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**MICROCREDIT SUMMIT CAMPAIGN**  
A Project of RESULTS Educational Fund

# Integrated Health and Microfinance in India:

**Harnessing the Strengths of Two Sectors to  
Improve Health and Alleviate Poverty**

*State of the Field of Integrated Health and Microfinance in India, 2012*





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# Integrated Health and Microfinance in India: Harnessing the Strengths of Two Sectors to Improve Health and Alleviate Poverty

**State of the Field of Integrated Health and Microfinance in India, 2012**

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## When microfinance secures health

Foreword by Ela R. Bhatt, Founder, Self-Employed Women's Association

Microfinance is today primarily understood as a financial activity, but it actually emerged from important development considerations. The need for access to capital was specifically articulated by women during the United Nations' Conference on Women and Development in Mexico City in 1975. The term "microfinance" came much later, and its association moved from savings to microcredit to financial services. However, the primary objective of microfinance has always been developmental in nature, aimed all along at removing poverty and hunger. But these two aims cannot be addressed adequately without factoring in the issue of health.

All too frequently, the poor default on paying back their loans because of the ill health of the borrowers—the accumulated financial strain of health care and being unable to earn. A poor woman's health is the first and foremost asset of her work and her life. For microfinance to achieve its objective of providing financial security to the poor, it has to address health security as a crucial element of social security. They are, indeed, two sides of the same coin.

When I started organizing informal-sector labor in the late 1960s and early 1970s, I asked the poor what they wanted the most. Invariably, it was work they sought and not charity. Yes, they longed for a better life but not one without dignity. At the same time, it was clear that their earnings could easily be wiped out without support services—most importantly, health and childcare.

In the final analysis, it is the women of the household who balance the family budget. They can, therefore, play a pivotal role in nourishing not just kinship ties, but the health and well-being of the family as well. Thus, when she borrows from a microfinance institution (MFI), she sees it not just as access to money, but access to an input that will strengthen her family. To ensure that women continue to play this pivotal role in MFIs, we must ensure they are protected through social security and health security.

As this report points out and illustrates with its examples of MFIs and healthcare providers that are

working together to improve the health of poor women and their families, an integrated approach to health that links microfinance with health can be enormously important for development. Health financing that includes health micro-insurance, flexible savings and emergency health loans are helping the poor to access and manage the costs of health care. Housing loans and loans to access clean water and sanitation systems—or even mosquito nets—improve living conditions and lead to better and healthier lives. Our experience shows that in isolation microfinance only partially meets the needs of those who are poor. Loans can easily become irrelevant in the absence of appropriate mechanisms to improve health knowledge, access to appropriate services and to finance health and insurance or housing needs.

It is my sincere hope that Indian microfinance and development practitioners, healthcare providers, policymakers and funders will heed the call to action imbedded in this report and take the necessary steps to achieve the promise of greater collaboration between the microfinance and health sectors. MFIs should invest in the provision of contributory, participative primary healthcare, build capacities at the community level for the delivery of this service—including the preparation of trained health workers at the local level—and provide a range of financing products to enable greater access to health services and protection from health shocks for their clients. Healthcare providers need to look to the important social intermediary role that MFIs play in local communities and the networks of millions of women borrowers and savers that can be accessed through partnership with the microfinance sector.

A government that fails in its duty to provide basic healthcare services at the local level adds to the indebtedness of the working poor and weakens its own ability to advance and grow as a nation. This is why, finally, it is vitally important that the Government of India look to the linking of the microfinance and health sectors as a particularly promising strategy for harnessing the strengths of two sectors to improve the health of the most vulnerable.

# Preface

The idea for this report grew out of a meeting of leaders of the microfinance and health communities held in Ahmedabad, India in July 2011, thanks to the support of the National Bank for Agriculture and Rural Development (NABARD), the Small Industries Development Bank of India (SIDBI), Johnson & Johnson, Ananya Finance for Inclusive Growth, and the Council for Scientific and Industrial Relation (CSIR). In an unusual exchange, leaders from microfinance and health—two diverse sectors—shared information, approaches, impact evidence, and the opportunities and challenges of combining health and microfinance to reach millions of underserved poor in India. They urged us to tell the story of this emerging field more broadly.

Freedom from Hunger, the Indian Institute of Public Health at Ghandinagar, and the Microcredit Summit Campaign prepared this report to inform and educate policymakers, microfinance institutions (MFIs), self-help promoting institutions (SHPIs), private and public health providers, researchers, donors and social investors, and other stakeholders about approaches to combining microfinance and health. We hope it will catalyze dialogue and debate and encourage further exploration of the potential to combine microfinance and health for a low-cost approach to improve health and productivity of the Indian poor.

We are grateful for the financial support of the Johnson & Johnson Foundation, NABARD, and SIDBI, who agreed that it was important to share more broadly the current state of the Indian field of health and microfinance. We especially acknowledge and thank the many pioneering microfinance and self-help promoting institutions, healthcare providers, and others who are working across sectors to improve the health and financial security of vulnerable Indian families. They have generously shared program information and experiences so that others might learn about both the opportunities and challenges of linking microfinance and health.

Kathleen Stack, Vice President for Asia and Africa, Freedom from Hunger  
 Dr. Dileep Mavalankar, Director, Indian Institute of Public Health, Ghandhinagar  
 Larry Reed, Director, Microcredit Summit Campaign



# Introduction

The microfinance crisis in India has been front-page news. What many do not know is that India's microfinance sector has become a promising platform for reaching the poor with vital health information, products, and services. Scores of microfinance institutions (MFIs) and self-help promoting institutions (SHPIs) regularly educate their clients and members on a wide range of health topics, from child and maternal health to prevention and management of diseases such as malaria, HIV/AIDS and diabetes. Some run health camps or have established health clinics. Others have innovative partnerships that connect microfinance service users with healthcare providers through telemedicine. Some institutions offer healthcare financing through health loans, health savings and health insurance.

