Integrated Health and Microfinance in India, Volume II:

The Way Forward

MICROCREDIT SUMMIT CAMPAIGN
A Project of RESULTS Educational Fund

Freedom from Hunger

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The Way Forward

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We are also grateful to the 23 organizations that participated in our survey, helping us to ground this report in the most recent data and truly reflect the state of the field for integrated health and microfinance.

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Foreword

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The Health and Microfinance Alliance constituted by the Microcredit Summit Campaign and Freedom from Hunger has been making efforts in India to create an enabling environment towards integrating microfinance and health programme through financial service providers such as MFI and SHG-serving NGOs. MFIs and SHGs reach more than 90 million clients in India, many of whom are poor women.

The rationale for integration of financial and health products and services, suitability of technology and know-how and challenges of up-scaling or replication on a larger scale based on the lessons of experiments undertaken were ably analysed in the first state of the field report published in 2012. The authors of this report have now prepared a second report to further inform and advocate for broader recognition by stakeholders and policy makers on the opportunity for improving access to health services using the very large channel that MFIs and SHGs offer to also reach poor families with simple but important health and nutrition interventions in a cost-effective manner.

The current volume presents an unbiased picture of the evolution of the microfinance sector in India (MFIs and SHGs), its growth and challenges, as well as the ongoing challenges that face our nation in providing equitable access to all Indians to quality health services. The justification for a closer look and development of microfinance as a platform for health education and healthcare access has been presented with appropriate evidence along with an agenda for how to further develop this opportunity.

The Government of India as a major provider of health and livelihood development services, the Reserve Bank of India, NABARD and other policymaking and regulatory institutions will find this volume useful and interesting as they continue to consider and re-define priorities and design programmes directed at poverty alleviation, sustainable income generation and universal health care. At the same time, the health sector may find much in here to consider with respect to the potential for expanding their capacity to reach the most underserved families. Finally, the financial services sector will find the case studies and lessons learned here by others to be exceptionally useful for consideration of how to strengthen their role in financial inclusion, increased productivity and more effective asset formation by poor clients for a win-win situation for them as well as their clients.

The distinguished authors of this study deserve kudos for bringing out this publication. I am hopeful that this volume will be the harbinger of more such research in future.

Preface

In 2012, the Microcredit Summit Campaign, Freedom from Hunger and the Indian Institute of Public Health Gandhinagar published the *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*. The report outlines the rationale for integrated health and microfinance services, documents various health products and services offered in combination with microfinance, suggests suitable know-how and technology to expand the adoption of integrated services, presents the social and financial outcomes for clients and institutions, and identifies the challenges that must be addressed to extend these services effectively on a large scale.

Two years hence, the authors of the 2012 state of the field report agree that there is a need to document and publish a follow-up report to highlight the context of integration of health and microfinance in light of India's journey towards universal health care by 2020, to document best practices in integration, and to highlight potential interventions that can be adopted by microfinance institutions (MFIs) as well as by non-governmental organizations (NGOs) that serve self-help groups (SHGs). In addition to a general update, Volume II of the state of the field report will aim to 1) map and document health programs that can be replicated by other financial service providers and 2) outline the role of India's existing livelihood promotion initiative through SHGs in addressing access barriers to health. The report will define the key features of the integrated practice of microfinance with health and its importance from the perspective of public health and microfinance/SHG promotion in India.

The Microcredit Summit Campaign, Freedom from Hunger and the Indian Institute of Public Health Gandhinagar prepared this second volume to further inform and educate policymakers, MFIs and SHG-serving NGOs, private and public health providers, researchers, donors and social investors, and other stakeholders about approaches to combining microfinance and health. We hope it will continue to catalyze dialogue and debate and encourage greater 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 Johnson & Johnson, SIDBI and the ICCO Corporation, 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 MFIs and SHG-serving NGOs, 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.

Larry Reed, Director, Microcredit Summit Campaign

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Microfinance in India

Indian microfinance is characterized by two dominant models: the self-help group (SHG)-Bank Linkage model and the microfinance institution (MFI) model. While the MFI model is growing rapidly, the SHG-Bank linkage model is by far the more dominant model in terms of outreach. The above two models are very different from each other, both in delivery methodology as well as the legal forms of institutions involved in service delivery (Sinha, 2009). The MFI model is privately managed with some institutions regulated by the Reserve Bank of India (RBI) whereas SHG-Bank Linkage model is implemented by non-governmental organizations (NGOs) and the state governments.

SHG-Bank Linkage Program (SBLP) is promoted by the National Bank for Agriculture and Rural Development (NABARD), the apex development bank in India. NABARD played a very important role in conceptualizing, designing and promoting the SBLP. Under this program, NABARD refinances loans to SHGs given by commercial banks, cooperative banks and the Regional Rural Banks.

