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Integrating Health Services into Microfinance Operations for Sustainable Poverty Alleviation: The Case of Female Clients in Edo State

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Microfinance role in women empowerment and poverty alleviation has received a lot of focus with negligible attention on health implications. This paper focuses on microfinance and health-integration services as pathway for sustainable poverty alleviation, using cross-sectional survey of 750 purposively selected respondents (400 from microfinance banks (MBs) with integrated health-related services (IHS) and 350 from MBs without IHS in Benin, Ugbowo, Iruekpen, Auchi, Jattu and Ekpoma. Fourteen In-depth interviews and 20 Key Informant Interviews were conducted. Respondents (60.3%) from MBs with IHS, who attached high importance to their health, doubled those from MBs without IHS (30.3%). IHS enabled clients practice preventive health behaviour and payment for health services. IHS helps women value their health and reduces health-risks. MBs should be encouraged and funded to integrate health-related services in their operations.

Key words: Microfinance, Integration of health service, Health education, Poverty

Introduction/Problem Statement

For over three decades, microfinance has been considered as one of the few poverty alleviation strategies that have helped impoverished individuals improve their household economic situation through job creation, development of micro enterprises and improved access to credit facilities (Dunford, 2002; Ozo-Eson, 2008). Despite such enterprise, a large number of women are extremely and experience poor health and inequitable access to health care services. (Human Development Report, 2005). Aside from the reproductive health challenges faced in the bid to contribute to societal continuity and survival, women are victims' of maternal mortality and more distressed from infant mortality resulting more often from poor health conditions (Nwokocha, 2005) and other poverty-related illness. This is further intensified by the poor health behaviour women exhibit in the midst of lack and attempted contributions to house hold needs even when being empowered financially through microfinance (Irobi, 2007).

Furthermore, women's inability to make informed decisions even with regards to their health and payment for health care in a patriarchal society aggravates their experience of poor health and inequality. This complicates their inability to consistently break away from the hold of disempowerment and the challenges of contributing adequately to national development. Their attitude towards their health as well as their behavioural disposition when experiencing illness symptom influences their health status and affects their economic productivity, thereby causing the cycle of poverty and poor health experienced by poor women to continue. Lack of economic empowerment to afford health care services and delay in seeking for medical treatment (Leatherman *et al*, 2012) have aggravated

the poor health conditions of women and adversely influenced their vulnerability to illness conditions. This has contributed to increasing their health expenditures (Drake, 2011) and heightened their economic powerlessness (Russell, 2004)

Microfinance has also been adopted as a strategy that positively impacts on the lives of clients' most of which are women, to improve their lives and lift them off the adverse effect of poverty (Ofori-Adjei, 2007). Studies have shown that female clients of microfinance services in places like India, Bolivia, Ghana, South Africa and some other countries get empowered financially, nutritionally and generally experience good health conditions (Dunford, 2002; Harris, 2002; Saha 2011). Furthermore, studies have repeatedly shown that microfinance institutions abroad have integrated health-related services such as health education through which clients have been educated on the need to practice better health techniques in the area of reproductive health, sanitation, prevention of malaria and reduction of the spread of HIV/AIDS (Leatherman et al 2012, Dunford, 2002; Watson, 2005). Such interventions have improved women's attitude towards their health, promoted the practice of healthy behavioural techniques and ultimately improved the health status of women generally, thereby reducing maternal and infant mortality (Cheston and Kuhn 2002; Dalley-Haris, 2002). However, while very few microfinance banks integrate health services, the influence of such services on women's health remain elusive. Many other microfinance banks do not integrate health care for fear of financial sustainability (Anchola, 2006), challenges of default in loan repayment by their clients due partly to ill-health and deaths and other health-related expenses (Drake, 2011).

Several advocacies and arguments have been made for the introduction of health services into microfinance so as to influence the health behavior of clients and in turn their health conditions. Yet, dearth of empirical information exists on the integration of health services in microfinance institutions in the Nigerian society. Hence, while studies in Nigeria abound on the influence of microfinance on the socio-economic status of women and the alleviation of poverty, negligible attention has been paid on the influence such intervention has on women's health and the need to appreciate the integration of health services into microfinance intervention as a pathway to sustainable poverty alleviation. This informs the focus of this paper which specifically seeks to identify the health related services offered in microfinance banks with integrated health services (IHS), examine the attitude of clients towards their personal health and level of importance attached to their health by clients and document the set and achieved goals of respondents.

Functionalist Theory

The functionalists emphasize that the survival of a whole system is analysed and evaluated as a product of its parts which though different, work together interdependently with a common goal of ensuring the well being of the whole. In this regard, it is also viewed that each part is expected to be functional as a dysfunction in one part may affect other parts and also have an effect on the function of the system. Microfinance as a poverty alleviation strategy is also viewed as a sub of the economic sub-structure of the society which functions to reduce poverty and empower women financially. Furthermore, by introducing the concept of manifest (intended) and latent (unintended) functions, the functionalist expressed how a part can perform a role or function that it was meant for (manifest). It further expresses how it affect other issues or indirectly perform other functions (latent) that it was not intended for. Thus, while microfinance alleviates women from poverty and empowers them financially as a manifest function, its effect may also be felt in empowering them to pay for health care services and reduce health risks due to the financial independence they may experience as a result of their access to loans through microfinance. More so, for

other microfinance banks that integrate health related services, it effect on women's health through health education may not only directly felt in their attitude towards their health, but also in their decision towards taking a health action such as utilization of health care services .