*An otherwise difficult situation has created an opportunity for microfinance to tackle one of the biggest barriers to economic advancement of the poor: ill health*

The microfinance environment in India is changing. MFIs face new regulatory guidelines and more cautious banks and investors. This has led them to re-commit to client-centered products and approaches. National Bank for Agriculture and Rural Development's (NABARD) SHG II calls for strengthening SHPIs and self-help groups (SHGs), and improving financial products and linkages with banks for their members. There is a renewed focus on social performance throughout the sector. An otherwise difficult situation has created an opportunity for microfinance to tackle one of the biggest barriers to economic advancement of the poor: ill health.

The benefits of combining microfinance and health are evident from cases presented in this report. MFIs and SHGs have achieved significant impacts in areas such as neonatal and maternal mortality and infant and child feeding (Metcalf et al., 2012; Tripathy et al., 2010). Rigorous cost studies have demonstrated the low marginal costs for MFIs to provide health services and good indications of a positive impact on the MFI bottom line (Reinsch, Dunford & Metcalfe, 2011). However, there is much more to learn. We need to determine the most effective and low-cost packages of health services that microfinance can provide. Which delivery systems work best? How can services be scaled for maximum outreach to MFI clients and SHG members? What can be done to educate the health sector about how best to work with microfinance service providers?

The microfinance sector cannot be a substitute for the health system. However, where tens of millions lack access to health information, services and financing, the microfinance sector—with its vast and regular contact with the poor—can go a long way to fill the gaps.

# India's Microfinance Sector: Opportunity Out of Crisis

India continues to be the home of the largest microfinance industry in the world. This global market dominance has continued since the late 1990s. *The State of the Microcredit Summit Campaign Report 2011* shows that there are a little more than 93 million microfinance clients in India. This represents close to one-half of the estimated 205 million microfinance clients reached worldwide (Reed, 2011).

Since late 2010, however, the sector has faced many critical challenges, particularly in the state of Andhra Pradesh where there was a major collapse in the market. In the fiercely competitive race to expand, many lenders lost sight of the value in paying close attention to client needs. Swept up in the intense competition among MFIs, many clients in this state took out multiple loans (an average of nine times) (Maes & Reed, 2012). When some of these clients couldn't repay their loans, some MFI loan officers resorted to coercive collection practices. Several over indebted clients committed suicide, which attracted widespread publicity in the press. The state government responded by enacting a harsh law that essentially made it impossible for MFIs to recover existing loans or enroll new customers. Many MFIs curtailed or suspended their operations in Andhra Pradesh as a result.

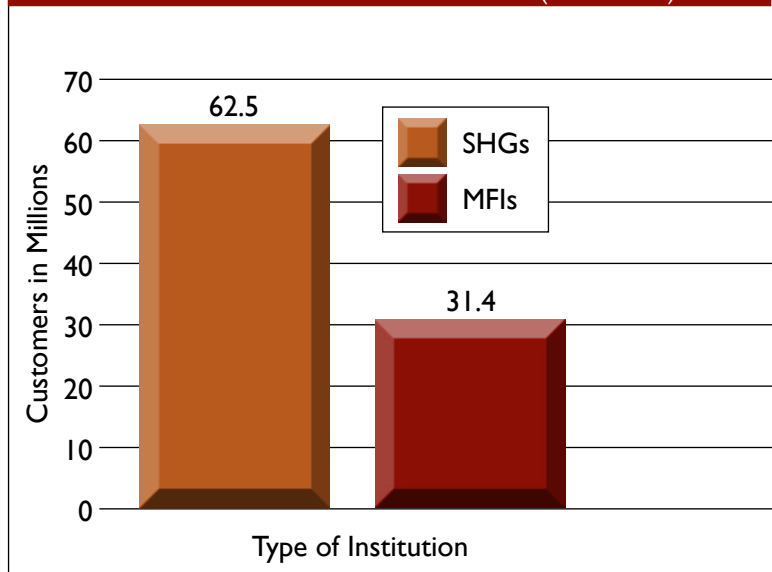
In response, the Microcredit Summit Campaign (Maes & Reed, 2010) and its partners have called on the microfinance community to refocus efforts on what clients most want to achieve: "[Clients] want regular meals for the whole family, a secure and safe place to live, and education that gives their children a better life.... When we design our financial services and other support systems so that our clients can achieve these objectives, then we will be providing a tool that our clients can use to help free themselves from the shackles of poverty."

## Forms of lending and how they function

The two most prominent models of delivery for microfinance in the country continue to be SHGs, promoted by the state governments, non-governmental organizations (NGOs) and a few

Regional Rural Banks, and specialized MFIs that use various models to make both group and individual loans.

FIGURE 1: MICROFINANCE CLIENT OUTREACH IN INDIA (2010–2011)



Source: *Microfinance India: State of the Sector Report 2011*, Access India.

