

THE ROLE OF MICROFINANCE-BASED SELF-HELP GROUPS IN THE CONTEXT OF HEALTH SERVICES IN INDIA

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Abstract

Women's participation in microfinance-based self-help groups (SHGs) and the resultant social capital may provide a basis to address the gap in health attainment for poor women and their children. We investigated the effect of combining a health program designed to improve health behaviours and outcomes with a microfinance-based SHG program. When Compared to a matched comparison group, women in SHGs that received the health program had higher odds of delivering their babies in an institution , feeding colostrums to their newborn , and having a toilet at home . However, while the change was in the expected direction, there was no statistically significant reduction in diarrhea among children in the intervention community and the hypothesis that the health program would result in decreased out-pocket expenditures on treatment was not supported. Our study found evidence that health programs implemented with microfinance based SHGs is associated with improved health behaviours. With broad population coverage of SHGs and the social capital produced by their activities, microfinance-based SHGs may provide an avenue for addressing the health needs of poor women.

Keywords: SHGs, Community, colostrums, Intervention

Introduction

An unfolding demographic and economic transition in India presents new challenges for the health of the population and the health system required to deliver appropriate care. With gross domestic product growing at an average 7.5 per cent per annum, a program of economic reforms and lower global oil prices, the International Monetary Fund and the World Bank predict India will become the world's fastest growing major economy, overtaking China (IMF, 2015). Demographic change is producing more population of working-age and a smaller dependent population, which is sustaining a high growth rate that requires a healthy workforce (Bloom, 2011). But progress will be limited without overcoming the inequalities in health and health care or addressing the needs of the poor. It describes the inequities in health status in India, the context of health care and the challenges in effectively financing health care. This is followed by a discussion of the microfinance system, its form and outreach, and women's participation in self-help group programs.

Objectives

- i. Investigate the independent effect of the presence of SHGs on health.
- ii. Investigate the effect of including a health program along with microfinance-based SHG program on health.

Health and the health system

Health status in India has improved markedly since independence in 1947. Life expectancy at birth has improved from 36 years in 1951 to 66 years in 2013, though this is four years less than the global average and 17 years less than the average of high income countries (Jeemon & Stephen, 2009). Mortality measured in terms of the crude death rate has fallen from 25 to 7 deaths per 1,000 people from 1951 to 2010 (Registrar General, 2011). The infant mortality rate has declined by more than 70 per cent, from 140 in the 1970s to 41 per 1,000 live births in 2013 (SRS, 2013). Maternal mortality has also fallen from 560 maternal deaths per 100,000 live births in 1998 to 190 in 2009 (The World Bank, 2015). But the health gains are not equally distributed. For example, maternal mortality varies

widely across states, ranging from 110 per 100,000 live births in Kerala to 517 per 100,000 live births in Uttar Pradesh (Jeemon & Stephen, 2009). Family size is becoming smaller. As per the Census of 2011, 12 states, covering half of the population, achieved the replacement level of fertility, though the national average is 2.44 births per woman.

Microfinance health program

While microfinance programs have traditionally emerged as a strategy for raising the financial security of the poor, the nature of microfinance arrangements, where members usually organise in an informal group of 10 to 20 members to obtain loans, presents an opportunity for introducing other development initiatives, such as programs to promote positive health behaviours and practices. Sheila Leatherman and Christopher Dunford identified two reasons for including health program with groups organised by microfinance institutions:

- Health services are an extension of the MFI mission of financial security and social protection of the client.
- When clients are healthier they provide better business and growth of microcredit business for the MFIs (Leatherman & Dunford, 2010).

In her foreword to a report on Integrated Health and Microfinance in India, the founder of the Self-Employed Women's Association, Ela Bhatt, summarized the rationale for MFIs to include health programs as part of their portfolios (Metcalf, Saha, Rao et al., 2012, page 3): 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. 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.