The MFI model uses a variety of methodologies for delivering services. The Grameen Bank methodology and joint liability groups are the most common and popular methodology. Through an ongoing process of experimentation and innovation in India over the years, MFIs now largely follow a mixed approach, customizing programs to their target segment and area of operation. The microfinance-delivery methodologies, MFI management approach, services and performance are influenced by their legal form, ranging from not-for-profit Societies or Trusts and not-for-profit Companies registered under Section 25 of the Companies Act to non-banking financial companies (NBFCs) licensed by RBI (Sinha, 2009).

Microfinance institutions: A decade of phenomenal growth and "The Crisis"

The last decade witnessed phenomenal growth of microfinance in India. During this period, some of the MFIs doubled their outreach each year. As institutions scaled up quickly, hiring and training processes were less thorough, resulting in employees indulging in inappropriate collection practices and lending models that led to customer over-indebtedness. This period was also characterized by lack of regulation on pricing, lending, and recovery practices. The combination of lack of regulation and rapid sector growth resulted in an environment where customers were dissatisfied with microfinance services (Kline & Sadhu, 2012).

SKS Microfinance, India's largest MFI with 5.8 million clients in 2010, became the first MFI in India to float its shares through an initial public offering (IPO). The IPO was successful by any financial market standard with the offering oversubscribed by 13 times. The company valuation reached the top of the offer band price at US$1.5 billion, and five weeks after trading began, the share price rose 42 percent (Chen, Rasmussen, Reille, & Rozas, 2010).

Following the IPO, there was a deluge of criticism characterizing the profits as taking advantage of the poor. Reports in the media linked sporadic suicides of microfinance clients in Andhra Pradesh to reckless lending by MFIs. Tension escalated, culminating in an ordinance passed by Andhra Pradesh Government, brutally restricting operations of MFIs in their state (Andhra Pradesh Ordinance, 2010). As a result of the ordinance and the general attitude towards microfinance in Andhra Pradesh, loan repayments dropped dramatically. This led to a flight of equity and commercial banks abstaining from lending to MFIs all over India, for fear that a similar situation might occur elsewhere. This resulted in a severe liquidity crunch for MFIs, and the sector came to a grinding halt.

Reserve Bank of India acted with alacrity

The Reserve Bank of India (RBI) responded to this crisis by appointing the Malegam Committee to look into the root of the Andhra Pradesh crisis, including coercive collection practices, usurious interest rates and over-indebtedness. The Malegam Committee report was released in January 2011. Accepting most of the recommendations of the Committee, RBI issued directions to non-banking financial company (NBFC) MFIs, with the objective of streamlining the operations of the sector.

MFIs are now efficient and client friendly

RBI regulations have brought much needed stability to the sector. Margin caps (MFIs must adhere to a 12 percent margin cap, which will soon reduce to 10 percent for larger MFIs) have brought about pressure to improve operating efficiency and cut costs. Operational strategies have been revised in terms of consolidating or merging branches, changing repayment frequency from weekly to fortnightly or monthly, or increasing the number of members per center (and subsequently increasing the case load and business per branch and credit officer). However, these measures, while enhancing the operational efficiency of MFIs, are likely to undermine MFI efforts of reaching poorer clients in sparsely inhabited areas. It is also true that MFIs would not wish to use their credit staff for providing non-financial services, such as health integration. MFIs prefer to deploy the separate cadre of employees (or volunteers) for such add on services.

MFI boards of directors are increasingly paying attention to the responsible financing agenda and social performance management (SPM). Committees of board members have been constituted by some MFIs for monitoring responsible financing and SPM performance. Some boards have inducted new members with expertise in SPM. Boards are also insisting on monitoring progress in implementing corporate social responsibility (CSR). Maintaining a balance between higher operating cost and lower profits with the addition of increased SPM activities is an area that boards need to consciously address (Srinivasan, 2013). Many MFIs are offering development loans—such as for water and sanitation, housing and solar energy—on a limited scale, keeping in mind the qualifying asset criteria of RBI. Emergency loans are also offered, particularly for supporting clients through health shocks.

Adherence to the Common Code of Conduct (CoCA)

The Microfinance India Network (MFIN) and Sa-Dhan, the two industry networks in India, have developed a common code of conduct (CoCA). MFIN is a group of NBFC-MFIs, while the membership of Sa-Dhan is more secular in nature and open to not-for-profit MFIs and NGOs. CoCA is in accordance with the Client Protection Code recommended by the Malegam Committee and as stipulated by the RBI. The new code insists that MFIs should avoid client over-indebtedness by assessing client need and repayment capacity before making a loan. The code also addresses the issues of governance, recruitment, client education, data sharing, feedback and grievance redress mechanisms, as well as prescribed guidelines for client protection and institutional conduct (Business Line, 2011).