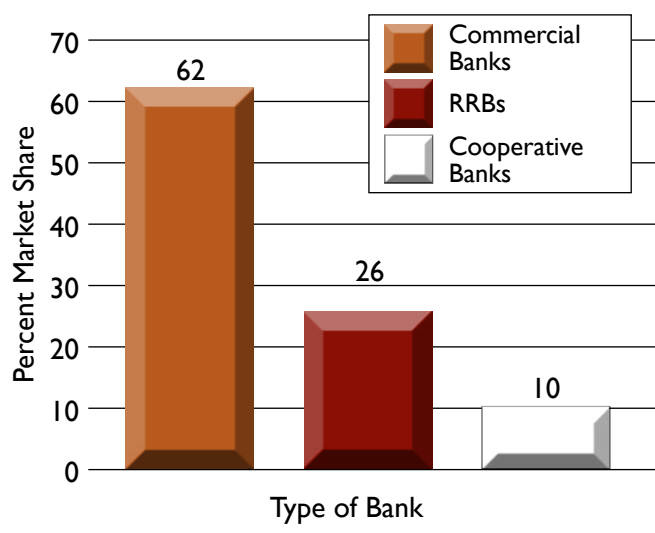
## Self-help groups

Self-help groups (SHGs) can in many ways be considered the cornerstone of much of the microfinance activity in India. These small groups (10–20 members each) of predominantly rural women coming together to form savings and credit organizations, are well established in the country. As shown in Figure 1, they represent the largest vehicle for client outreach. In response to SHG growth and influence, policymakers took notice and established a countrywide Self-Help Group Bank Linkage Programme (SBLP) in the early 1990s. SBLP, promoted aggressively by NABARD, links mature SHGs with the formal banking system (commercial banks, Regional Rural Banks and cooperative banks).

SHGs are linked to Regional Rural Banks (RRB), commercial banks and cooperative banks to access microcredit as a source of additional capital for the group members to supplement their savings. As illustrated in Figure 2, between 2010 and 2011, commercial banks serviced 64 percent of all SHGs with outstanding loans, followed by RRBs at 26 percent and cooperative banks at 10 percent.



FIGURE 2: MARKET SHARE OF NUMBER OF SHGs WITH OUTSTANDING LOANS BY BANK TYPE (2010–2011)



Source: *Microfinance India: State of the Sector Report 2011*, Access India.

The number of SHGs in India is geographically skewed. The southern part of the country has the greatest concentration (55.3 percent), followed by the eastern region (24.3 percent). In the northern and northeastern parts of the country, where poverty is the most pervasive, growth of SHGs has been slow. The Government of India, NABARD and the Central Bank are making persistent efforts to facilitate growth of SHGs in those regions that need them most. NABARD, in particular, is working to energize SHGs through a reengineering with the SHG II program and model, which is still emerging.

## Microfinance institutions

Microfinance institutions (MFIs) in India have had phenomenal growth in their client outreach over

the last decade, but it has been very concentrated. The top 10 Indian MFIs accounted for approximately 76 percent of client outreach and 76 percent of outstanding loan portfolio as of March 2011. Overall, MFIs posted growth rates of 6.4 million clients and about 26.4 percent in loans outstanding during 2010–2011.

## Recent challenges and a prognosis for the future of microfinance in India

A close examination of the industry growth rates over the last year shows evidence of slowed growth. This slowdown can be directly linked to the crisis in the state of Andhra Pradesh, which accounts for more than 30 percent of all borrower accounts. The crisis resulted in a drop of more than 20 percentage points in the number of new client accounts served between 2010 and 2011. Growth in these accounts, while still a healthy 20 percent, was much lower than the 43 percent growth of the previous year (2009–2010). Indications are that the industry has stabilized and commercial banks that had stalled any lending to the sector are slowly re-entering the market.

There is evidence that in India, and indeed globally, the microfinance market is changing. One of the main lessons learned from the Andhra Pradesh crisis is that customer focus cannot be compromised. The crisis was a wake-up call to government and the industry. The two leading industry associations, Sa-Dhan and Microfinance Institutions Network (MFIN), have created a unified Code of Conduct (CoC) intended as a safeguard against similar future meltdowns and to ensure that microfinance services

TABLE 1: PROGRESS OF MFIs

	2009	2010	Growth rate (percentage)	2011	Growth rate (percentage)
No. of MFIs reporting	233	264	—	170	—
Customer outreach (million)	22.6	26.7	18.1	31.4	17.6
Outstanding loans (billion rupees)	117.34	183.44	56.7	207.56	13.1

Source: *Microfinance India: State of the Sector Report 2011*, Access India.

benefit clients in a holistic, ethical and transparent manner.

In addition, the Andhra Pradesh statute triggered a comprehensive response from the Indian government. The Malegam Committee's recommendations and extensive consultations with the banks, microfinance practitioners and their networks have resulted in a well-rounded Microfinance Regulatory Bill that, if enacted, is likely to help the sector continue to regain its legitimacy and encourage the banks to resume lending to the sector, lifting the liquidity bottlenecks.

Indian microfinance is experiencing a historic shift from a nearly exclusive focus on financial performance of MFIs to a more active concern for their clients. Overall we are beginning to see much more emphasis on the social performance of the industry, with a focus on client protection and institutional transparency, especially regarding the cost of funds. There is also a new openness in the sector for MFIs to add valuable additional social services to improve the condition of the poor. In this context, organizations like SIDBI and other MFI investors and funders are playing an active role in impressing upon MFIs the importance of responsible microfinance practices and the adoption of microfinance plus activities such as health to bring about a positive transformation in the lives of their poor client families.

# India's Health Sector: Cause for Both Celebration and Concern

The public health sector in India is at an important crossroads, with Government spending on health poised to nearly double from 1.4 to 2.5 percent of GDP by the end of its twelfth five-year plan (2017),<sup>1</sup> radically increasing its share of overall health spending. This increased spending will provide support towards a vision of universal health care, which will enable every citizen to access preventive, diagnostic, therapeutic, and rehabilitative services. To accomplish this, the country is pursuing a plethora of development programs aimed towards improving access to healthcare services and reducing the burden of healthcare expenditures on poor families. In 2005, India embarked on the National Rural Health Mission, an extraordinary effort to strengthen the health systems.

