children where she operates a small store out of her house selling basic foods like the common pasta eaten daily, eggs, sodas, candy, beer, canned fish, and fresh bread daily. Although she never attended school all of her children have finished secondary school. Her husband and one of her children have regular work but the household still only earns 2000 Bolivianos (US$250) a month and other than the obligatory savings within CRECER, they have none. This puts them among the "poorest of the poor," living on less than US$1/day/person. She took out her first CRECER loan for 500 Bolivianos (US$62.50), borrowed money from her husband and accessed savings to start her business. By 2009 her CRECER loan had increased to 5000 Bolivianos (US$640) and she had been borrowing another 1000 or so Bolivianos (US$128) from another MFI for 2 years all of which she was applying toward increasing the merchandise for her store. This active entrepreneurial effort does not appear to be generating much, if any profit. In 2007 she stated she earned Bs.350 (US$44) per month but in calculating her earnings by subtracting her stated business expenses from her stated income she is in fact earning only Bs.80/month. That had improved dramatically by 2009 when her stated income was Bs.600/month (assuming she is open 7 days a week); if she closes on Sunday (as most do), her income is around Bs.520/month. In 2007, she stated her loan payments were Bs.300 every 14 days (Bs.600/month – US$75) which means, whether using her stated profit or the calculated profit, she doesn't make as much as she owes in any given month. While that had improved dramatically by 2009 her combined loan payments of Bs.750 (US$96) is still substantially greater than her business income and would still have left her with a negative balance most months (assuming both loans have similar terms).

In spite of this she always makes her payments though she and other members of her loan group need to loan some of their colleagues money to make their payments each cycle. While there is no way to demonstrate a one-to-one correspondence, Maria's household is pretty consistently food insecure, occasionally acutely so. The household was "food insecure without hunger" in the 2007 survey and as can be seen in Figure One below, the family was consistently, though not always, food insecure month to month.

[22] Names in these two case studies have been changed to protect client privacy.

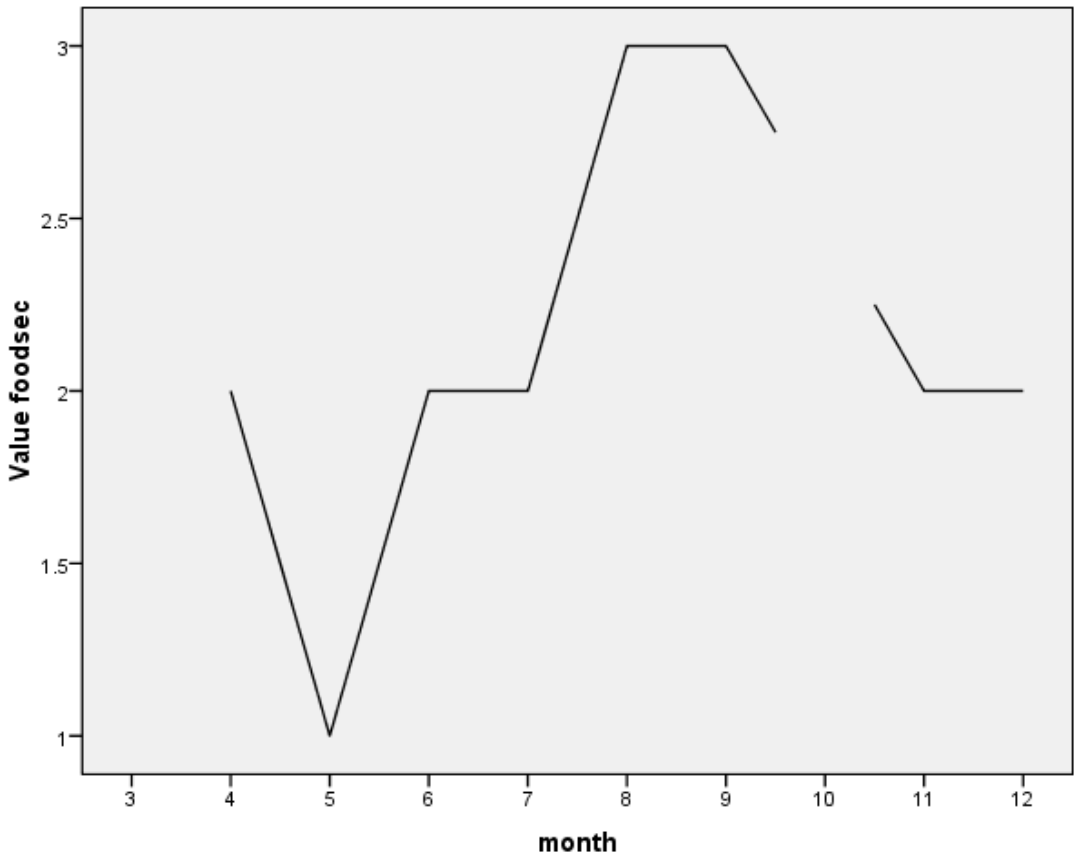

Figure one: Monthly food security: 1 is food secure, 2 is food insecure without hunger (mildly food insecure) and 3 is food insecure with hunger (severely food insecure)