Many MFIs are paying due attention to training their staff on CoCA compliance. Staff are trained on client-protection principles and on what is appropriate behavior; e.g., places for meeting customers and forms of addressing the customers as well as the nuances in communication that are appropriate in the local context. In addition, MFIs are working to make clients more financially literate. However, it is reported that not all MFIs have been able to track staff behavior with clients, which is so crucial for effective CoCA compliance (Srinivasan, 2013).

Transparency is the key

MFIs are much more transparent now. They issue loan passbooks that provide information on the loan terms, the number of installments, the amount of principal and interest payable by the customer, the effective rate of interest on reduced balance and the processing charges. The loan passbooks also include a toll-free number for feedback and grievance redress as well as other means of contacting senior MFI officials. In most cases, clients are aware of product and pricing details and the ethical behavioral needs of staff (Srinivasan, 2013).

MicroFinance Transparency (MFT), a global initiative to promote transparency in microfinance operations, has reported that Indian MFIs are now more focused on the poor, carry lower interest rates and provide credit plus services despite charging low interest rates. India boasts of the largest number of MFIs reporting social performance data to the MIX from any single country. As of the middle of 2013, 74 Indian institutions submitted this data, i.e., 46 percent of the Indian MFIs currently reporting to MIX (Srinivasan, 2013).

Indian microfinance is resilient

The resilience of the sector could be gauged from the fact that it has survived many setbacks and renewed its growth story. The last three years witnessed the emergence of "client" as the protagonist in all the major events concerning microfinance. Multiple instruments—codes of conduct, client-protection principles and fair practices code, for example—are being used to reinforce the idea of responsible microfinance. Institutions that lend to MFIs are insisting MFIs join credit bureaus to ensure that multiple lending does not occur. Thanks to the regulatory guidelines issued by RBI, the sector has begun to behave in an orderly fashion (Nair T. and Tankha A, 2013).

As a result of this important progress, banks have resumed lending to MFIs. Investors have regained their interest in them, mainly in those located outside Andhra Pradesh, resulting in a rise in the number of investment deals. MFIs are today reaching 28 million active borrowers, steadily approaching the all-time high of 32 million reached in 2010-11 **(Table 1).**

TABLE 1: CURRENT OUTREACH OF MFIS IN INDIA

Year	No. of clients (million)		Loan outstanding (Rs. Billion)	
	MFIs	Total	MFI	Total
2006–07	10	48	34.56	158.22
2007–08	14	61	59.54	229.53
2008–09	23	77	117.34	344.13
2009–10	27	87	183.43	463.81
2010–11	32	94	215.56	527.77
2011–12	27	88	209.13	572.53
2012–13	28	93	223.00	616.75

Source: (Nair T. and Tankha A, 2013)

Self-Help Groups

Self-help groups (SHGs) are small informal groups of 10–20 individuals, mostly women, promoting savings habits among members. The internal savings mobilized by the group are lent to its members for emergent needs or such purposes as decided by the group. When groups are able to successfully manage their savings and lending portfolio, banks step in to finance the groups. The bank loan is generally two to four times the savings mobilized by the group. Quality of group functioning is the prime criteria banks use when deciding to lend. To become eligible to receive a bank loan, groups that need to have operated for about six months and have successfully undertaken savings and credit operations from its own resources while maintaining proper records.

As per District Level Household Survey (DLHS 3) data, 57.9 percent of Indian villages have an SHG **(Figure 1).** The majority of these groups are present in southern and northeastern India. The government of India and NABARD are making persistent efforts to facilitate the growth of SHGs in those regions that need them most (Saha, Annear, & Pathak, 2013).

After experiencing phenomenal growth for 18 years during the decades of 1990s and 2000s, SBLP reached its peak of 4.8 million credit-linked groups in 2010. Since then, there has been a decline in the number, even in the southern region where it performed consistently well in the past **(Table 2).** NABARD explains that the decline in the number of SHGs is due to the adoption of better reporting standards by banks, such as counting only operative accounts.

FIGURE 1: SHGS IN INDIA

Source: (Saha et al., 2013)

TABLE 2: REGIONAL SHARE IN LINKAGE: SHGS WITH OUTSTANDING LOANS

Region	2009		2010		2011		2012		2013	
	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)
Northern	166,511	3.9	152,491	3.1	149,108	3.1	212,041	4.9	213,955	4.8
Northeastern	117,812	2.8	133,785	2.8	150,021	3.1	159,416	3.7	143,660	3.2
Eastern	933,489	22.1	1,027,570	21.2	1,105,533	23.1	985,329	22.6	1,020,656	22.9
Central	332,116	7.9	497,922	10.3	358,872	7.5	352,452	8.1	362,521	8.1
Western	393,499	9.3	457,476	9.4	316,821	6.6	289,472	6.6	295,451	6.6
Southern	2,280,911	54.0	2,582,112	53.2	2,706,408	56.6	2,355,732	54.1	2,415,191	54.3
Total	**4,224,338**	**100.0**	**4,851,356**	**100.0**	**4,786,763**	**100.0**	**4,353,442**	**100.0**	**4,451,434**	**100.0**