The Health Belief Model conceptualizes decision to take a health action by an individual as motivated by perceived threat (either susceptibility to a particularly condition, or perception that the condition is severe) and judgment about the barriers to taking such action and benefit associated with specific changes in behaviour, which could also be influenced by other issues such as relatives and spouses. The perception of women about their health may influence their attitudes towards health seeking or preventive measures required to maintain a healthy state such as consulting medical practitioners for health care, going for proper check-ups and utilizing healthcare services as part of their priorities. However when symptoms are not perceived as severe or life threatening, women may not utilize healthcare and may be less anxious about their state of health, even with access to the financial means. Again, these perceptions can be influenced by the knowledge people have about health and health care practices which can be acquired or improved, through health education. While the perceived benefits of taking health actions may not only be influenced by the knowledge of these benefits, but also by the access to the health programs and services which can also be provided by a microfinance bank that integrates health related services as shown in figure 1. below.

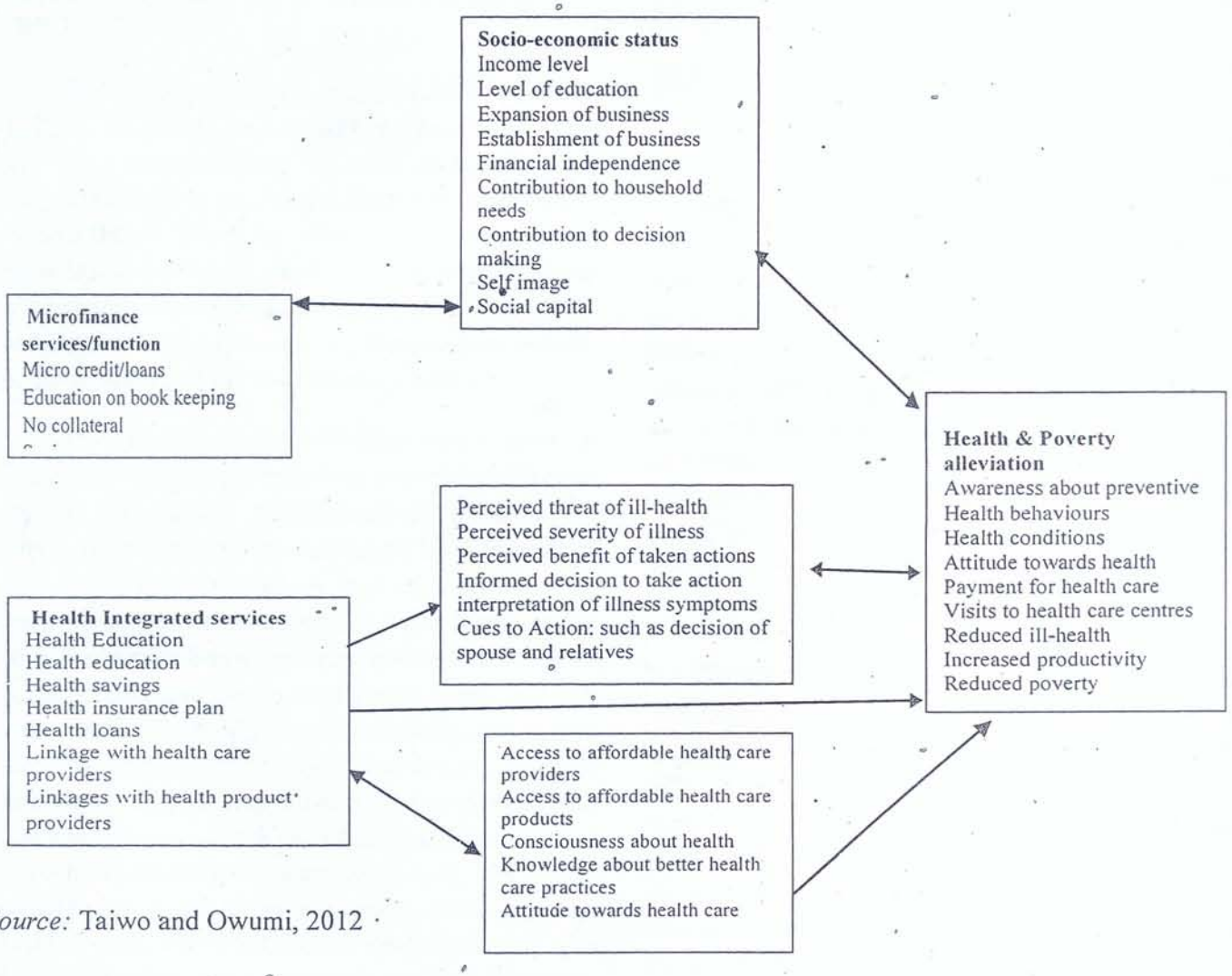
Foult *et al.* (1983) further contributed to this model by saying that patients who understand their problems in terms similar to those of their doctors are more likely to follow treatment procedures than patients who believe their illness results from religious, magical or other sources not generally considered valid by modern medicine. Thus women who do not perceive their health is at risk will not have an attitude to effect changes even when the doctors suggest so. This is because even when it is proven or suggested that more priority should be given by women to their health to avoid breakdowns in the midst of low income, perception of the individuals need to go in line with such view for attitudinal and behavioural changes to occur. Thus, some health integrated services in microfinance institutions such as health education are targeted at influencing women's attitude and awareness about a healthy living and its connection with productivity in business.

Conceptual Framework

Microfinance has been proven to empower women through micro credit to start and expand micro enterprise and trainings on how to manage the enterprise without requesting for collateral based on the recognition that the poor do not have assets that can serve as collateral and on the trust in people and not on the assets (collateral), they own. This in turn influences women's level of education, level of income, occupation, financial independence contribution to household needs and decision as well as their self image. This also influences poverty reduction as well as the health of the clients in terms of their visits to hospital and payment for health care. Their ability to repay loans as well as the interest rates and group pressure are influenced by the success of their businesses, level of income and other expenses which could include household needs and health expenses.