*Women in India are three times more likely than men to go without treatment for long-term ailments.*

With recognition of the importance of health and nutrition for national development, the prospects for improved and equitable health and nutrition are now better than they have ever been. Yet despite federal and state efforts to increase access to health care and to provide greater financial protection, India's health sector faces many challenges. National health indicators have improved somewhat over the past decade, yet 5,000 Indian children still die every day from preventable childhood diseases, accounting for 20 percent of all childhood deaths in the world. Likewise, overall maternal death rates have dropped, but the rate is still far above the Millennium Development Goal, with 78,000 women (largely the poor) dying annually in childbirth. The underlying cause of insufficient progress is weak

health systems and substantial inadequacies in planning, financing, human resources, infrastructure, supply systems, governance, and monitoring (Paul et al., 2011). Both the delivery of care and its financing are highly privatized, and most of the costs are out-of-pocket payments. About 70 percent of all health expenditures are funded from out-of-pocket payments, most of which—about 87 percent—are for medicines and out-patient care (Garg & Karan, 2009). While infectious and preventable diseases remain a significant burden for poor Indian families, non-communicable diseases such as diabetes and cardiovascular disease are a steadily rising and looming threat to health and livelihoods (Ministry of Health and Family Welfare, 2005).

It is well-documented that health and poverty are inextricably linked. The Multidimensional Poverty Index estimates that about 54 percent of India's population lives in poverty, with large variations from state to state.<sup>2</sup> For example while only 10 percent of the population in Kerala lives in poverty, over 81 percent of Bihar's people are poor. Poor health contributes to the persistence of India's high poverty rates, with health expenditures driving 39 million families into poverty each year (Selvaraj & Karan, 2009).

The poor generally have worse health outcomes and access to care compared to the non-poor. Infants in the poorest two quintiles are twice as likely to die before their first birthday compared to infants in the richest quintile. Even as the Indian economy has grown rapidly, the nutritional status of children has remained stunted, suggesting that wide income disparities are preventing the poor from becoming the beneficiaries of growth. The revelations from the National Family Health Survey (NFHS-3; 2005–2006) are a cause for grave concern: 40.4 percent of children under 3 years of age are underweight; 78.9 percent of children between 6 and 35 months are anemic, and only 43.5 percent of children are fully immunized. Maternal anemia remains rampant.

<sup>1</sup>Press Release, 29 February 2012, PMO. <http://pmindia.nic.in/press-details.php?nodeid=1378>

<sup>2</sup>UNDP Multidimensional Poverty Index, 2011. <http://hdr.undp.org/en/statistics/mpi/>

Tuberculosis, malaria, and HIV/AIDS are infections still to be controlled. New public health threats are emerging in the form of cardiovascular and respiratory diseases, diabetes, cancers, mental illnesses, and traffic injuries. India is now estimated to have about 120 million persons with hypertension and 40 million with diabetes.

Profound gender inequities in access to health services also exist. In rural India, women are three times more likely than men to go without treatment for long-term ailments, a trend that persists even among the non-poor. When treatment is sought, significantly smaller sums of money are spent on treatment of women than on men (Iyer, Sen & George, 2007).



# Current Landscape of Microfinance and Health Practitioners

MFI and SHPI leaders and field agents report that the failure to repay loans or to build and sustain successful income-generating activity is most often the result of poor health and sometimes from even a single, but devastating, health event. A number of MFIs and SHGs have responded by adding one or more health services to the financial services they provide to clients. An analysis of desk research shows that of 134 MFIs in India (2009), approximately 25 percent had provided some type of health services to clients (Saha, 2011). Freedom from Hunger; the Indian Institute of Public Health at Ghandinagar; and

the Microcredit Summit Campaign also collected information from 19 self-identified MFIs and SHPIs providing health services in 2011. Although this survey does not represent a comprehensive mapping of the practice of health and microfinance in India, it does provide a rich overview of the types of organizations that are engaged in linking microfinance and health, client needs, the types of services provided, and some approximations of costs. Table 2 lists these programs, their locations, total active borrowers and reach of the health program.

**TABLE 2: MFIs REPORTING ACTIVE HEALTH PROGRAMS (2011)**

MFI	Registered Office	MFI Est.	Active Borrowers	Health Program Est.	Access to a Health Program
Bandhan	West Bengal	2002	3,227,864	2007	345,750
BWDA	Tamil Nadu	2003	159,684	2003	400,000*
Cashpor	Uttar Pradesh	1997	377,987	2010	45,000
Community Development Society	Maharashtra	1988	5,720	1996	12,000*
ESAF	Kerala	1995	295,270	1995	200,000
Equitas	Tamil Nadu	2007	1,300,000	2007	700,000
Gram Utthan	Odisha	1990	53,142	2004	25,000
Gram Vidiyal	Tamil Nadu	2003	1,046,497	2008	68,933
Kajila Janakalyan Samiti	West Bengal	2000	8,255	2007	5,000
Kotalipara Development Society	West Bengal	1992	60,648	1992	NA
Mahasemam Trust	Tamil Nadu	1999	102,345	2002	200,000*
NEED	Uttar Pradesh	1995	30,751	1997	20,000
Nidan	Bihar	2009	4,614	1997	25,000*
OAZOANE	Tamil Nadu	1998	6,398	1997	3,000
PioneerTrad	Tamil Nadu	1993	22,000	2006	NA
PMD	Tamil Nadu	1975	NA	2009	5,300
SERP	Andhra Pradesh	2000	8,000,000	2005	100,000
SKDRDP	Karnataka	1995	1,400,000	2004	1,690,000*
Star Youth Association	Andhra Pradesh	1997	25,499	2007	6,430
TOTALS			16,126,674		3,851,413

NA: Data Not Available

\*Reporting reaching community members with health programs beyond their clients

# Health Needs Addressed by MFI Health Programs

MFIs in India and globally strive to design health products and programs to address a range of client health needs. As Table 3 below shows, the MFIs in our survey indicated that maternal care and

childhood illnesses were two of the highest priorities, followed by malnutrition, HIV/AIDS, and hygiene sanitation.