Source: (Nair T. and Tankha A, 2013)

TABLE 3: GROWTH TRENDS IN SHG-BANK LINKAGE PROGRAM

Particulars	2009	2010	2011	2012	2013
No. of SHGs with savings accounts with banks (Rs. millions)	6.12	6.95	7.46	7.96	7.32
No. of SHGs with outstanding bank loans (Rs. millions)	4.22	4.85	4.79	4.35	4.45
Southern Region as a share of total SHGs (%)	54	53	57	54	54
Loans disbursed during the year (Rs. billions)	122.54	144.53	145.48	165.35	205.85
Average loan disbursed per group (Rs.)	76,131	91,081	121,625	144,048	168,754
Total bank loan outstanding to SHGs (Rs. billions)	226.79	280.38	312.21	363.41	393.75
Average loan outstanding per SHG (Rs.)	53,687	57,794	65,224	83,457	88,455
Average savings of SHGs with banks (Rs.)	9,060	8,915	9,402	8,230	11,229

Source: (Nair T. and Tankha A, 2013)

Though there is a decline in the number of SHGs, the volume of fresh loans issued by banks to SHGs has shown significant growth **(Table 3)**, reaching Rs. 206 billion ($3.4 billion[1]) in 2013. The average outstanding loan of an SHG stood at Rs. 88,455 ($1449) on March 31, 2013, compared to Rs. 83,457 ($1367) the previous year. It is evident that both physical and financial performance of SHGs suffered during 2010–13 but is now on an upswing.

Commercial banks had the leading share (56%) in the number of groups with savings accounts, while Regional Rural Banks (RRBs) had 28 percent of the accounts and cooperative banks had 16 percent (Nair T. and Tankha A, 2013).

Non-performing assets

It is disturbing to note that there is a sharp rise in the non-performing assets (NPAs) of bank lending to SHGs. As reported by NABARD, gross NPAs, which were 2.94 percent of outstanding bank loans to SHGs as of March 31, 2010, increased to 6.09 percent by 2012 and 7.08 percent by 2013. The source of the concern is the even higher NPAs in some of such large states as Madhya Pradesh (21.16%), Uttar Pradesh (18.22%), Odisha (18.27%), Tamil Nadu (10.81%) and Kerala (12.38%) (NABARD, 2013).

Product-level changes: SHG2

In view of the above sagging performance of SHGs and keeping in line with recent developments, NABARD decided to make a few crucial changes to the approach and design of the SHG program to make it more flexible and client friendly, calling it "SHG2." Some of the important changes include,

- Encouraging voluntary savings, allowing SHG members to park their surplus funds as savings with the groups.
- Allowing a cash credit/overdraft system of lending to enable SHGs to be flexible in meeting their emergency needs and help them reduce the cost of borrowing.
- Allowing SHG members who are in a position to expand economic activities that require higher levels of loans to form Joint Liability Groups (JLGs) for the purpose of availing bank loans against mutual guarantees.
- Allowing well-functioning SHGs and NGOs to be engaged by banks as Banking Facilitators.

There are many reservations about SHG2, mainly due to the lack of a role for SHG federations as financial intermediaries. SHG2 also fails to address policy issues or operational requirements. Further,

[1]The exchange rate used throughout this report is US $1 for Rs. 61 on March 24, 2014.

the declining interest of banks in SHG lending makes the road map drawn by NABARD for SHG2 to be farfetched. At a time when the business correspondent model is making new strides, NABARD is silent on the role of SHGs and their relationship to the new strategy within or outside the SBLP (Nair T. and Tankha A, 2013).

The way forward

The policy measures taken in the microfinance sector in the last three years had the clear goal of preventing systemic failure of the sector and to reduce uncertainty and vulnerability. To that extent, the policy measures have succeeded in their objective, with the exception of Andhra Pradesh. Unfortunately, the proposed microfinance regulation act has not actually been implemented. This has left the sector confused and uncertain about the future. Self-regulation alone will not be sufficient, for without a robust regulatory arrangement with clear cut enforcement mechanisms, it will be difficult to make MFIs comply with the voluntary codes and client-protection principles for longer periods. Self-regulating organizations cannot be expected to be enforcers of rules and codes (Nair T. and Tankha A, 2013).