Other non financial services of microfinance that have strongly been advocated for are health education, health savings, linkages with health care providers, prepaid health insurance package. These services provides clients with the opportunities to access knowledge on better health practices, that will also improve their attitudes and consciousness about their health, access to affordable health care and health care products. Such accessibility also influences clients health awareness, visit to health care centres when ill payment for health care and behavioural change

depending on their perception of the threat and severity of such illness and the perceived benefits of taking the action of accessing health services provided. These in turn affects poverty alleviation following the viewpoint that poverty can result in poor health and vice versa.



Source: Taiwo and Owumi, 2012

METHODS

The study is Edo state (the capital of Benin city). This location was chosen because the headquarters of an internationally recognised microfinance bank (Lift Above Poverty Organization (LAPO) which has a health component integrated into its services is situated in it. The state was also selected because of the phenomenal increase in women trafficking which was attributed to poverty and unemployment in the area (Onyeonoru, 2003; Jerome & Owumi, 2007). The 2006 population census put the population of Edo State at 3,218,332consisting of 1,460,461 male and 1,577,871 female thus revealing that the state has more females

than males. There are 18 local government areas in the state with its citizen being involved craftsmanship and agricultural activities. The study adopted a descriptive and cross-sectional in design, employing a combination of the quantitative and qualitative methods of data collection. This involved the use of survey method, In-depth Interviews (IDIs), Focus group discussions (FGDs) and key informant interviews (KIIs).

The study population consisted of women who had been clients of selected MFIs for over three years. The MFIs included three branches of the one with integrated health services (IHS) and four others without IHS in Edo state. Also included are selected microfinance officials such as Managers, Program officers and Client/ Credit Officers (COs) of the MFIs and the (women) representatives/executives (excos) of group/unions of the microfinance banks.

Purposive sampling technique was utilized for data collection at the community (situating MFIs that are over 6 years old), the institutional (MBs that are over 6 years old) and the individual level (clients of MBs for three or above). A total of seven hundred and fifty copies of questionnaire were administered on 400 respondents in microfinance banks that integrate health-related services in their programmes and 350 respondents in microfinance banks that do not. Thirty-four (34) interviews consisting of fourteen (14) in-depth interviews and 20 key-informant interviews with prominent female clients and officials of microfinance institutions respectively were conducted, and finally eight (8) FGDs one for each microfinance and except LAPO Benin, where two FGDS were conducted. The FGDs and interviews were monitored by a facilitator and an interviewer respectively. In both events, discussions were tape-recorded along side with note-taking. While quantitative data were gathered through field-assistants (more of whom were females) who had under-gone a two-days training.

Ethical considerations were ensured before and during the data collection process as respondents consent was sought before commencement of their participation and were assured of confidentiality. The rights of withdrawal at any point or withhold of information that are perceived as impingement on their privacy were completely recognised and no physical harm was experienced by respondents for participating in the research.

The quantitative data were edited and cleaned to reduce errors which could affect the validity and reliability of results. The data which was generated from pre-coded, fixed choice and open-ended questions were inputted using a Microsoft Access Software so as to ensure effective data management and minimize data error. The statistical package of the Social sciences (SPSS) was then utilized to analyze the data at univariate and bi-variate levels to indicate percentages and test of associations. Qualitative data was analyzed using the computer assisted data analysis (CAQDAS) package in line with the objectives of the study after being translated and transcribed.

RESULTS

The socio-demographic characteristics of respondents as shown in table 1, revealed that most of them (nearly 60%) fell within the ages of 31-40 which according to Aina, (1998), Otite and Ogionwo (2006), Ehighiamusoe (2009) represents the most active ages of women in the informal sector where their contributions to societal development are highly felt. The total population of those who were less than 30 and above 50 years of age accounted for only a quarter of the entire population. Over 80 percent of the women (from both categories of microfinance banks) are married. The rest 20 percent who fell within the categories of singles and widowed are covered by the strength of the majority who are married.

Table 1

Demographic Characteristics of Microfinance Bank (MB) respondents

Characteristics	*Total N=750*	*MBs with IHS N=400*	*MB without IHS N=350*
Age in Groups (%)			
21-30	12.0	12.5	11.4
31-40	47.1	43.5	51.1
41-50	27.9	28.0	27.7
Above 50	13.1	16.0	9.7
Marital Status (%)			
Single/Never married	6.1	6.1	6.1
Married	82.1	83.3	80.7
Separated/Divorced	1.7	1.5	2.0
Widowed	10.0	9.1	11.0
Residential Type (%)			
Face to face apartment	46.5	46.6	46.3
One bedroom self-contained	17.1	14.7	19.9
2-3 bedroom flat	32.7	34.9	30.2
Bungalow/Duplex	3.7	3.8	3.5
Residential Area (%)			
Low density	3.8	3.3	4.3
Moderate density	60.3	60.9	59.6
High density	36.0	35.9	36.1
Dependants above 18 years (%)			
1	17.4	19.5	15.6
2	38.3	42.2	33.9
3	18.7	18.7	18.7
4	12.4	10.4	14.7
5 and above	13.1	13.1	13.1
Dependants below 18 years (%)			
1	18.7	17.5	20.1
2	24.0	24.6	23.4
3	30.5	30.4	30.5
4	19.5	19.8	19.1
5 and above	7.4	7.7	7.0

Source; field survey, 2011

Almost half of the respondents (46.5%) reside in face to face apartments, while nearly 33 percent lived in 2-3 bedroom apartments. Those who reported they resided in bungalows or duplex some of which were inherited or belonged to relations, accounted for less than 4 percent of the population.