Case study: Juana

Juana is a young mother living with her husband and their three children in a home they are building little by little in one of the remote peri-urban neighborhoods of El Alto, adding on as they accrue small amounts of money. She began her small business of selling food in area markets the year before joining CRECER with a loan from a different organization. Her decision to enter into small-scale selling was based on several factors: it provides the flexibility she needs with three small children, doesn't cost much to get started and is something she can do with her very limited education. Her first loan from CRECER was for a modest Bs 500 which she had doubled by the following cycle using the money to buy more display space and products for her business. Although they live in the city, they own a small piece of farm land that they visit a few times each year on which they produce some potatoes, some of which they eat fresh and some of which they dry as chuño which keeps through the year, providing them a small relief from their daily food costs. They have another loan from a different company they took out so her husband could buy a car which he operates as a taxi. Between them they earn about 2000 Bolivianos a month (US$250) which means they are very poor having a little over US$1.50/day/person on which to survive. One small advantage for the time being is that their two youngest children are not yet in school so they do not yet incur the roughly Bs.500 in school expenses each year. She considers herself a very responsible borrower because she dedicates the entire loan amount to supporting and building her business; still, her stated return on her investment is still quite modest at about Bs.10/day (US$1.25) which is just what she has to pay on her loan every two weeks. Calculating her profit from her expense and sales figures puts her very much in the red on a monthly basis.

Her family has had a difficult year. She has a chronic health condition that causes her a lot of pain and requires visits to the hospital and the more expensive clinic. She put up with the pain for quite a while before her husband decided she had to see someone about her condition. Although she is covered by the national health plan for women and children (SUMI), it does not cover non-reproductive health costs so they must pay for each of these visits out of pocket (SUMI paid for the prenatal visits for their most recent baby). While they are able to pay for her health care, it is expensive and so is money that is not available for other necessities. In addition to her own health problems, one of her relatives was involved in a serious accident and another died, both of which incurred expenses they were required to help with.

Juana is very careful with her money but some months there just isn't enough to go around and they do not get enough to eat.

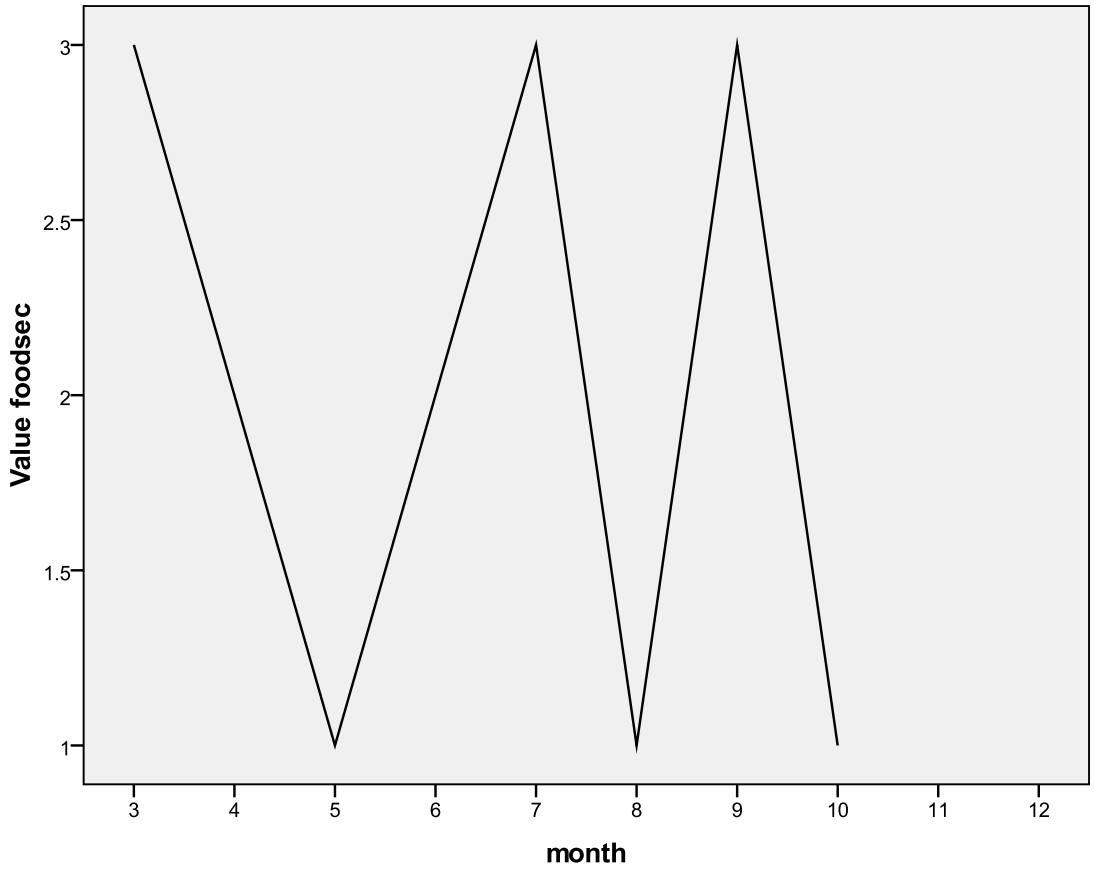

Figure two: Monthly food security: 1 is food-secure, 2 is food-insecure without hunger (mildly food-insecure) and 3 is food-insecure with hunger (severely food-insecure)