Problems of the Health Sector in India

In the past 60 years, the health status of Indians has improved markedly. Mortality measured in terms of crude death rate or deaths per year per 1000 people has fallen from 25 per 1,000 in 1951 to 7 per 1000 in 2010 (Registrar General, 2011). The infant mortality rate has fallen from 120 per 1,000 in the 1970s to 44 per 1,000 in 2011 (Statistical Report, 2013). Life expectancy at birth has risen from 36 years in 1951 to 66 years in 2011 (World Bank Indicators, 2011). Maternal mortality has also fallen from 400 maternal deaths per 100,000 live births in 1998 to 200 in 2010 (World Bank Indicators).

However, despite growth in GDP over the last two decades, a government report from the Ministry of Statistics and Program Implementation (2013) shows that India's progress towards MDG targets "eradication of extreme hunger" and "improved maternal health" to be either slow or off-schedule (MOSPI, 2013). Improvements in these targets are slower than in other Asian countries, including China, Sri Lanka, Bangladesh and Thailand. India continues to have high rates of maternal and child mortality. One-quarter of all child deaths and 20 percent of all maternal deaths in the world occur in India. People living in rural areas, marginalized castes, religious minorities, women and the poor are the first to suffer gross health inequalities.

India is facing a "double burden" of diseases: large proportions of mortality can be attributed to communicable diseases on one hand and chronic conditions on the other. The former, such as respiratory infections and diarrheal diseases, are predominantly diseases of poverty and disproportionately affect children and the poor. The latter, such as cancers, mental health disorders, diabetes, and cardiovascular diseases, mainly cause death among adults. Though they are more frequent in urban areas in the initial stages, poor and rural areas are becoming increasingly affected by chronic conditions.

Health care in India is characterized by poor public infrastructure and human resource management, a growing and largely unregulated private sector, and vast disparity in health access and outcomes between the rich and poor. The poor frequently delay accessing care, do not access it at all, or fall further into poverty or debt through spending on private care (S Mishra, 2008). The vast majority of poor and middle-class households are vulnerable to catastrophic health spending, particularly when the sick are earning members of the household. A 2002 World Bank report found that 40 percent of all people hospitalized in India in a single year sold belongings or took on debt and about 24 percent fell below the poverty line due to hospitalization (Peters, 2002).

Health has many determinants that lie outside the conventional biomedical paradigm and are influenced by interventions that have a profound population-wide impact. For example, water and sanitation have a major impact on health. Studies show that half of childhood under-nutrition cases in India can be ascribed to poor sanitation. Nutrition and health exhibit a two-way correlation. For example, a child with diarrhea cannot retain nutrients, and a poorly nourished child easily falls prey to infections. Similarly, many chronic or non-communicable diseases such as cardio-vascular disease, diabetes, and some cancers are related to diet and environmental exposure, and persons with these diseases end up being economically and nutritionally compromised in many ways.

The link between health and education, too, is strong. In a graded fashion, one can see that the better-educated exhibit better health outcomes. This relationship persists even after adjusting for income differences and is stronger, in many cases, than the income-health relationship. In the other direction, a sick child becomes educationally disadvantaged, if not altogether deprived. Even adult learning is adversely affected by ill-health.

Gender is another area that has a strong interface with health. Women are less likely to access health services due to a variety of socio-cultural barriers. When they do, they are also less likely to receive the attention and quality of care men receive, and many lack access to a wide range of reproductive health services. With lower income levels, they are also more likely to be impoverished by healthcare costs.

It is amazing then that women are among the foremost agents for improving health of families and communities. Women's education and employment have been shown to improve immunization rates, reduce child mortality, and result in a smaller size and greater well-being of families. As SHG members, community health volunteers, frontline health workers, as well as nurses and doctors, women are transforming health. These roles, in turn, are enhancing their social standing and enabling them to acquire and assert greater autonomy, providing much-needed elements of empowerment.

Microfinance as a Platform for Access to Healthcare

Increasingly, MFIs and SHGs in India are exploring the addition of other non-financial services critical to the well-being of the poor, most notably, the delivery of simple but life-saving health services. MFIs and SHGs 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.

The group meetings coordinated by the MFI or SHG are timely and disciplined around the collection and accounting for savings and credit transactions. A growing body of evidence from around the world indicates that when health and financial services for the poor are linked in a systematic and cohesive manner, key barriers to health for the poor can be reduced (Leatherman, Metcalfe, Geissler, & Dunford, 2012).

Well-designed health education provided to routine group meetings, mostly of women between the ages of 20 and 45, serve as an effective platform to promote and address such health services as institutional delivery, care for newborns, contraceptive use, under-nutrition among children, anemia among women and girls, and hygiene and sanitation—among other topics.

Health education could also support other interventions that MFIs and SHGs can design and implement that link families to appropriate healthcare services and products, and help to finance health services and manage the impact of health shocks.