Table 2
Socio-economic characteristics of Microfinance Clients

Characteristics	*Total N=750*	*MBs with IHS N=400*	*MBs without IHS N=350*
Educational Qualification (%)			
No education	5.9	2.8	9.4
Non-formal education (vocational)	6.9	5.8	8.3
Primary	26.8	27.1	26.6
Secondary	51.7	52.6	50.6
Tertiary	8.7	11.8	5.1
Occupation (%)			
Farming	2.0	2.0	2.0
Trading	86.8	87.7	85.8
Artisan	9.9	9.0	11.0
Private employee	0.8	0.9	0.9
Government employee	0.4	0.5	0.3
Income (%)			
10000 and below	6.7	4.5	9.1
10001-20000	26.8	16.8	38.3
20001-30000	15.1	18.5	11.1
30001-50000	32.8	37.5	27.4
Above 50000	18.7	22.8	14.0
Spouse Occupation (%)			
Farming	4.4	3.8	4.8
Trading	33.6	33.1	34.3
Artisan	40.7	45.4	34.6
Private employee	8.2	9.7	7.0
Government employee	10.8	10.8	10.8
Spouse Income (%)			
10000 and below	4.6	4.5	4.7
10001-20000	9.1	7.8	11.3
20001-30000	11.9	16.3	5.1
30001-50000	56.6	55.3	58.6
Above 50000	17.8	16.3	20.3

Source; field survey, 2011

Furthermore respondents who lived in areas that are perceived to be moderately dense had the highest percentage representing 60.3 percent of the total population. While those who lived in highly dense areas were represented by 36 percent. Again, this shows that respondents socio-economic status were low considering that nearly half of them lived in face to face apartments in these kind of residential area with the stated number of dependants some of who reside in these homes. The level of dependency on the microfinance clients was observed to be high as majority revealed that they had at least two to three dependants both below and above 18 years of age either as their children or siblings staying with them. This supports the views of Daley-Harris (2002) that the influence of microfinance on the well being of clients extends even to their family members. The ages of dependants below and above 18 years were separated considering the fact that youth above this age in Nigeria are considered legally old enough to make decisions themselves and therefore could work and provide their means of livelihood.

Slightly over half of the respondents had secondary education while very few 8.7% had tertiary education with more of them being clients from the microfinance banks that offer health-related services (11.8%). These findings confirmed those of Ehighiamusoe (2009) which revealed that many microfinance respondents in Nigeria lack tertiary education and formal skills. Over 80 percent of the respondents were traders while the rest are farmers, artisans or employees in private and government enterprise. The huge proportion of the respondents who are traders are likely a function of the categories of people being studied i.e microfinance clients, as involvement in a trade is a largely a criteria to accessing loan. Thus, it is not uncommon that while some are involved in other forms of occupation, they combine them with small business enterprise, for which they require loans to expand or sustain while meeting other economic demands.

The income of respondents and their spouse were elicited in order to gain an insight into the average family income of each respondent which has implication for their socio-economic status and in turn, their decision and willing to expend on their health when the need arise. Those with income less than N20,000 were represented by more of clients in MBs with IHS. Over a quarter (26 percent) of the respondents had income range from N10,001-N20,000. These groups were represented by 16.8% and 38.3% of clients of MBs with and without IHS respectively. Nearly half (47.9%) represented by 56.0 and 38.5% of clients from MBs with IHS and without IHS respectively, earned between N20,001-N50,000. It was however observed that the respondent lacked proper book-keeping skill and therefore could not draw a line between the profit they made and the capital of the business. Again this had been expressed by Ehighiamusoe (2009). The income was computed by the daily sales made as revealed by the respondents which are a combination of both profit and capital. Those who earned above N50000 were 18.7% represented by 22.8% and 14.0% of clients from MBs with and without IHS respectively. Although, the income of spouse were speculated and by most of the respondents since they could not give accurate figures, those who reported that their spouse earned between N30001-N500000 per month accounted for over half (56.6%) of the entire population. These were represented by 55.3% and 58.6% of clients of MBs with and without IHS respectively. Thus, while more respondents from MBs with IHS seem to have more income than those from MBs without IHS, the reverse seem to be the case for the income of their spouses.

Integrated Health Services of Microfinance banks (MBs)

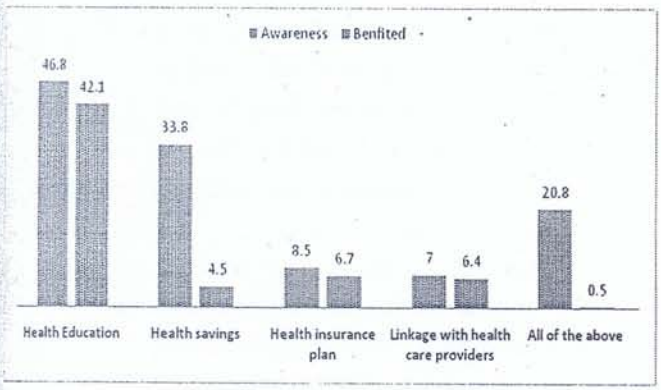
For the purpose of the study, there was need to identify the services of microfinance banks which are targeted at meeting the health needs of clients as the first objective. This is especially due to the fact that greater

reduction in poverty is experienced when microfinance services are combined with increased access to social services including health. (Dunford 2002, Harris 2002, and Saha, 2011). A significant proportion of the respondents (68.0 percent) revealed that their Microfinance bank (MCB) offer health-related services. However, only one microfinance bank Lift Above Poverty Organization (LAPO) with its other branches, fall under this category. The other microfinance banks provided only financial services.

Respondents in MBs with IHS who are aware that the microfinance bank integrates health services.

On the type of health-related services rendered, 46.8 percent of the respondents who aware that their banks offer health related services, stated that their banks offer health education as part of the health- related services. While 33.8 percent of the respondents mentioned health savings are part of the health-related services rendered.

Fig 1. **Percentage of respondents in MBs with IHS by awareness and benefit from health-related services**



Other health-related services that were known to be offered by the microfinance banks are health insurance plan (8.5 percent) and linkages with health care providers (7 percent). Also, about 20.8 percent of the respondents added that their microfinance bank offer a combination of all the stated health-related service.