TABLE 3: MFI BY TYPE OF HEALTH NEEDS ADDRESSED

Programs	Health Needs									
	Maternal Care	Childhood Illness	Malnutrition	HIV/AIDS	Hygiene and Sanitation	NCD	Adolescent	Malaria	Respiratory Illness	Others: Dental, Ophthalmic, Family Planning
Bandhan	●	●	●		●	●				●
BWDA	●			●	●					
Cashpor	●	●	●	●	●	●	●	●	●	●
Community Development Society	●	●	●		●	●	●	●	●	
ESAF	●		●	●	●		●			
Equitas		●							●	
Gram Utthan	●	●	●	●	●		●	●		
Gram Vidiyal						●	●			●
Kajila Janakalyan Samiti	●	●	●	●	●	●				
Kotalipara Development Society	●	●	●	●						
Mahasemam Trust	●	●	●			●				●
NEED		●			●					●
Nidan			●	●						
OAZOANE	●	●	●		●					●
Pioneer Trad		●		●		●				
PMD	●	●	●	●		●				
SERP	●	●	●	●	●	●	●	●	●	
SKDRDP	●				●					
Star Youth Association	●	●	●	●			●	●		
<b>Frequency</b>	<b>14</b>	<b>14</b>	<b>13</b>	<b>11</b>	<b>11</b>	<b>9</b>	<b>7</b>	<b>5</b>	<b>4</b>	<b>6</b>

Almost all of the MFIs reported that they provide a combination of approaches to address these needs (see Table 4). While health education was the most commonly reported intervention, MFIs are also venturing into the provision of health services through health camps, linkages to health providers,

and the direct provision of services through clinics and health product distribution. The MFIs also reported providing health financing tools that include health loans, health savings (for those institutions that are allowed to take savings), and health micro-insurance.

TABLE 4: MFI BY TYPE OF HEALTH INTERVENTIONS PROVIDED

Programs	Health Interventions														
	Health Education			Healthcare Services and Products								Financial Products			
	Group	Individual	Health Promotion	Direct Delivery	Contracts with Healthcare Providers	Negotiated Discounts	Referrals	Mobile Health	Community Health Workers or Volunteers	Distribution of Health Products	Telemedicine	Health Loans (Individual)	Health Loans (Group)	Health Savings	Health Micro-insurance
Bandhan	●	●	●	●			●		●	●		●			
BWDA	●		●			●			●	●		●		●	●
Cashpor	●													●	●
Community Development Society	●	●	●	●	●	●	●		●			●	●		
ESAF	●	●	●	●		●						●			
Equitas			●		●						●				
Gram Utthan	●		●	●	●	●			●	●			●	●	
Gram Vidiyal															
Kajila Janakalyan Samiti	●				●		●		●	●		●		●	●
Kotalipara Development Society	●		●									●		●	●
Mahasemam Trust			●	●				●							
NEED															
Nidan	●														●
OAZOANE	●		●												
Pioneer Trad	●														
PMD	●			●											
SERP	●	●		●					●			●		●	
SKDRDP	●									●			●		●
Star Youth Association	●	●	●		●							●			
Frequency	15	5	10	7	5	4	3	1	6	5	1	8	3	6	6

## What's in it for the MFIs?

### The rationale for adding health programs

The MFIs reported that they had developed their health programs for a variety of reasons. Many—about 50 percent—indicated that the lack of client knowledge about health, client inability to afford care, and lack of access to preventive care were very important considerations for developing health interventions. An equally important consideration was that the MFIs believed that addressing client health issues was a strategy for advancing their social mission. Somewhat less important was that the MFIs viewed health as a factor in client loan repayment and for ensuring a competitive advantage in attracting and retaining clients.

Data on program cost were shared by 10 MFIs. The information needs to be viewed with caution given the uneven rigor in reporting the cost figure, the absence of independent verification and because these are costs over a wide range of programs and services. Total costs provided by the MFIs were divided by numbers of clients reached by the health program to get an estimated average cost per client per year that ranged from 0.12 to 3 USD.

Interestingly, this rough estimate of per-client costs is consistent with more rigorous cost analyses conducted by Freedom from Hunger in India as part of its work to support the development of integrated health programs with MFIs. Cost analyses of three programs operating in West Bengal (Reinsch et al., 2011) and Odisha (internal Freedom from Hunger document) estimated total costs that ranged from 1 USD to about 2 USD per client per year. Even with a caveat about comparability, the costs to an MFI of adding on health services such as education and access to health products through community health volunteers appear to be low and especially so given the findings of positive client impact and indirect social and business benefits to the MFIs themselves (Reinsch et al., 2011).



# Program Examples: Improving Health Knowledge, Behaviors and Access to Care

## Health information through education

Multiple studies from around the world show that adding health education alone improves knowledge and health behaviors (Leatherman, Metcalfe, Geissler & Dunford, 2012). As seen in Table 4, health education is by far the most common health service offered. This is likely to be true for several reasons: (1) the relative ease of implementation; (2) the availability of numerous adaptable delivery models; and (3) the existence of supporting technical guides, curricula, and evaluation tools. Health education can be integrated into regular MFI and SHG group meetings by staff trained to deliver simple but interactive and effective health messages. Or it can be provided through regular community-based education sessions often provided by non-credit staff or trained volunteers.