As MFIs and SHGs reach clients with simple and effective health interventions, they change knowledge and behaviors that are known to reduce the incidences of the most common and preventable diseases. Promising evidence and examples in India suggest that MFIs and SHGs can improve client access to and use of affordable health services and products. MFIs and SHGs with their financial-service capacity are also viable channels for linking MFI and SHG clients with health microinsurance, as well as to other financing tools such as savings and health loans. Experience with pioneering MFIs and SHGs in India shows that once a financial service organization has developed and piloted an efficient and effective health program, the program can be expanded to very large numbers of people at low cost to the institution and with significant positive impacts on clients and the financial service organization itself.

Evidence of Impact of Integrated Health and Microfinance in India

A small but growing body of evidence suggests high potential for a low-cost and sustainable way to reach poor families with simple, but important health interventions. Such interventions can take various forms to address key client needs. These include,

I. Programs to address client awareness about preventive and promotive health care such as the program to train women SHG members as health workers and to provide literacy training in the Comprehensive Rural Health Project in Jamkhed, Maharashtra.

II. Programs to address financing cost of treatment such as the mandatory pilot health-insurance program of SKS Microfinance that offered cashless maternity, hospitalization and accident benefits among network hospitals to its members (Banerjee, Banerjee, & Duflo, 2011). Another example of such a program is the Velugu II project in Andhra Pradesh (renamed as Indira Kanti Patham) that sought to mitigate risk and improved security through a comprehensive insurance package covering health, life, crops and livestock.

III. Programs for access to healthcare products and services at doorstep such as community medicine points of Gram-Utthan, an MFI in Odisha that makes a range of generic medicines and health supplies available in small villages; or other programs that facilitate referrals of clients to diagnostic and screening services.

Improved health knowledge and behaviors related to maternal and child health

Evaluations of integrated programs show positive impact on improved health behaviors, especially with respect to maternal and child health.

Using data from the national district level household survey (DLHS-3) in India, Saha et al., reported respondents from villages with an SHG in India were 19 percent more likely to have delivered in an institution, are 8 percent more likely to have fed colostrum to newborns, and have better knowledge and utilization of family planning products and services (Saha et al., 2013).

A randomized trial to assess the impact of a community mobilization program conducted through participatory women's groups in rural areas of Jharkhand and Odisha found a 32 percent reduction in neonatal mortality rate compared to control areas. The trial found that newborn babies born to mothers who are the main decision-makers within their households in SHG communities had a significantly improved likelihood of surviving the first six weeks of their lives in response to the Ekjut intervention compared to babies born to analogous households in non-SHG communities (Tripathy P, 2010).

The Comprehensive Rural Health Project in Jamkhed (Maharashtra state) trained women SHG members as health workers, initiated literacy programs and provided funds for household health emergencies. Data from the project area showed in two decades after 1970, a reduction in infant mortality from 176 to 19 per 1,000; a birth-rate decline from 40 to 20 per 1,000; nearly universal access to antenatal care, safe delivery and immunization; and a decline in rates of malnutrition from 40 percent to less than 5 percent (Arole & Arole, 2002; Rosato et al., 2008).

Bandhan, an MFI serving nearly 4 million members in 18 Indian states initiated health services in West Bengal, including monthly educational sessions reinforced by a network of Shastho Shohayikas (SS). SS are community health volunteer women who make home visits and sell a range of health products at the doorstep (e.g., oral rehydration solution, paracetamol, oral contraceptives, pregnancy tests, de-worming pills and antiseptic lotions). The SS also encourage people to use local health services when appropriate. Bandhan makes health loans available to assist clients with high medical cost events and for latrine and water-hookup construction.

A longitudinal study of Bandhan's program found evidence of improved health knowledge and behaviors that are directly related to improved survival and the health and nutrition of infants and children. The magnitude of the reported changes was

also shown to be sustainable over time (Metcalfe, Leatherman, & Gash, 2012).

Sampark is an NGO in Karnataka that helps underprivileged, rural poor women form savings and credit SHGs. The NGO developed an intervention to integrate mental health within a developmental framework of microcredit activity for economically underprivileged women. This has resulted in enhancing both the economic and social capital among rural poor women (Rao, Vanguri, & Premchander, 2011).

Improved financing to protect health and improve awareness and use of services

Microcredit loans by SEWA Bank for basic infrastructure improvement in water supply and sanitation in urban slums resulted in a decrease in likelihood of health claims for waterborne disease from 32 percent before the intervention to 14 percent after the intervention (Butala, VanRooyen, & Patel, 2010).

In Odisha, a cluster randomized controlled trial with members of BISWA was conducted to evaluate the uptake of insecticide-treated bed nets (ITNs) through micro-consumer loans compared to a control group in which the nets were distributed free. The trial found use of ITNs increased substantially in the group that had microloans for net purchase, with 16 percent of individuals using a treated net the previous night compared to only 2 percent in control areas where nets were distributed free (Tarozzi A, 2011).