Majority of the clients were aware of the existence of health-related services in their microfinance banks (this is however peculiar to clients who are from health related service microfinance banks). A fewer majority are however aware of the type of health-related services offered by their microfinance. Further responses also showed that the major service offered is health education as this was expected to improve the knowledge of clients about health care practices which could include, adequate nutritional practices, good sanitation (both personal and environmental), family planning, malaria prevention, immunization, HIV/AIDS prevention and others. Such knowledge will one way or another, influence the attitude of women towards their health, make them more conscious about their health, boost their level of consciousness about their health and encourage preventive strategies of ensuring good health. Health savings was another major services as this was expected to encourage clients to save towards maintaining good health and cope with the cost of illness when the need arise as buttressed by Saha 2011.

Health savings could also contribute immensely to the financial sustainability of microfinance banks. It was also necessary to get information on the perceived benefits of respondents with respect to the health-related services of the microfinance banks. On this note, 42.1 percent of the respondents stated that they had benefitted from health education services. About 6.4 and 6.7 percent stated that they had benefitted from linkages with health care providers and health insurance plans respectively, while 4.5 percent stated that they had benefitted from health savings. Two respondents (0.5 percent) added that they

benefitted from all of the programs. This goes further not only to show that some microfinance banks in Nigeria are integrating and have integrated health-related services along side with credit services, but that clients of these banks also benefit from these services. Although the study found the integration of health-related service in only one major microfinance bank which does not only have very wide coverage, but has met international standard and accreditations. The other microfinance banks are not only small in size, but are yet to integrate health-related services into their credit/financial services.

Health education of client is one of the major areas that microfinance has influenced the health of their client in their integration of health-related services. An official from the health service providing microfinance confirms this by saying:

> *We combine financial services with health-related service in our microfinance organization, because we are very much aware that if poverty is to be alleviated, then the health aspect must also be taken care of. An unhealthy client will not be productive to make money out of the loan we have given her and pay it back rather she will spend it on ill-health and there is nothing you can do about it, except refusing to give her another loan. Hence we train their union representatives on health matters especially in the areas of preventing major diseases like malaria and typhoid and discussing health issues like good nutrition, family planning, even HIV/AIDS. (female/manager/KII/ Ugbowo/March 2011)*

Another official from a microfinance bank that integrated health related services went further to explain the types of services offered by stating:

> *We also give them health talks on keeping their environment and themselves very clean, Immunizing themselves and their kids and treating diseases when they feel their symptoms because we observe that most of them manage sickness symptoms until they can no longer get up and have to be admitted in the hospitals. We have also devised means to make them save in advance for their health so that they can have access to health loans if need be...(female/ manager/MBs with IHS/KII/Benin city/March 2011)*

The above response supports Saha (2011), illustration that there is great reduction in poverty when microfinance are combined with increased access to basic social services including health services especially because poor women who have access to credit but not to health service are still living in poverty coupled with poor health.

From the information above, it is obvious that while realizing the enormous task involved, this microfinance organization aside from providing credits or funds through microfinance has concern for improving the lives of the poor through health enlightenment and other social empowerment. Hence their services includes provision of social and health education which is aimed primarily at delivering information on HIV/AIDS, breastfeeding, measles, malaria, family planning and management/prevention of diarrhea. One of the women representatives during the in-depth interview in Benin-city responded in line with that of the official by saying:

> ...They talk to us on cleanliness, keeping our environment clean to prevent mosquitoes and sickness

like malaria. They discuss family planning with us and how to prevent unwanted pregnancies, immunize and breast feed our babies. It was in one of the sessions I ever knew that female condoms exist and how it can be used. They train us on these health issues and ask us to always create time to talk about it in our unions so that we can make more money and pay their loan which is compulsory too. They also train us on how to manage our business very well. That is why I am proud to be a member of this kind of microfinance bank. It is very helpful to us. (Female group leader/HRSmb/IDI/Ugbowo/April 2011)

The above response also reveals that aside from health-related services, the microfinance banks train their clients on business skills and management in order to ensure financial sustainability in their business which in turn will impact on the microfinance banks themselves.

On the contrary, during one of the Focus Group Discussions (FGDs), one of the discussants from a microfinance bank without integrated health services in Benin City responded annoyingly by stating.

We do not have any health discussion or service in the microfinance bank where I collect my loan, theirs is for you to pay back their money no matter what and face trouble if you don't. The thought of making sure that the contribution on Thursday is compulsory even makes me develop blood pressure, but nobody cares about that. It is purely a financial setting even the interest rate is high as if they are trying to use our money to enrich themselves. They do not care about our health let alone talking about it with us. Although the money I borrow from them helps me take care of my health a times. (Female group leader/FGD/ Ugbowo/march 2011)

The above response again reiterates the fact that respondents who do not have access to integrated services even in the form of health education feel exploited and not being cared for. This is especially so with relation to their evaluation of the goal for which microfinance was introduced vis-a-vis poverty alleviation. The concern about the high interest rates and repayment of loans which must be ensured for the banks to be financially sustained are misunderstood to be exploitative and having a negative influence on respondents health.

Perceived influence of microfinance access to health care services

In relation to the perceived influence of microfinance on respondents' health care and payment for health care, findings from the study revealed that microfinance had in one way or another, influenced clients' health care by empowering them to be able pay for health care services and afford the necessary drugs required during the course of seeking for treatment.

Several clients revealed how microfinance had empowered them to access health care as well as practice health improving strategies both in the qualitative and quantitative data. Table 4 below, provides the percentages of respondents' perception on the influence of microfinance on their access for health care. Not less than 40.7 percent of the respondents stated that their involvement in

microfinance has influenced their health care and payment for health care services. This consisted of 56 percent and 23.1 percent of respondents from MBs with and without IHS respectively. In these regards, 37.3 percent of the respondents affirmed that microfinance had empowered them to afford all the required drugs when undergoing treatment for health care.

the other bank. Furthermore, 43 percent of respondents from MBs with IHS as against 0.9 percent of respondents from MBs without IHS reported that their knowledge about their preventive health care had improved as a result of their involvement with microfinance. This goes further to emphasize the fact that the health education services offered by MBs with IHS, has influence on the knowledge of their respondents regarding their health. Also, 41.5 percent of respondents from MBs with IHS reported that they can afford to pay their hospital bills, while only 18.6

Table 3.
Distribution of Respondents' by perception of the influence microfinance on their access to healthcare services (HCS).