Appendix E: Health Loan-Use Data

	Used Health Loan	Had Access to Health Loan	Had No Access to Health Loan	Total
Sought preventive services	34.1%	44.4%	28.6%	36.0%
Average medical visits per year	1.60	1.40	1.30	1.50
Feel they take good care of their health	46.3%	59.3%	61.9%	53.9%
Average health expense in last 3 months (in Bolivianos)	1,062.4	82.6	637.0	700.8
In any occasion, did you:				
Necesitó atención odontológica pero no fue al dentista	39.0%	40.7%	61.9%	44.9%
Tuvo un problema de salud pero no acudió a consulta	26.8%	22.2%	38.1%	28.1%
Ninguno	24.4%	33.3%	19.0%	25.8%
No se tomó las dosis indicadas	26.8%	22.2%	14.3%	22.5%
Dejó de hacer el tratamiento indicado por un médico	19.5%	22.2%	23.8%	21.3%
Dejó de hacerse un chequeo o evaluación física anual	17.1%	11.1%	42.9%	21.3%
No compró las medicinas que le recetaron	19.5%	14.8%	19.0%	18.0%
Dejó de hacerse análisis	17.1%	14.8%	9.5%	14.6%
Didn't seek out medical attention in last year due to cost	51.2%	40.7%	66.7%	51.7%
Have person voluntary savings at home	73.20%	74.10%	71.40%	73%
Belong to a *Pasanaku* (merry-go-round)	4.90%	25.90%	23.80%	15.70%
Used CRECER obligatory savings for health expenses	43.9%	44.4%	23.8%	39.3%
Have saved apart from CRECER for purpose of saving for health	12.0%	22.2%	14.3%	15.7%
Another family member has saved for health purposes	29.30%	29.60%	14.30%	25.80%
Reasons for saving				
For future needs	26.8%	33.3%	9.5%	24.7%
Household Expenses	17.1%	25.9%	19.0%	20.2%
Education	19.5%	18.5%	14.3%	18.0%
Health Emergencies	19.5%	22.2%	9.5%	18.0%
Construction or home improvements	7.3%	14.8%	23.8%	13.5%
To have business capital	7.3%	7.4%	14.3%	9.0%
Business inputs	7.3%	3.7%	14.3%	7.9%
Food	0.0%	11.1%	14.3%	6.7%
Business repairs	4.9%	0.0%	14.3%	5.6%
Purchase household assets	9.8%	0.0%	0.0%	4.5%
For retirement	2.4%	7.4%	0.0%	3.4%
To pay debts	2.4%	3.7%	4.8%	3.4%
Clothing	2.4%	0.0%	4.8%	2.2%
Christmas gifts	2.4%	0.0%	0.0%	1.1%
Funeral expenses	0.0%	3.7%	0.0%	1.1%
Housing rental	0.0%	0.0%	4.8%	1.1%
Don't Know/Didn't respond	2.4%	0.0%	0.0%	1.1%

Appendix E: Health Loan-Use Data (continued)

	Used Health Loan	Had Access to Health Loan	Had No Access to Health Loan	Total
Reasons why client joined CRECER				
Microenterprise loan	63.4%	63.0%	61.9%	62.9%
Savings	46.3%	40.7%	42.9%	43.8%
Group solidarity	22.0%	55.6%	38.1%	36.0%
Family Recommendation	36.6%	25.9%	19.0%	29.2%
Easy Requirements for obtaining loan	9.8%	11.1%	4.8%	9.0%
Earnings generated by group	7.3%	7.4%	9.5%	7.9%
Interest rate	7.3%	11.1%	0.0%	6.7%
Simple guarantee	7.3%	11.1%	0.0%	6.7%
Speed of disbursement	4.9%	7.4%	9.5%	6.7%
Need to cover home expenses	2.4%	11.1%	9.5%	6.7%
CRECER has individual credits	7.3%	0.0%	4.8%	4.5%
Education	2.4%	7.4%	0.0%	3.4%
Relationship with Field Agent	0.0%	0.0%	14.3%	3.4%
Repayment Period	2.4%	3.7%	0.0%	2.2%
No other financial institution	0.0%	3.7%	0.0%	1.1%
Because it was "CRECER"	2.4%	0.0%	0.0%	1.1%
Recommendation made by others	2.4%	0.0%	0.0%	1.1%
Internal Loan	2.4%	0.0%	0.0%	1.1%
To help a family member	2.4%	0.0%	0.0%	1.1%
Curiosity	0.0%	3.7%	0.0%	1.1%
For Health insurance	0.0%	0.0%	4.8%	1.1%
Used first loan for the following purposes:				
Didn't use loan	68.3%	55.6%	61.9%	62.9%
Food	19.5%	14.8%	9.5%	15.7%
School Fees	7.3%	22.2%	19.0%	14.6%
Personal Business	4.9%	11.1%	14.3%	9.0%
Clothing	17.1%	3.7%	0.0%	9.0%
Health expenses	17.1%	0.0%	0.0%	7.9%
Transport	7.3%	7.4%	4.8%	6.7%
Repair or home improvement	2.4%	7.4%	9.5%	5.6%
To pay another loan	0.0%	0.0%	4.8%	1.1%
Used most current loan for the following:				
Didn't use loan	56.1%	44.4%	57.1%	52.8%
School Fees	12.2%	14.8%	19.0%	14.6%
Food	12.2%	7.4%	23.8%	13.5%
Personal Business	4.9%	22.2%	9.5%	11.2%
Transport	7.3%	18.5%	0.0%	9.0%
Repair or home improvement	7.3%	14.8%	0.0%	7.9%
Clothing	12.2%	7.4%	0.0%	7.9%
Health expenses	4.9%	0.0%	4.8%	3.4%
To pay another loan	2.4%	0.0%	0.0%	1.1%
Funeral expenses	0.0%	3.7%	0.0%	1.1%