SHGs and social capital

Self-help group meetings are coordinated by a facilitator (credit officer in case of a microfinance institution) and occur at regular intervals. They generally adopt strict financial discipline regarding collection and accounting for savings and credit transactions. This involves significant face-to-face interaction between members and strong commitment to the well-being of all group members. Typically, each member of the group tries to help other members as the need arises, according to the 'helper therapy principle' (Gartner & Riessman, 1977). Members help to find solutions to the personal problems of other members and at the same time contribute to the group's collective affairs (Folgheraiter & Pasini, 2009). This promotes horizontal associations among group members that enhances mutual trust and reduces their sense of isolation (d'Hombres, Rocco, Suhrcke et al., 2010; Szreter & Woolcock, 2004). The key feature of SHGs is the principle of reciprocity and the strong emphasis on building social cohesion among members. To achieve this, members have to overcome their social, economic, and political differences and develop the strength to promote their collective interests (Chen, Jhabvala, Kanbur et al., 2006). By strengthening the networks and trust within their communities, these groups are better able to work collaboratively to resolve the social, economic and health care issues affecting the community (Whittaker & Banwell, 2002).

Membership in these groups can therefore act to create solidarity and social capital among group members (Narayan-Parker, 2002). Social capital refers to the networks, norms and trust that exists within communities and that can be mobilised as a resource for addressing several development needs (Productivity Commission, 2003; Kawachi & Berkman, 2000; Putnam, 1995). Social capital is recognized as having a positive effect on individual and community health status (Wilkinson, 1997). Social capital influences health care in two ways:

- Through formal networks of members as a means to access social and health care
- Through informal networks in which an individual draws upon groups' collective body of knowledge that facilitates access to health care and scarce resources, including information exchange that enhances members' ability to make healthy choices (d'Hombres, Rocco, Suhrcke et al., 2010).

In their study of maternal education and childhood immunization, Vikram and colleagues (2012) noted there are several different types of social capital depending on the type of network affiliation. Within their study context, they observed membership of an organization related to one's religion or caste may reinforce traditional practices such as the use of indigenous medicine and encourages conservative norms, which may discourage mothers from using more modern health interventions such as childhood immunisation programs. In contrast, membership of development organisations such as SHGs tends to encourage more modern practices and may increase the availability of information about the benefits of immunisation and promote patronage of local immunisation campaigns (Vikram, Vanneman, & Desai, 2012). However, membership alone does not automatically lead to women's empowerment; women's empowerment also has to be an integral part of the program design and planning process.

In order to redress traditional gender imbalances in education access the *Mahila Samakhyas* (MS) program was launched in 1989 by the Ministry of Human Resource Development. The program acknowledges women's

empowerment as the key to social transformation (Baru and Dhaleta, 2012; Arends-Kuenning, 2012). The program strategy empowers women to explore the power of collective action. Women are mobilized and organized into groups (referred as *sanghas* or *samoohs*) where they come together, discuss, reflect, organise and analyse, and articulate their needs and address them jointly. While the major responsibility for redressing inequity in health care should rest with public policies, there is an important role for civil society groups, including women's active participation in SHGs. In a study on social exclusion from the RSBY scheme, involvement of SHGs was recommended to identify, enrol and assist vulnerable groups of women (Ganesh, 2014). Earlier studies indicated that participation of mothers in saving groups in Bangladesh (such as Grameen Bank), or even residing in a program area served by such groups, increased mothers' knowledge about child care practices and their children's probability of being fully immunized (Amin & Li, 1997). The Integrated Child Development Services of the Government of India utilizes NGOs and SHGs in its distribution of supplementary nutrition program. The initiative reaches out to all beneficiaries with a standard weekly menu, meeting the protein and calorie norms within the allocated ration cost, removing contractors and encouraging local SHGs and *mahila mandal* to be involved in the supply and distribution of the meals. Results from a social audit indicate that 71% of the respondents felt that the menu chart was followed (Paul, Sachdev, Mavalankar et al., 2011).

Social capital as a result of participation in development organizations such as microfinance programs, is associated with: improved child development; well-being of adolescents; better mental health care; a reduction in violent crime and youth delinquency; a reduction in mortality; and lower susceptibility to binge drinking, depression, and loneliness (Howard, 2001; Kawachi & Berkman, 2001; Keating, 2000; Kawachi, Kennedy, Lochner et al., 1997; Hagan, Merken, & Boehnke, 1995). Social capital is also linked to sustained participation in anti-smoking programs and higher perceptions of well-being and self-rated health status (Szreter & Woolcock, 2004). An analysis of indicators of social capital and individual self rated health status among 167,259 individuals residing in 39 US states found strong associations between low social capital and self-rated poor health status (Kawachi, Kennedy, Lochner et al., 1997). However, it was D'Hombres and his colleagues who established the causal impact of social capital on self-rated health status in eight transition countries of Eastern Europe and central Asia (d'Hombres, Rocco, Suhrcke et al., 2010). They found that individual levels of trust were positively and significantly correlated with health care and social isolation was negatively and significantly associated with health care. Similarly, microfinance programs could potentially harness members' social capital for positive health outcomes.