Variables/Categories	*Total N=750*	*Health-service MCB N=400*	*No-health service MCB N=350*
Microfinance influenced payment for HCS (%)	40.7	56.0	23.1
Perceived influence of microfinance on respondents' access to HCS (multiple responses) (%)			
Empowered financially to buy necessary/ required drugs	37.3	49.0	24.0
Improved knowledge about preventive healthcare	42.0	43.0	0.9
Afford to pay healthcare bills	30.8	41.5	18.6
Empowered to make health care decisions independently	31.5	43.5	17.7
All of the above	20.0	37.5	0.0

Field survey, 2011

The responses however revealed that the influence was felt more by respondents from MBs with IHS as 49 percent of these groups, responded in this regard, as against 24 percent of respondents from MBs without IHS which was less than half of the respondents from

percent of respondent from MBs without IHS responded in the same light. The trend is not so different for responses regarding being empowered to make independent decisions about their payment for health care, as the percentages of respondents who confirmed

this from MBs with and without IHS are 43.5 percent and 17.7 percent respectively. Furthermore, while 37.5 percent of respondent from MBs with IHS stated that microfinance has influenced them in all of these areas, none of the clients from MBs without IHS responded in this regard.

It is however interesting that microfinance has a general influence on the health and access to health care of clients. Although the influence differs from the type of microfinance bank to another as more clients from MBs with IHS experienced more influence than clients from MBs without IHS. Access to loans microfinance loans by clients was reported to have empowered clients to be able to afford health care services, take independent decisions regarding their health care and effectively involve themselves in health-related practices such as eating good food, sanitation, quick health care intervention and proper rest. These are some of the direct and indirect benefits of health educating clients which confirms the views of Dunford 2002 and Saha 2011.

A union leader in one of the interview sessions reported to this issue by saying;

> ...Before I join this microfinance bank, I use to borrow money even to buy ordinary malaria drug when I feel sick once in a while. I cannot even think of hospital because of money. Worst still, I will buy drug from chemist. But now, I can buy the drugs I need and even go to hospital without borrowing money because my health is very important. I even eat very well and rest when I am tired so that I don't fall sick anyhow... (Union leader/ MB with IHS/ Benin/ March, 2011)

The above response supports the views of Butcher, (2010), which states that microfinance economically empowers women and influences their health behaviours in three ways, two of which are that it will increase health expenditure, and increase the ability of clients to cope with illness. It also obvious that women can have access to better health care facilities and eat more nutritious food main batter health conditions. The above response supports the views of the health belief model which opines that respondents will engage in health-seeking behavior when they perceive the benefit of taking such actions as high. Thus, respondents who perceive that eating good food and resting properly will reduce illness will practice it to improve their health. The responses from some of the FGDs both categories of MBs were also very fascinating as majority of the discussants affirmed that their involvement in microfinance has helped them in one way or another in matters relating to their health especially during the rare periods that they fall sick. Their responses ranged from issues of no longer having to borrow money to see a doctor as they can take some from their market money to do so, no longer buying fewer drugs or not buying at all, no longer eating below standard, no longer waiting for their husbands to come and give them money and decide when they should see a physician when they are sick due to dependency on their financial supports.

It should however be noted that majority of the respondents stated that they hardly ever fall sick, as most added that they only cater for their sick children or family members. A discussant in the FGDs stated:

> ....Actually, women hardly ever fall really sick. If you see a woman in the hospital, most of them are there to cater for their children or spouse, only on very rare occasion do you see a woman in the hospital for treatment of sickness except when she is pregnant. I for instance I can't remember the last time I went to the hospital for treatment of one serious sickness after I delivered my last child 5 years ago...(Female/ FGDs/Ugbowo/ March, 2012)

Most of the discussants in the FGDs supported this response. Again the view of the health belief model on the perceived severity of illness conditions influences individuals understanding of being ill and seeking health care.

Table 3

Importance attached to personal health care

	Importance attached to personal health by respondents of two categories of MBs (%)		
	Highly important	*Moderately important*	*Less important*
Health-related service MB	60.3	28.8	10.3
No health related service MB	30.3	30.0	39.7

Table 3 shows that 60 percent of women from MBs that integrated health services attached a high importance to their health. This is twice the percentage (30.3) of those from MBs that do not. The percentage of clients of MBs without IHS who reported they attach less importance to their health is over three times that of clients from MBs with IHS. The disparity in the importance attached to their personal health by client is likely to be a function of the health education services that clients from MBs with IHS have been exposed to. It was hypothesized that:

"Women under microfinance banks that integrate health related services will display more positive attitude towards their health than those that those from microfinance banks that do not integrate health related services"

Table 4. shows the result of the analysis of variance on respondents attitude towards their personal health which revealed a significant difference in the attitude of women under microfinance banks that integrated health Services among women under microfinance than those women who are not under microfinance banks ($F=26.563$, $df=4$, $P<.05$). It could be observed from the table that the respondents have positive attitude towards their personal health considering the mean score of the clients from both MBs with and without IHS being 63 and 47 respectively. However,