Appendix E: Health Loan-Use Data (continued)

	Used Health Loan	Had Access to Health Loan	Had No Access to Health Loan	Total
Used a CRECER internal loan for health expenses	31.7%	40.7%	33.3%	34.8%
Used part of a CRECER microenterprise loan for health expenses	34.1%	44.4%	33.3%	37.1%
Reasons why client stays with CRECER				
Savings	39.0%	33.3%	42.9%	38.2%
to belong to group	31.7%	51.9%	23.8%	36.0%
Ease of obtaining credit	29.3%	33.3%	23.8%	29.2%
Education	29.3%	14.8%	19.0%	22.5%
Group guarantee	19.5%	11.1%	33.3%	20.2%
Internal Loan	22.0%	14.8%	4.8%	15.7%
Ease of paying loan	12.2%	7.4%	9.5%	10.1%
Speed of disbursement	12.2%	7.4%	4.8%	9.0%
Earnings generated by group	7.3%	11.1%	4.8%	7.9%
Group solidarity	4.9%	3.7%	19.0%	7.9%
Repayment Period	4.9%	0.0%	19.0%	6.7%
Interest rate	4.9%	11.1%	0.0%	5.6%
Opportunity Credit	4.9%	11.1%	0.0%	5.6%
Health Loan	9.8%	0.0%	0.0%	4.5%
Few requirements to obtain loan	0.0%	11.1%	0.0%	3.4%
Jornadas	2.4%	3.7%	0.0%	2.2%
Relationship with Field Agent	2.4%	0.0%	4.8%	2.2%
Microinsurance	2.4%	3.7%	0.0%	2.2%
Quick meetings	0.0%	3.7%	0.0%	1.1%
Proximity of meetings to home	0.0%	3.7%	0.0%	1.1%
Personal treatment	2.4%	0.0%	0.0%	1.1%
Other financial services	2.4%	0.0%	0.0%	1.1%
Don't Know/Didn't respond	0.0%	0.0%	9.5%	2.2%
Number of Health loans obtained (1)	100%			
How they heard about the health loan				
Field Agent	78.0%			
Promotional Materials	14.6%			
Other group members	7.3%			
Average size of health loan	**732.7**			

Appendix E: Health Loan-Use Data (continued)

	Used Health Loan	Had Access to Health Loan	Had No Access to Health Loan	Total
Loan taken for whom				
Client	43.9%			
Children	19.5%			
Spouse	14.6%			
Brother	4.9%			
Sister	4.9%			
Caretaker	4.9%			
Mother	2.4%			
Mother-in-law	2.4%			
Father	2.4%			
Father-in-law	2.4%			
Cousin	2.4%			
Son-in-law	2.4%			
Motive for loan				
Esthetic Dental Attention	29.3%			
Surgery	26.8%			
Preventive or Curative Dental	17.1%			
Gall Bladder	9.8%			
Bone break	9.8%			
Difficulty Breathing	4.9%			
Tumor	4.9%			
Cesarean Section	4.9%			
Convulsions	2.4%			
Back Pain	2.4%			
Kidney Pain	2.4%			
Diabetes	2.4%			
Hip replacement	2.4%			
Accident	2.4%			
Average amount of medical expenses	**1895.0**			
Loan covered all medical expenses	36.6%			

Appendix E: Health Loan-Use Data (continued)

	Used Health Loan	Had Access to Health Loan	Had No Access to Health Loan	Total
Expenses not covered				
Medicine	76.9%			
Follow-up exams	50.0%			
Part of surgery	19.2%			
Emergency transport	15.4%			
Hospitalization	15.4%			
Physical Therapy	15.4%			
Specialized studies	15.4%			
Public transport/food	11.5%			
Medical Equipment	11.5%			
Oral medications (for dental treatments)	7.7%			
How covered remaining expenses (n=23)				
Family money	53.8%			
Business earnings	26.9%			
Personal savings at home	19.2%			
Savings from other family member	11.5%			
Loan from other institution	7.7%			
Personal savings guarded with other family member	7.7%			
Savings account with CRECER	7.7%			
Other Earnings	7.7%			
CRECER Microenterprise loan	3.8%			
If loan had not been available, the client would have:				
Borrowed from family or friends	26.8%			
Postponed treatment	24.4%			
Sold a personal asset	24.4%			
Borrowed from other financial institution	14.6%			
Not have sought treatment at all	12.2%			
Opted for less-quality care	4.9%			
Reduced personal expenses such as food	2.4%			
Used savings	2.4%			
Loan from commercial bank	2.4%			
Mortgaged home	2.4%			
Don't Know/Didn't respond	2.4%			
Would recommend Health Loan to family and friends	**100.0%**			