### **Ekjut: Empowering women to reduce infant and maternal mortality**

Ekjut, an NGO based in Jharkand and Odisha, uses an SHG model to empower women to reduce infant and maternal mortality. To improve maternal and infant health, Ekjut community facilitators conducted meetings with SHGs using games, puppet shows and story-telling to help the women prioritize their health problems, identify the cause, and learn together for implementing measures to improve

*Ekjut found a 32 percent reduction of neonatal mortality rates, a 20 percent reduction in maternal mortality, and a 57 percent reduction in postnatal depression.*

health. Using a randomized control study over three years (2005–2008), Ekjut found a 32 percent reduction of neonatal mortality rates, a 20 percent reduction in maternal mortality and a 57 percent reduction in postnatal depression (Tripathy et al.,



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2010). Ekjut has replicated this intervention in new areas and is now evaluating a possible replication through ASHA (Accredited Social Health Activists) volunteers in five more districts.

### **Bandhan: Community-based health education**

Bandhan's comprehensive health program provides community-based health education and access to health products from community health volunteers

*Respondents who reported breastfeeding an infant within one hour of birth increased from 61 percent to 96 percent, and initiation of complementary feeding at six months or older increased from 39 percent to 55 percent.*

to over 382,000 beneficiaries in West Bengal and Tripura (January 2012). In a non-experimental study conducted pre- and post-delivery of community-based health education on infant feeding and maternal health, the percentage of respondents who reported breastfeeding an infant within one hour of birth increased from 61 to 96 percent, and the percentage who reported initiating complementary feeding at six months or older increased from 39 to 55 percent. There was further evidence that the



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positive impacts extended beyond just the Bandhan clients, as the number of women who reported providing advice to others regarding breastfeeding and malnutrition also increased substantially (Metcalfe, 2012).

## Access to appropriate and affordable health services and products

Direct delivery of healthcare services, including health products by microfinance providers and/or the linkage of clients to independent care providers, is less common than health education. Likely, this results from the severe shortage of locally available modern health services, especially in rural areas and urban slums where many MFIs and SHGs operate. A number of MFIs are responding with programs that include the training and supervision of lay community health volunteers who provide affordable over-the-counter medicines and health supplies, the development of linkages and referral relationships with public and private providers, the organization of regular health camps, and even through telemedicine that links rural clients to doctors using technology.

### **Equitas and Apollo Hospitals: Telemedicine centers**

Equitas, a microfinance organization based in Chennai, has set up “telemedicine centers” in three of its branch offices in partnership with Apollo Hospitals. Located in urban slums, the centers are

staffed by nurses and stocked with medical testing equipment and a laptop with video-conferencing. Women and their families who take loans through Equitas can schedule an appointment at the center and consult with a doctor through video-conferencing about symptoms and care. Center-based nurses measure vital signs such as blood pressure and heartbeat rate through equipment that transmits readings directly to the doctor and into a patient’s computerized medical file. The per-visit cost to the patient is 50 INR (.96 USD). Following the successful pilot, Equitas plans to scale the telemedicine centers to more of its 300 branches that provide financial services to over 1 million clients.

*Equitas, a microfinance organization based in Chennai, is setting up “telemedicine centers” in 300 of its offices in partnership with Apollo Hospitals.*

### **NEED and FHI 360: Increasing access and use of family planning methods**

The Network of Entrepreneurship and Economic Development (NEED) and Family Health International (FHI) 360 are partnering in rural Uttar Pradesh to improve access to family planning methods among MFI clients. FHI 360 is providing content technical assistance and training to a cadre of 35 community-based outreach workers called Village Health Guides (VHGs). The VHGs deliver bimonthly sessions over eight months that provide information about the benefits and available methods of family planning (FP) to 70 villages. Although the VHGs do not directly distribute FP methods, they actively assist clients in accessing family planning services based on a locally developed referral resource directory. Research that will be completed later in 2012 will look at the effect of education and facilitation of referrals on increased awareness of options, use of family planning methods, client and VHG satisfaction and program costs.

### **Gram Utthan: Affordable healthcare products at the doorstep**

Gram Utthan, an MFI from Odisha, provides microfinance and other development services to over 100,000 clients. Gram Utthan's health program includes health education, regular health camps staffed with public and private doctors, health savings organized through SHGs, and community "medicine points" that make a range of generic medicines and health supplies available in small villages. The "medicine points" are operated out of the homes of 100 village health volunteers (VHVs), who also provide health education and facilitate the formation



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of health savings groups with organized village SHGs. The VHVs make visits to client homes and earn 20 percent commission on the sale of a selection of most commonly needed generic medicines. Training and careful supervision of the VHVs are provided by Gram Utthan health professionals, including a licensed pharmacist. The net cost of the program to Gram Utthan is estimated at less than 1 USD per client per year and cost has declined as sales have increased and new products have been added.

*The net cost of the program to Gram Utthan is estimated at less than 1 USD per client per year.*

### **Financing for health**

The direct costs of health care, when needed, as well as the indirect costs in lost productivity, represent risk and vulnerability for the poor in India and worldwide. The poor use a variety of mechanisms for financing direct health costs—depleting their savings, borrowing from family and moneylenders, selling assets, and using their business loans—but often with untoward consequences. Evidence also indicates that the poor often put off or forego care altogether because of cost. Microfinance clients want and can benefit from health savings, health loans and health microinsurance to improve access to health services and products, and to help manage and protect them from the risks of healthcare shocks.