Conclusion

Our study found evidence that combining a health program with microfinance-based SHG activities is associated with a significant increase in women delivering their babies in an institution, feeding colostrum to their newborn, and a nonsignificant increase in having a toilet at home. However, the program did not produce a significant change in the outcome indicator related to diarrhoea among children, and had no effect in reducing money spent on treatment. With broad population coverage, microfinance-based SHGs provide an avenue for increasing universal health coverage and particularly for addressing the health needs of poor women. Our results indicate that further research on this theme is required. There are additional reasons, from a social perspective, for investigating the possible positive impact of these programs. These include the impact of broad population coverage provided by SHGs and the social capital produced by their activities. A key area of future research would be an assessment of cost of adding a health program to SHGs more widely, and an analysis of cost-effectiveness of such an integrated approach. Public health planners stand to benefit from the membership-based structures and social capital that already exist through microfinance-based SHGs. However, such programs should not be viewed as a panacea for government failures. Rather, the SHG-based programs can be seen as complementary to public provisioning of health services, and as a means for increasing awareness about entitlement for public services in the community.

Governments and non-government organisations in India have implemented large-scale programs for promotion of SHGs. However, evaluation of the impact of these programs and their real and potential impact on population-level health indicators and other health related outcomes, including financial protection, has been limited. In the absence of rigorous evaluation, the potential for working with SHGs to improve people's access to health services has not been an active part of the national policy discourse. The positive role of microfinance-based SHGs in improving maternal and child health indicators observed in this study suggests a mechanism for increasing universal health coverage and addressing the health needs of poor women and their families. There are additional reasons, from a social perspective, for investigating the possible positive impact of these programs including the broad population coverage of SHGs and the social capital they produce.

While findings from this study provide important insights into the role of microfinancebased SHGs, there are issues that are still open to question. Any further evaluation of the value of SHGs in extending health coverage and financial protection to poor women and their families in India would have to adopt a design with a long time horizon

in order to incorporate slower and gradual change in health behaviours. The cost of forming and nurturing of SHGs and subsequently of SHG federations is a concern among policy makers. There is very limited evidence on the cost and cost effectiveness of SHG health programs and only a few rigorous studies on the costs of formation and nurturing of SHGs. Several of these estimates are quite old. A key area of future research would be costing the addition of a health program to the SHGs and an analysis of cost-effectiveness of such an integrated approach. As discussed earlier, SHG health programs can take different forms and shapes. Mature SHGs are expected to deliver better results compared to newly formed groups. Future evaluation of SHG programs, including their health programs, should take this group maturity and functionality of SHGs into account.

There has been interest among federal and state governments and non-government organisations to invest in the SHG movement for livelihood generation and financial inclusion among poor women and their families. There is a bigger role for the government and SHG federations in supporting individual SHGs as well as integrating health programs within the broader SHG development and livelihood programs. More research is needed on the range of health programs and services that can be integrated with SHGs and the extent to which this contributes to improved health knowledge, behaviours and outcomes. Additionally, the nature and quality of the health program itself and the effectiveness of its delivery could well influence the effectiveness of the outcomes. It is the participation predominantly of women in the SHGs that adds to their effectiveness in achieving better health behaviours because of the characteristics that women bring to these groups. While some of the measured behaviours showed further improvement with the addition of an SHG health program, certain gaps and limitations were identified. The observed behavioural changes assessed in the study are plausible pathways to improve maternal and child health.

With the established organised networks of SHGs, through government and non-government programs, these findings have implications in making progress in UHC. Public health planners could leverage SHGs to increase the proportion of the population enjoying health coverage and make progress in relation to financial coverage and utilisation of existing publically-financed health protection schemes, although a lot more work is needed to optimise these possibilities. The established organised networks of SHGs provide an administrative apparatus to more effectively reach poor women and their families with essential health programs. Public health planners should invest in further investigating the role of existing SHG programs to expand health coverage among the difficult to reach population, particularly poor women and their families.

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