Appendix F: *Jornada* Use Data

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	**n=22**	**n=20**	**n=83**
Average length of membership in CRECER (in cycles)	7.05	7.27	4.4	6.47
Reasons why they joined CRECER for first time				
Microenterprise Loan	82.9%	81.8%	90.0%	84.3%
Savings	41.5%	36.4%	15.0%	33.7%
Group Solidarity	12.2%	13.6%	15.0%	13.3%
Interest Rate	12.2%	22.7%	0.0%	12.0%
Recommendation from Friends	12.2%	9.1%	15.0%	12.0%
Education/training	12.2%	9.1%	5.0%	9.6%
Recommendation from Family	7.3%	18.2%	5.0%	9.6%
For other financial services	7.3%	4.5%	0.0%	4.8%
Simple Guarantee	2.4%	4.5%	5.0%	3.6%
Internal Group Loan	4.9%	4.5%	0.0%	3.6%
Proximity to home	2.4%	0.0%	10.0%	3.6%
Because CRECER provides Health services	4.9%	0.0%	0.0%	2.4%
Good attention from CRECER	2.4%	4.5%	0.0%	2.4%
Good attention from the field agent	0.0%	9.1%	0.0%	2.4%
Sharing with the group	2.4%	4.5%	0.0%	2.4%
Easy requirements	0.0%	4.5%	0.0%	1.2%
Rapid loan disbursement	2.4%	0.0%	0.0%	1.2%
Need of money for home	0.0%	0.0%	5.0%	1.2%
Size of loan	2.4%	0.0%	0.0%	1.2%
To replace another client in a group	2.4%	0.0%	0.0%	1.2%
Convenience of monthly payment	0.0%	4.5%	0.0%	1.2%
Opportunity Credit	0.0%	0.0%	5.0%	1.2%
Diagnosed with a chronic illness	61.0%	59.1%	45.0%	56.6%
Gall Bladder Disease	29.3%	22.7%	20.0%	25.3%
High Blood Pressure	7.3%	13.6%	5.0%	8.4%
Digestive Disorders	9.8%	0.0%	10.0%	7.2%
Kidney Disease	2.4%	9.1%	5.0%	4.8%
Gynecological Problems	7.3%	0.0%	5.0%	4.8%
Heart Problems	0.0%	9.1%	5.0%	3.6%
Anemia	2.4%	0.0%	10.0%	3.6%
Liver Disease	2.4%	4.5%	0.0%	2.4%
Low Blood Pressure	4.9%	0.0%	0.0%	2.4%
Cancer	2.4%	0.0%	0.0%	1.2%
Diabetes	2.4%	0.0%	0.0%	1.2%

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	**n=22**	**n=20**	**n=83**
Diagnosed with a chronic illness	61.0%	59.1%	45.0%	56.6%
Asthma	0.0%	0.0%	5.0%	1.2%
Arthritis	0.0%	0.0%	5.0%	1.2%
High Cholesterol	2.4%	0.0%	0.0%	1.2%
Vision Deficiencies	2.4%	0.0%	0.0%	1.2%
Allergies	0.0%	4.5%	0.0%	1.2%
Vericose veins	0.0%	0.0%	5.0%	1.2%
Sinusitis	2.4%	0.0%	0.0%	1.2%
Cysts and Tumors	2.4%	0.0%	0.0%	1.2%
Other family member diagnosed with Chronic Illness	41.5	45.5	60.00%	470%
Gall Bladder Disease	17.1%	22.7%	30.0%	21.7%
Diabetes	9.8%	13.6%	10.0%	10.8%
Kidney Disease	4.9%	4.5%	15.0%	7.2%
Digestive Disorders	2.4%	0.0%	20.0%	6.0%
Arthritis	2.4%	9.1%	10.0%	6.0%
Cancer	4.9%	0.0%	10.0%	4.8%
Heart Problems	4.9%	4.5%	0.0%	3.6%
Asthma	4.9%	0.0%	5.0%	3.6%
Liver Disease	2.4%	0.0%	5.0%	2.4%
Lung Disease	2.4%	4.5%	0.0%	2.4%
Depression	2.4%	0.0%	0.0%	1.2%
High Cholesterol	2.4%	0.0%	0.0%	1.2%
Rheumatism	0.0%	0.0%	5.0%	1.2%
Epilepsy	2.4%	0.0%	0.0%	1.2%
Gynecological Problems	2.4%	0.0%	0.0%	1.2%
Varicose veins	0.0%	0.0%	5.0%	1.2%
Where they normally seek out medical attention				
Hospital	39.0%	27.3%	40.0%	36.1%
Health Center	29.3%	40.9%	40.0%	34.9%
Health Insurance	19.5%	13.6%	15.0%	16.9%
Medical office	12.2%	9.1%	0.0%	8.4%
Health Post	2.4%	4.5%	10.0%	4.8%
Pharmacy	4.9%	0.0%	10.0%	4.8%
Clinic	0.0%	4.5%	5.0%	2.4%
Traditional Healer	0.0%	4.5%	0.0%	1.2%
Family doctor	0.0%	0.0%	5.0%	1.2%
Do not seek medical attention	2.4%	4.5%	0.0%	2.4%
Ever heard of health loan	56.1%	54.5%	35.0%	50.6%
Ever thought of taking a health loan	47.8%	66.7%	28.6%	50.0%
Ever taken a health loan	0.0%	0.0%	0.0%	0.0%