Table 4

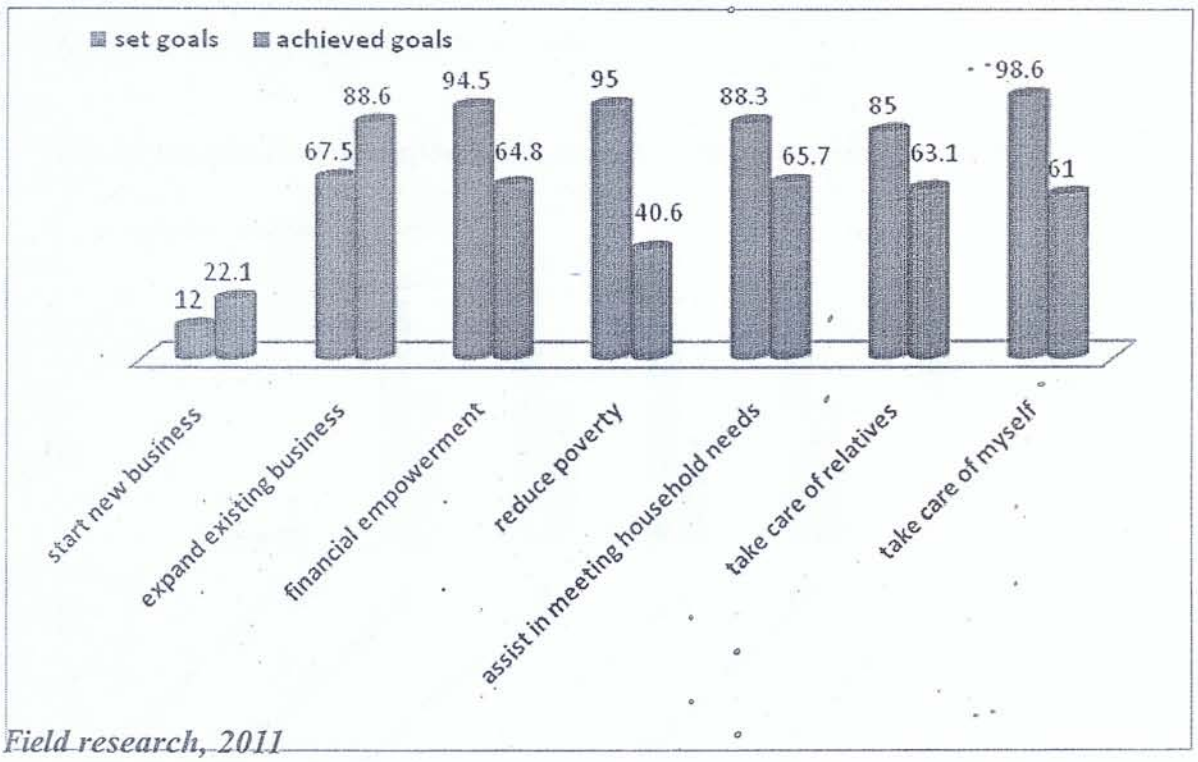
Analysis of variance on respondents' attitude towards personal health care

Microfinance banks	N	Mean	Std. Dev.	F-Value	df	P-Value
with integrated health services (IHS)	400	63.9650	3.3549	26.563	4	.000
without integrated health services (IHS)	350	47.8914	4.0617			

The hypothesis that female clients of microfinance services that integrate health services are likely to display more positive attitude than those from microfinance banks that do not integrate health services is therefore accepted. The implication is that more women from microfinance may likely seek for health care or display better health practices towards maintaining a healthy living considering their they have higher attitude.

Microfinance clients were also asked questions regarding the goals they had set as well as the ones they had achieved as microfinance clients to complement the responses.

Fig 1: Distribution of respondents from MBs with IHS by set and achieved goals



Field research, 2011

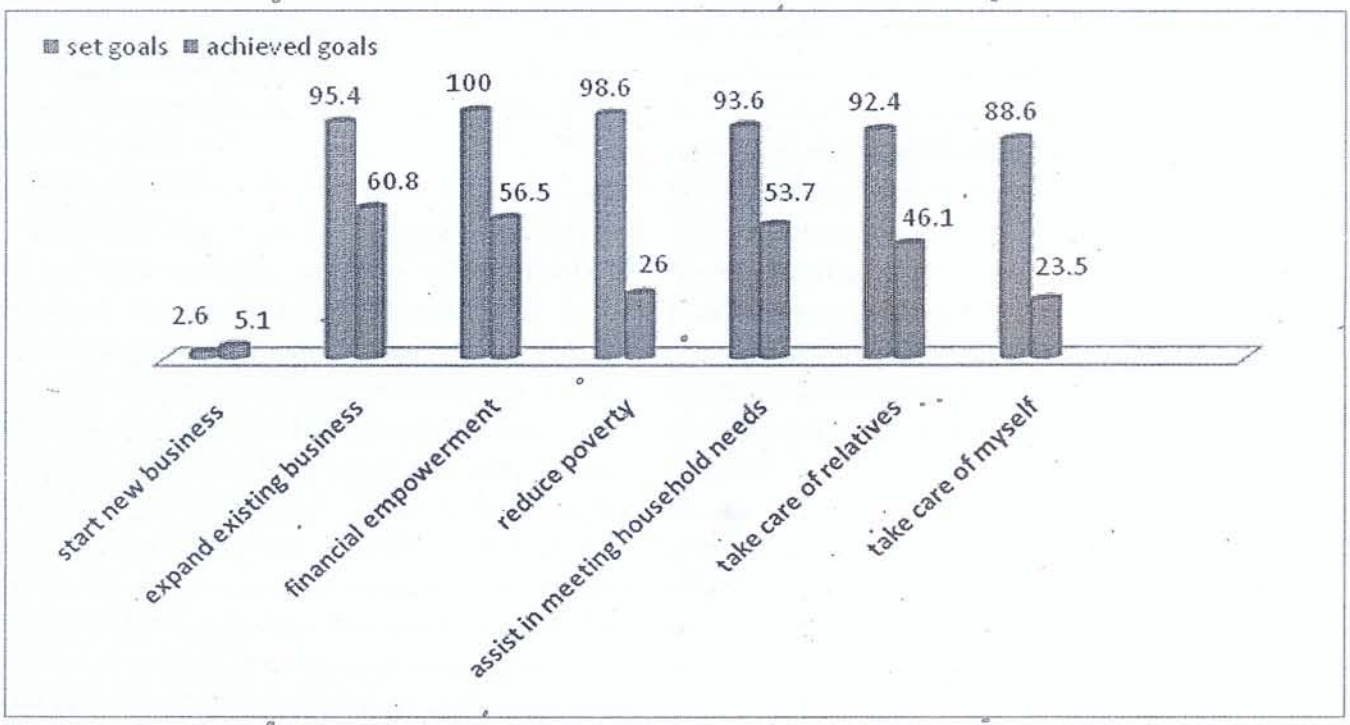
All the respondents from the health-related service microfinance banks (100%) reported having goals or reasons for patronizing microfinance. Furthermore, 99.7 percent which is also equivalent to all the respondents gave similar response from non-health-related microfinance banks. These shows that clients who apply for loans in microfinance banks do not just do so because they are aware of the existence of the loans, but because they are faced with poverty-related challenges that require financial intervention. Amongst the goals stipulated by clients for joining microfinance are to start a new business, expand existing business, get financially empowered, assist in meeting house hold needs, take care of relatives, reduce poverty and take care of themselves.