The Grameen Bank in Bangladesh provides members with health microinsurance schemes to protect its clients from health risks. A 2006 survey among 32 branches of Grameen Bank found that participation in this program contributed to increasing awareness of important health problems and to the probability of seeking formal care. Microinsurance programs for health reduced barriers to health services for the poor for basic and preventative healthcare (Werner, 2009).

Improved access to healthcare products and services

A pilot project in Southern India by UNICEF and Hindustan Unilever Limited to improve the quality of drinking water for children showed that membership in SHGs was critical to both increasing awareness and for the household purchase of a water purifier. The intervention consisted of 1) placing a water purification system in classrooms and 2) providing basic instruction to students, parents and teachers on waterborne diseases and generic information on effective point-of-use water treatment (i.e., boiling, chlorination, filtration, solar disinfection and safe storage) (Freeman & Clasen, 2011).

In Bangladesh, a program involved members of organized microcredit groups as outreach volunteers for door-to-door educational campaigns and delivery of non-clinical family planning methods and child immunization, and later focused on provision of an essential service package. Between 1992 and 1997, contraceptive prevalence rate increased from 28 to 53 percent, while the fertility rate has fallen to an average of 3.66 children per woman from 4.66 (Amin, St Pierre, Ahmed, & Haq, 2001).

In summary, evidence does indicate that financial service providers such as MFIs and SHGs can provide a platform for integrating poverty alleviation and health improvement programs. Integrating health programs with financial-service provision not only addresses demand-side access barriers related to awareness and care-seeking, but also address several supply-side barriers such as access to finance, consumption smoothing and products such as insecticide-treated bed nets or water filters.

Landscape of Integrated Products, Services and Innovations

In order to assess the current state of integrated health and financial services in India, we conducted a rapid mail-in questionnaire survey with key MFIs and SHG-serving NGOs in India that had an integrated health program in their portfolio. Fifty-five MFIs and NGOs that potentially had a health program in India were identified from a review of the MIX Market database and querying personal contacts and microfinance network references. Of the 55 contacted, 25 shared information on their health program.

The survey provided 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 4** lists the states in which the organization operates and the number of active borrowers in the organization. Together, the 25 organizations reported nearly 18 million active borrowers in their microfinance program, which vary from single-state operations to operations across multiple states in India. Lack of awareness among clients about essential health issues was one of the main drivers for MFIs and SHG-serving NGOs to introduce health programs for their clients.

TABLE 4: MFIS REPORTING ACTIVE HEALTH PROGRAMS (2014)

Organization	No. of active borrowers
Annapurna Microfinance Pvt. Ltd.	86,445
Asomi Finance Pvt. Ltd.	110,456
Bandhan	5,000,000
Bharat Integrated Social Welfare Agency	413,713
Bullock-cart Workers Development Association(BWDA)	96,143
CASHPOR Micro Credit	548,934
ESAF	450,000
Equitas Microfinance Pvt. Ltd.	1,850,000
Gram Utthan	79,327
Grama Vidiyal Microfinance Ltd.	738,218
Grameen Financial Services Pvt. Ltd.	381,749
Growing Opportunity Finance (India) Pvt. Ltd.	33,049
Hand in Hand India	41,164
Kotalipara Development Society	60,457
Parinaam Foundation	1,006,052
Pioneer Trad	20,000
People's Multipurpose Development Society	70,800
RGVN (North East) Microfinance Ltd.	162,575
RashtriyaSevaSamitit (RASS)	34,426
Sarala Women Welfare Society	87,998
Sahara Utsarga Welfare Society	93,000
Samasta Microfinance Ltd.	51,351
SKDRDP	2,819,500
SKS Microfinance Ltd.	4,100,000
Welfare Services Ernakulam	-
Frequency	**18,335,357**

Odisha	Assam	Chhattisgarh	Karnataka	Bihar	West Bengal	Jharkhand	Madhya Pradesh	Tamil Nadu	Pondicherry	Andaman &	Uttar Pradesh	Rajasthan	Gujarat	Maharashtra	Arunachal	Meghalaya	Nagaland	Sikkim	Andhra Pradesh	Kerala
●																				
	●																			
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7	4	5	5	5	6	3	6	12	3	1	4	4	3	7	1	3	2	2	2	2

Health interventions to address client needs

Health programs reported from MFIs and SHG-serving NGOs have been designed to address priority client needs that are identified as lack of awareness among clients, affordability of care and access to health products and services **(Table 5)**. Programs to create community awareness through individual-level health education and counseling and through conducting screening camps are predominant health programs offered by MFIs and NGOs. Organizations also seek to actively link clients to subsidies provided through existing government programs, and also provide micro-insurance to address financial needs of clients in case of illness **(Table 6).**