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	n=22	n=20	n=83
Reasons for not taking a health loan				
Didn't need it	18.2%	62.5%	0.0%	33.3%
Don't want to indebt myself further	9.1%	0.0%	50.0%	9.5%
I have insurance	9.1%	0.0%	0.0%	4.8%
Health loan is too slow	9.1%	0.0%	0.0%	4.8%
Don't know details of the health loan	36.4%	0.0%	50.0%	23.8%
High interest	0.0%	12.5%	0.0%	4.8%
Required guarantees	9.1%	0.0%	0.0%	4.8%
Don't Know/Didn't respond	9.1%	25.0%	0.0%	14.3%
Clients that would prefer to borrow from friends or family to cover health expenses	19.5%	13.6%	10.0%	15.7%
Clients that would prefer to borrow from CRECER to cover health expenses	80.5%	86.4%	90.0%	84.3%
Have ever sought preventive care	19.5%	31.8%	20.0%	22.9%
Reasons they have sought preventive care				
Fear of contracting an illness	4.9%	4.5%	0.0%	3.6%
For prevention	2.4%	9.1%	0.0%	3.6%
For medical check-ups	9.8%	18.2%	10.0%	12.0%
To stay healthy	4.9%	9.1%	10.0%	7.2%
Reasons they haven't sought preventive care				
Lack of money	12.2%	27.3%	25.0%	19.3%
Wait too long for medical attention	2.4%	0.0%	5.0%	2.4%
Expensive	0.0%	4.5%	0.0%	1.2%
Fear of getting sick	2.4%	0.0%	0.0%	1.2%
Because I feel well	39.0%	13.6%	25.0%	28.9%
I don't like going to the doctor	12.2%	0.0%	0.0%	6.0%
Lack of confidence in doctors	2.4%	0.0%	0.0%	1.2%
Fear of male doctors	9.8%	13.6%	5.0%	9.6%
Shame	0.0%	0.0%	5.0%	1.2%
Lack of time	4.9%	18.2%	25.0%	13.3%
Fear of what results would find	2.4%	9.1%	5.0%	4.8%
Feel they take good care of their health	58.5%	50.0%	45.0%	53.0%
Health expenses in last 3 months				
Average spent (in Bolivianos)	622	224	258	409
Minimum spent	5	10	5	5
Maximum spent	6000	1000	1500	6000

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	n=22	n=20	n=83
In the last year, have you:				
Needed dental attention but didn't go to the dentist	15%	23%	45%	24%
Not purchased medicines you were prescribed	29%	5%	10%	18%
Had a health problem but didn't go to the doctor	12%	23%	20%	17%
Stopped a treatment prescribed by a doctor	17%	18%	10%	16%
Didn't take a medicine dosis as indicated	17%	18%	5%	15%
Didn't seek out a medical check-up as needed	7%	18%	10%	11%
Didn't continue a medical analysis as suggested	10%	9%	0%	7%
Didn't purchase medical equipment as needed	0%	0%	5%	1%
Sought treatment in last two years at an emergency medical center	29%	27%	30%	29%
In last 12 months, didn't seek medical attention due to cost	22%	50%	50%	36%
Reasons why you stay with CRECER				
Microenterprise Loan	29.3%	27.3%	25.0%	27.7%
Group Solidarity	19.5%	31.8%	20.0%	22.9%
Access to loan is easy	24.4%	22.7%	15.0%	21.7%
Savings	9.8%	27.3%	25.0%	18.1%
Education/training	9.8%	22.7%	10.0%	13.3%
Internal Group Loan	2.4%	13.6%	10.0%	7.2%
To pay off loan	7.3%	4.5%	10.0%	7.2%
Interest Rate	4.9%	4.5%	10.0%	6.0%
Availability of money for the home	4.9%	9.1%	0.0%	4.8%
Monthly payment	2.4%	4.5%	10.0%	4.8%
Jornadas	9.8%	0.0%	0.0%	4.8%
Easy to repay loan	2.4%	0.0%	15.0%	4.8%
To not lose membership with group	4.9%	4.5%	0.0%	3.6%
Group Solidarity	4.9%	0.0%	5.0%	3.6%
Opportunity Credit	0.0%	9.1%	5.0%	3.6%
Microeinsurance	4.9%	4.5%	0.0%	3.6%
Good field agents	0.0%	9.1%	0.0%	2.4%
To open a business	2.4%	0.0%	0.0%	1.2%
Feels like home	2.4%	0.0%	0.0%	1.2%
Loan sizes are high	2.4%	0.0%	0.0%	1.2%
Proximity to home	0.0%	0.0%	5.0%	1.2%
Earnings generated in the group	0.0%	0.0%	5.0%	1.2%
Agreements with health centers	0.0%	4.5%	0.0%	1.2%
Don't Know/Didn't respond	4.9%	0.0%	0.0%	2.4%