Findings revealed that nearly all the clients of both microfinance banks above ninety-five percent for both microfinance, have existing business which they intend to expand as a goal for joining microfinance. The same

goes for the issue of financial empowerment. Reduction of poverty is another major goal of joining microfinance banks as 75 percent and 98.6 percent of clients from MBs with and without MBs respectively reported it as part of their goals for joining microfinance banks. These responses especially with respect to reduction in poverty and financial empowerment of women, confirm the major reasons for the emergence of microfinance as stipulated in the articles of Ehighiamusoe 2009, Littlefield et al 2003, Anyanwu 2004, Egbu 2004, Morduch 2005.

(2007). On the over all, an average of ninety percent (90 percent) of the respondents aim at meeting their house hold needs as part of the goals they set for joining microfinance banks, although, more of the clients with this goal (93.6 percent) are from MBs without IHS. In line with the above, over 85 percent of the respondents also aim at taking care of relative or dependants as part of the goals they set to join MBs with majority (92.4 percent) of these group being clients from MBs without IHS, while ninety-

Fig 2: Distribution of respondents from MBs without IHS by set and achieved goals



Field research, 2011

Furthermore women also want to be relevant in the households as assisting spouse in meeting house hold need was another goal majority of them aspire to fulfil as microfinance clients. Thus, women in the course of spending their income, spend a great deal on house hold needs as also buttressed by Irobi

three percent want to be able to cater for their personal needs or take care of themselves.

It is expedient to note that the set goals for clients were higher than the achieved goals except with reference to the goal on the need to start a new business for both clients including the expansion of

existing business for clients from MBs with IHS who set goals in this regards is less than the achieved goals. Majority of the clients from this category of microfinance banks had channelled their aspiration to being financially empowered, reduction of poverty and personal care. Also, very few of all the respondents from both categories of microfinance banks, aspire to start a new business as a goal for joining microfinance banks. This is not unconnected with the fact that most microfinance clients are usually into one microenterprise or another before seeking for loans or financial supports from microfinance banks. This is reflected and confirmed by the very high percentage of clients from both microfinance banks who aim at expanding their already existing businesses. The few, who had achieved starting a new business, were those who had either opened new branches or had more finances to divert into some other business aside from their existing ones.

Interestingly all the mentioned goals were achieved above average except reduction in poverty and clients taking care of themselves. More so, achievement of each set goal was reported more among clients from MBs with IHS especially with regards to being able to take care of themselves. This is probably due to the health education received by members from this category of microfinance bank, or due to the accessibility to funds and lower interest rate experienced more by clients this MBs. However, the low response with respect to being able to reduce poverty, goes further to show that much still remains undone by microfinance banks in alleviating poverty among their clients and the yet to be reached population of the very poor in the society who make up the population of marginalized women in the Nigerian community. It is however pertinent to note that 40.6 percent of clients MBs with IHS reported that they had experienced reduction in poverty. While only 26 percent of clients from MBs without IHS reported they experienced same. Again, the role of integrating health services comes to play as this has a direct or indirect effect in the reduction of poverty in terms of maintaining better health which reduces health risks and increases productivity as illustrated by Butcher 2010 and Saha 2011.

CONCLUSIONAND RECOMMENDATIONS

The influence of microfinance on women empowerment and poverty alleviation is observed across continents in the world. A new dimension to increasing its impact is the integration of health services. This is connected to the fact that poverty and poor health are two phenomena that continually interplayed with one, influencing and leading to the other in both directions. Several studies abroad have in recent times advocated for and argued in favour of integrating health services into microfinance program. While several microfinance banks abroad have integrated health services into their programmes and recorded positive results and surmounted challenges of cost and financial sustainability. Those in Nigeria except for LAPO are yet to adopt such models for fear its implication on the financial sustainability of the organization, default in loan repayment, management both health and financial programmes and anticipated inability of sustaining a health integrated programme. By comparing the views of clients from branches of the microfinance bank that offer only financial services, the study has established the essence of integrating health services into microfinance activities in alleviating poverty as more clients of microfinance banks with integrated health services experienced reduction in poverty. Thus, it is recommended that:

- Adequate educate of clients on the need to be conscious of their health in order to ensure increased level of awareness and positive attitude towards their personal health which is essential in elongating their life span and contributing to national development should be

an integral services of every microfinance bank.

- Microfinance banks in Nigeria integrate services in Nigeria.

- Government and other international organization should provide increased support for both locally and internationally recognized microfinance banks in Nigeria to enable them offer health integrated services to their clients.

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