*As of July 2011, 253,000 SHG members had established health savings accounts and about 38,000 had availed loans through the health-risk product.*

### **SERP: Health savings, loans and microinsurance**

The Society for Elimination of Rural Poverty (SERP) is an autonomous organization set up in 2000 by the Andhra Pradesh state government to implement rural development projects in a professional and accelerated manner. Working through networks of SHGs and their federations, SERP programs reach 3 million poor households. Health improvement is a primary component of SERP's holistic approach to community development and poverty alleviation as it strives to break the link between poverty and poor health and reduce the use of SHG member loans to cover health expenses. SERP provides health education, operates child feeding and maternal health centers, and has established health savings and a low-interest loan that aim to provide financial support for health emergencies and assist clients to save ahead and prepare for health needs. SHG members save 10–30 INR (0.20–0.60 USD) per

month and after six months of savings may access health loans at 6 to 12 percent interest with flexible repayment terms. SERP also provides a community-managed insurance product called Sanjeevani that works with public and private hospitals and interfaces with the Andhra Pradesh AarogyaSri public insurance scheme. As of July 2011, 253,000 SHG members had established health savings accounts and about 38,000 had availed loans through the health-risk product. As of March 2011, 70,000 SHG members had been enrolled.

### **Spandana and PATH: In-home water filtration devices**

PATH's Safe Water Project (SWP) and Spandana piloted the sale of durable water filters to households through Spandana's MFI network. The in-home water filtration devices were promoted during the MFI's group meetings and clients could access a loan to finance the purchase of the units, which were priced at INR 2000 (40 USD). After 6 to 12 months, 12 percent of clients had taken a loan, with a take-up rate of 30 percent in one branch. Two different repayment plans were tested: weekly payments over 50 or 25 weeks. Clients strongly preferred the longer repayment period. Program evaluation revealed that clients often stopped using the device when the units required a replacement filter (required after 1,500 litres) and cited difficulty with affording purchase of the new filter (INR 350, or 7 USD). This suggests that the availability of financing for replacement filters may also be important to sustain access to clean drinking water for poor families. Spandana was able to realize full cost-recovery for its role in promoting and financing the devices and has continued the program.

### **BISWA: Loans for mosquito nets**

BISWA (Bharat Integrated Social Welfare Agency) is a rural micro-lending and development organization that provides a range of integrated financial and non-financial services to over 380,000 clients in rural Odisha where existing markets and public distribution had not been successful in achieving widespread coverage of insecticide-treated bednets (ITNs) to prevent malaria. From 2007–2008,



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BISWA was involved in a randomized control trial to evaluate the extent to which loans provided by the MFI would increase ownership of ITNs among poor households. The provision of MFI loans to purchase ITNs at market rates was compared to both free distribution and a control group (with no interventions). Education was provided to all clients about the use of ITNs to prevent malaria and to encourage regular retreatment of nets. The ownership of ITNs increased substantially in the group that had micro-loans for net purchase, with 52 percent of the sample households purchasing at least one net. The increased ownership was also associated with large increases in use (Tarozzi A, 2011).

These findings add to those from the PATH-Spandana initiative and support the importance of the role that MFI financing may have to increase uptake and use of higher-priced health-protection products and interventions with proven health benefits.

## **Fully integrated solutions**

As indicated in the survey of the 19 MFIs in Table 4, most of the institutions offer multiple types of health services, and several of the examples presented above provide packages of related health interventions. Development organizations such as SEWA serve as effective and trusted integrators of a range of health and other services needed and valued by clients. Another strategy for MFIs and SHGs aspiring to



a more holistic approach is to seek opportunities to link with healthcare and/or healthcare-financing organizations such as the innovative IKP Centre for Technologies in Public Health (ICTPH) and Sughavazhvu Healthcare in Tamil Nadu.



© SEWA

### ***SEWA: Integrated healthcare delivery and financing by and for women***

The Self Employed Women's Association (SEWA) is an Indian trade union registered in 1972 that provides financial and many other development services to over 1.3 million members in nine states of India. Since 1990, SEWA's Lok Swasthya SEWA Cooperative has provided a comprehensive set of health services that includes health education, TB detection and treatment supported by community health workers, mobile health camps, and primary healthcare services delivered through partnership with government and other NGOs.

SEWA also provides members and communities access to high-quality, low-cost medicines and SEWA-branded Ayurvedic medicines sold through community pharmacies and by the community health workers. The pharmacies offer medicines at costs below market rates yet are profitable and have had the effect of influencing other retailers to reduce prices. Health insurance products are available to SEWA members through the National Insurance VimoSEWA Cooperative. Future plans include the development of a low-cost laboratory, providing women-centered health and hygiene products,

and the creation of new insurance products for marketing with MFIs and NGOs.

### ***ICTPH and Sughavazhvu Health Care: Managed care for rural communities***

The IKP Centre for Technologies in Public Health (ICTPH) and partner Sughavazhvu Health Care are demonstrating an innovative managed healthcare model designed to provide high-quality, cohesive and low-cost health services to rural populations. The program operates six village-based Rural Micro Health Centers (RMHC) in Thanjavur (Tamil Nadu) that provide nearby access to primary medical care and diagnostic services, dental care, eye exams and eyeglass-dispensing to 15,000 families.

The RMHCs are staffed by nurses, community health workers, and locally hired doctors with undergraduate degrees in Ayurveda, Unani, or Siddha systems of medicine. The doctors are trained and recertified in an ICTPH year-long program. The clinic doctors and staff work with clearly developed protocols that have a technological interface with the organization's medical information system, providing real-time monitoring of services provided and performance. Service provider costs and medicines are covered with a small per-visit fee (INR 50, or 1 USD), with no charge for some community residents identified as being at high risk for non-communicable diseases.

ICTPH and Sughavazhvu are working with IFMR Rural Finance, the KGFS network of small branch-based village banks and insurance partners, to design and market a product that will couple fixed-price, pre-paid primary care and insurance mechanisms to pool risk for secondary and tertiary care. The goal is to demonstrate an affordable, fully integrated managed healthcare model to enable the poor to reduce the impact of high out-of-pocket spending and the risk of catastrophic healthcare needs. Although still emerging, the Sughavazhu model is an innovative and comprehensive approach that, if replicated, will offer opportunities for linkages with MFIs and SHGs seeking to improve access to quality care in rural communities.