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	n=22	n=20	n=83
Reasons why you would or others leave CRECER				
Someone in group fails to repay	14.6%	18.2%	15.0%	15.7%
No longer need the loan	9.8%	9.1%	30.0%	14.5%
Difficulty to make payments	19.5%	0.0%	10.0%	12.0%
Moved or had to travel	14.6%	4.5%	15.0%	12.0%
Don't have debt	4.9%	18.2%	0.0%	7.2%
When have own money	7.3%	4.5%	5.0%	6.0%
Lack of time to attend meetings	4.9%	9.1%	5.0%	6.0%
When interest rate is raised	4.9%	9.1%	0.0%	4.8%
When there are no savings	4.9%	9.1%	0.0%	4.8%
Fail to repay loan	7.3%	0.0%	0.0%	3.6%
Lack of work	0.0%	4.5%	10.0%	3.6%
Too old to be a member	2.4%	4.5%	0.0%	2.4%
Health problems	0.0%	4.5%	5.0%	2.4%
If CRECER turns into a bank	2.4%	0.0%	0.0%	1.2%
When you can't work	2.4%	0.0%	0.0%	1.2%
Lack of clarity on how to manage savings	2.4%	0.0%	0.0%	1.2%
To rest between cycles	2.4%	0.0%	0.0%	1.2%
If norms become more rigid	0.0%	4.5%	0.0%	1.2%
If meetings were far away	0.0%	4.5%	0.0%	1.2%
Breakdown of the group	0.0%	0.0%	5.0%	1.2%
Would not leave	7.3%	9.1%	5.0%	7.2%
Services that have been accessed at the *jornadas*				
Pap Smear	29.3%			
Colposcopy	19.5%			
Deworming	19.5%			
Blood pressure screening	19.5%			
Ultrasound Scan	14.6%			
Adult vaccinations	14.6%			
Analysis of Glucose and Creatine	12.2%			
Height and weight measurements	12.2%			
Diabetes screening	9.8%			
Flu Vaccine (including H1N1)	7.3%			
Dentistry	4.9%			
Kidney disease detection	4.9%			
Ultrasound (Gynecology, Kidney, Bladder)	4.9%			
Women's health and diabetes detection	2.4%			
Women's health and Pap Smear	2.4%			
Average amount spent at jornada (in Bs)	34.05			
Minimum spent at *Jornada* (in Bs)	10			
Maximum spent at *Jornada* (in Bs)	70			

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	n=22	n=20	n=83
Form of payment for *Jornada*				
Used business earnings	38.1%			
Borrowed from friends or family	9.5%			
Used savings kept at home	14.3%			
Used health loan	4.8%			
Used CRECER savings	28.6%			
Husband gave me the money	4.8%			
Felt the cost of *jornada* was fair	71.4%			
Would pay a higher price to attend same *jornada*	60.0%			
Would pay how many bolivianos more for *jornada*?				
5 Bolivanos	11.1%			
10	22.2%			
20	22.2%			
25	11.1%			
50	22.2%			
100	11.1%			
Average amount more they'd pay	32.22			
Clients that felt comfortable with treatment provided by doctor at *jornada*	95.1%			
Reasons they felt comfortable with treatment provided by doctor				
Good attention	41.0%			
Good explanations	28.2%			
I was attended to by a woman	10.3%			
They didn't hurt me	7.7%			
Results were immediate	7.7%			
I felt confident	5.1%			
I found out I was health	5.1%			
Exam was not complicated	5.1%			
I liked the medical visit	2.6%			
I wanted to know something about my health	2.6%			
I saw the ultrasound on the screen	2.6%			
He seemed genuine	2.6%			
Because now I know my weight and height	2.6%			
There was privacy	2.6%			
Wasn't afraid	5.1%			
Reasons they felt uncomfortable (n=2)				
Didn't like how they took my blood pressure	50.0%			
I was afraid	50.0%			
Clients who had confidence in the doctor at the *jornada*	82.9%			
Clients that were very satisfied with level of service at *jornada*	14.6%			
Clients that were satisfied	75.6%			

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	**n=22**	**n=20**	**n=83**
Felt the medical professional treated them with respect	100.0%			
Would attend similar services again at *jornada*	41.5%			
Visit other health establishments outside of CRECER	82.9%			
In relation to other establishments, the *jornada* service is:				
Much better	26.5%			
Somewhat better	14.7%			
The same	50.0%			
Worse	8.8%			
In relation to other establishments, the jornada cost is:				
More expensive	2.9%			
Less expensive	44.1%			
I didn't pay anything	47.1%			
Don't Know/Didn't respond	5.9%			
In relation to other establishments, the *jornada* medical service is:				
More comfortable	38.2%			
Same	23.5%			
Less comfortable	38.2%			
Would visit same *jornada* provider in future	78.0%			
What they liked most from the *jornada*				
Diabetes screening	4.9%			
Health videos	2.4%			
Privacy of the consultation	2.4%			
Vaccinations	4.9%			
Quick results	4.9%			
Good attention	19.5%			
Education/training	17.1%			
Raffle	2.4%			
Tests took place in the office	2.4%			
Ultrasound	2.4%			
Accessibility of services	19.5%			
Rapid medical attention	7.3%			
Medical review	9.8%			
Good explanations	12.2%			
Blood pressure screening	2.4%			
Presence of various specialists	2.4%			
Medical equipment	2.4%			
The break	2.4%			
Medical treatment provided in the group	2.4%			
CRECER preoccupation with client health	2.4%			
Nothing	7.3%			

Appendix F: *Jornada* Use Data (continued)

	Jornada Participants	*Jornada* Non-participants	*Jornada* Comparisons	Total
	n=41	**n=22**	**n=20**	**n=83**
How they heard about the *jornada*				
Field agent	97.6%			
Other CRECER staff person	7.3%			
Group members	2.4%			
Aspects most valued from *jornada*				
The medical professional came to them	19.5%			
The doctors	4.9%			
The glycemia test	2.4%			
Medical attention	22.0%			
Colposcopy	2.4%			
Vaccinations	2.4%			
Rapid results	4.9%			
Low cost	2.4%			
Education/training	17.1%			
They gave explanations	4.9%			
Deworming	2.4%			
Free service	7.3%			
Medical attention provided to the entire group	9.8%			
CRECER preoccupation with client health	9.8%			
It's mandatory	2.4%			
Don't Know/Didn't respond	2.4%			
Were given medical referrals as result of *jornada*	17.1%			
Followed up on referral	28.6%			
Had never visisted a medical provider before the *jornada*	24.4%			

Appendix G: Impact Story

Jeanette Paco Jerastegui (urban Achacachi)

Jeanette is a young woman who sells "a little of everything" in her small stand. After four years she is at the maximum CRECER loan size of 12,000 Bolivians because her business has grown so fast. She has a daughter and still lives with her mother and the rest of her siblings contributing a lot toward the household. Her sense of a good life encompassed having good, honest work, access to adequate capital, and not being mistreated. It is important to have work, food and opportunities to study.

She has had an abundance of difficulties in her 24 years; her father died when she was 15, her mother was extremely sick last year with a dental abscess (for which they took out a CRECER health loan) and she got pregnant before she was 20. There isn't much one can do in the face of these kinds of problems besides "be strong" and work hard. There was minimal help available outside family resources though she had strong praise for Jenina of CRECER *Saludable* who helped with the health loan for her mother. The loan was arranged and approved quickly and efficiently.

She noted: "Tendre que trabajar y ahorrar para que mi hija tenga uny major vida"; I need to work and save so that my daughter will have a better life."

When her mother was sick, it was a difficult time for the entire family; even now that things are better she did not feel they had a particularly good diet because they do not eat much fruit and vegetables; they do not suffer from hunger but do not eat as healthfully as they should. Because she still lives with her mother and siblings there is no difference in the way they cook and eat. When she was young it was "*pura haba y arveja; pure fava [beans] and peas*" meaning a very basic, traditional diet. Now everything is different for her daughter, there's yogurt, fruit and other foods not widely available before. Interestingly, the many in the younger generation do not like many of the traditional foods.

Good health starts with good nutrition; if one isn't well nourished that's how one gets sick. She and the rest of the family are in good health but she worries a lot about her mother and some about her daughter.

Her mother could not borrow money; they worked only to eat with few opportunities to get ahead. This gives her many more opportunities than her mother had because she has her own business, decides what she wants to sell and how which gives her much more freedom than her mother had when she was young.

Although she has many more opportunities and a greater sense of belonging she doesn't have time or interest to get involved in community activities and leadership. Because she is unmarried and her father died, she pushes her younger siblings to study and to do well. She sees possibilities because from a history of discrimination, the situation for women is getting better; women were "timid" meaning they did not/could not easily express themselves in ways they can now; "*somos iquales los hombres y mujeres; we're equal, men and women*". Things have to be better for her daughter, especially if she becomes a professional.

She joined CRECER because the group she entered lacked a member and she did not have a business but needed to plan for something because she was pregnant and had finished high school.

She took her current loan, as with all the previous ones, to buy material for her business, cloths, fruit, etc. She always saves out some to buy food or for medical attention. She's at the maximum she can take but hasn't and doesn't want to take bigger loans, preferring to work with what she has now. Her business has grown substantially since she began—borrowing has increased from 1000 Bolivianos to 12,000 in four years as her business has increased in size and variety of things for sale. This has resulted in a substantial improvement in the state of the family; they can buy more things and have more food. If she were to take on larger loans, half would be for increasing the business and half would be for buying land.

She has used most of her savings to help with graduation expenses for her younger siblings, adding to their house and her store. She is a great fan of CRECER and feels she has benefited a lot through her participation. She regularly invites other women to join because of the economic and educational benefits she receives but cautions women not to join if they do not have their own business. They also need to start small; taking the minimum loan to be sure they can manage the business and loan.

Appendix H: Healthy Habits Mini-Survey Results

Measure	Pre-Test (n=73)	Post-Test (n=158)
Clients that knew at least 1 risk of diabetes	61%	70%
Clients that knew at least 1 cause of diabetes (such as drinking soft drinks, consuming food with a lot of sugar or fat, not exercising)	89%	98%
Clients who sought preventive care	48%	49%
Clients who knew at least 2 causes of cancer	8%	21%
Clients who knew that cancer could show up anywhere in the body	19%	40%
Clients who knew causes of high blood pressure	7%	19%
Clients who indicated they ate fruit	60%	77%
Clients who knew the foods they should consume in small quantities	7%	42%
Clients who knew that 9 spoonfuls of sugar is the maximum someone should consume per day	15%	45%
Clients who knew that 1 spoonful of salt is the maximum someone should consume per day	32%	56%
Clients who knew that 4 spoonfuls of fat is the maximum someone should consume per day	2%	35%
Clients who could mention all 5 healthy habits one should have	9%	39%
Clients who reported putting all 5 healthy habits into practice	6%	11%