# Conclusions: Call to Action and for Support

These short case examples from India are an important addition to our knowledge about the value of the established, self-sustaining MFI sector and SHG networks as unique, relatively low-cost and underutilized opportunities for delivery and financing of health-related services to poor families. Increasingly, the microfinance sector is exploring the addition of other non-financial services critical to the well-being of the poor that can be delivered on the platform of microfinance—most notably, the delivery of simple but life-saving health services.

MFI not only have compelling business reasons to attend to their clients' health needs, they are often uniquely positioned in the communities they serve as trusted intermediaries between community members and the outside world. Early evidence suggests that a range of health services can be provided by MFIs and SHGs for relatively low-per-beneficiary cost. For the health sector, working with MFI and SHG networks of women and families provides a relatively unexplored opportunity to address the need and demand for dependable, affordable and quality health services for millions of low-income and poor families. The integration of health and financial services can harness and complement existing governmental programs in health and development and private providers, to have a synergistic impact on health and poverty.

Yet despite this promise for benefit to multiple stakeholders, acceptance of this integrated approach remains low, and more evidence of impact and examples of sustainable business models are needed. Evidence from current programs is indeed promising, yet perhaps insufficient to motivate the significant shift in thinking, practice, and policy that is needed to reach substantially more of the 93 million MFI and SHG clients and families. MFIs and SHGs understandably fear the added costs that come with the integration of microfinance and health and the inability of their staff to take on what they perceive as competing tasks. The development of more alliances between healthcare providers, MFIs and SHGs similar to the ones we observe in the case studies is impeded by a lack of expertise to forge successful alliances, and by policymakers and donors

whose preferences for support lean towards more vertically integrated strategies and programs.

Given both the potential and the barriers to integration of microfinance and health, there is a need for policymakers, researchers, donors, social investors, and practitioners to come together to endorse and support the integration of these services. Of highest priority is the need to support larger-scale demonstration, documentation and dissemination of program-development methods and operational processes. Financial support in the form of grants, social capital, government sub-contracts, or other incentives is needed to encourage MFIs, SHGs, and healthcare providers to make initial investments in program design and implementation, to establish the monitoring and evaluation systems to capture data on the impact of this integrated approach, to support further innovation in the areas of healthcare financing and to address the emerging threat of non-communicable diseases. Additionally, there is a need to find effective ways to bring practitioners together to disseminate and share information on best practices and impact findings, and to collectively address the ongoing barriers. Along with livelihood generation, national programs such as the National Rural Livelihood Mission have an increased responsibility to create capacity among the poor, particularly women, to enable last-mile service delivery for health and nutrition.

As a nation, India is increasingly committed to the further reduction of poverty and the improvement of the health, well-being and productivity of its citizens. With the potential to reach a higher proportion of the 93 million clients engaged by MFIs and SHG-bank linkage programs, India could take the international lead on testing the methods and impact of integrating various strategies for microfinance and health. Such an initiative, with active support from international donors and national programs for rural health and livelihood generation, has the potential to make a very substantial contribution to the well-being of the poor in India and lead the way with valuable insight and knowledge for the global health and development communities.

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## About the Organizations

### Freedom from Hunger

Freedom from Hunger is an international development organization dedicated to bringing innovative and sustainable ways to support the self-help efforts of very poor families around the world. Freedom from Hunger partners with local organizations to demonstrate the value of these innovations and trains those partners to implement the programs sustainably. To ensure that our programs are beneficial and sustainable, we conduct extensive research, evaluate and monitor for impacts, and distribute successful interventions as widely as possible for others to adopt and adapt in their own anti-hunger and anti-poverty efforts. As of December 2011, Freedom from Hunger has trained and supported 150 partner organizations in 19 countries that are currently reaching over 3.9 million people (almost all women in poor, rural communities), benefiting a total of over 24 million when their family members are included.

[www.freefromhunger.org](http://www.freefromhunger.org)

### Indian Institute of Public Health, Gandhinagar

The Indian Institute of Public Health, Gandhinagar (IIPH-G) is part of a network of four Indian Institutes of Public Health, affiliated with the Public Health Foundation of India. IIPH-G's mandate is to address the shortage of trained and qualified human resources in public health and to contribute to the building of strong public health system across the length and breadth of India. To do this, IIPH-G educates and nurtures human resources by providing quality training to graduates from different disciplines in various public health domains, thus contributing to overall national health goals for India. The full-time IIPH-G faculty offer a world-class academic program that incorporates the latest advances in public health. Faculty are active in a range of research in areas of maternal and child health, disease surveillance, nutrition, micro-finance, monitoring health programs and advocacy, and health due to climate change. Research and academic partners include Karolinska Institute Sweden, Aberdeen University (UK), Boston University (USA), and Columbia University (USA).

[www.phfi.org/iiph-gandhinagar](http://www.phfi.org/iiph-gandhinagar)

### Microcredit Summit Campaign

The Microcredit Summit Campaign (the "Campaign") is the largest global network of institutions and individuals involved in microfinance. The Campaign is committed to achieving these two goals by 2015: (1) reaching 175 million poorest families with microfinance and (2) helping lift 100 million families out of extreme poverty. The Campaign convenes microcredit practitioners, advocates, educational institutions, donor agencies, international financial institutions, NGOs, and others involved with microcredit to promote best practices in the field, to stimulate the interchanging of knowledge, and to work towards alleviating world poverty through microfinance.

[www.microcreditsummit.org](http://www.microcreditsummit.org)

For questions on this report or to learn more about the field of health and microfinance in India, contact:

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