TABLE 5: MOTIVATION TO INTRODUCE HEALTH PROGRAMS

Organization	Lack of awareness	Difficulty in getting preventive care	Difficulty in accessing care when sick	Affordability of care	Access to health products and services
Annapurna Microfinance Pvt. Ltd.	●		●	●	
Asomi Finance Pvt. Ltd.	●	●		●	
Bandhan	●	●	●	●	●
Bharat Integrated Social Welfare Agency	●	●		●	●
Bullock-cart Workers Development Association (BWDA)	●	●		●	●
CASHPOR Micro Credit	●				●
ESAF	●		●	●	
Equitas Microfinance Pvt. Ltd.					
Gram-Utthan	●	●	●		●
Grama Vidiyal Microfinance Ltd.					●
Grameen Financial Services Pvt. Ltd.	●		●	●	●
Growing Opportunity Finance (India) Pvt. Ltd.	●			●	●
Hand in Hand India	●				
Kotalipara Development Society	●		●	●	
Parinaam Foundation	●	●			
Pioneer Trad	●	●		●	●
People's Multipurpose Development Society	●		●	●	●
RGVN (North East) Microfinance Ltd.	●		●	●	
RashtriyaSevaSamitit (RASS)	●		●	●	●
Sarala Women Welfare Society	●		●	●	●
Sahara Utsarga Welfare Society					●
Samasta Microfinance Ltd.	●			●	
SKDRDP	●		●	●	
SKS Microfinance Ltd.	●			●	●
Frequency	21	7	11	17	14

TABLE 6: MFIS AND SHG-SERVING NGOS BY TYPE OF HEALTH INTERVENTIONS

Organization	Health Education		Healthcare Services and Products					Financial Products		
	Awareness and counseling	Health camps	Linking with other providers	Discounted health providers	Health products	Linking clients to government subsidy	Tele-medicine	Loans for health/ water filters/ sanitary	Health micro-insurance	Health savings
Asomi Finance Pvt. Ltd,	●	●				●		●		
Bandhan	●	●	●		●			●		
Bharat Integrated Social Welfare Agency	●	●	●	●	●	●		●		
Bullock-cart Workers Development Association(BWDA)	●	●	●			●		●	●	
CASHPOR Micro Credit	●	●			●					
Equitas Microfinance Pvt. Ltd.	●	●	●	●			●			
ESAF	●									
Gram-Utthan	●	●	●		●			●		●
Grama Vidiyal Microfinance Ltd.	●	●		●	●	●		●	●	
Grameen Financial Services Pvt. Ltd.	●	●	●			●		●	●	
Growing Opportunity Finance (India) Pvt. Ltd.	●	●	●	●	●	●		●	●	
Hand in Hand India	●	●	●	●	●	●		●	●	
Kotalipara Development Society	●	●	●							
Pioneer Trad	●	●	●		●	●				
People's Multipurpose Development Society	●	●				●		●		
RGVN (North East) Microfinance Ltd.	●	●	●					●		
RashtriyaSevaSamitit (RASS)	●	●				●		●		
Sarala Women Welfare Society	●	●		●	●	●				
Sahara Utsarga Welfare Society	●	●				●		●		
Samasta Microfinance Ltd.		●						●		
SKS Microfinance Ltd.	●	●	●			●		●		
SKDRDP	●			●		●		●	●	
Welfare Services Ernakulam	●	●	●	●		●		●	●	
Frequency	21	21	11	7	8	14	1	16	6	1

Case Studies of Combined Health and Financial Services Interventions

Equitas Microfinance

Equitas was established in 2007 for extending business loans to women microentrepreneurs who have limited access to formal financial services. Health care tops Equitas' non-financial services and includes health education, telemedicine services, linkage to hospitals for subsidized treatment, regular health camps and pharmacies for discounted medicines.

Health camps, conducted in partnership with leading hospitals and healthcare providers, have provided services to nearly 2 million members. Services provided during the camps include general health checkups, dental/eye camps, pediatric and gynecological care, and cancer screening. The aim is to ensure that each member has access to at least one health checkup in a year, and 330 camps per month are conducted across India to cover about 60,000 members a month. Monthly budget of Rs. 2,000 ($33) per branch is allocated for health camps to defray the costs of conducting one free health camp per month for 150–200 beneficiaries.

Equitas also has provided vision camps that have benefited over 854,000 people. The camps provided screening, distribution of free spectacles for over 57,300 people, and free cataract operations for more than 22,300 members.

Health education for Equitas members is provided through partnership with the Microcredit Summit Campaign and Freedom from Hunger. The "Healthy Habits" module encourages participants to improve their nutrition, increase regular physical exercise and cease smoking and drinking to prevent non-communicable diseases, such as hypertension, diabetes and cancer. Equitas piloted the education in its Chennai branches with enthusiastic client participation and with clients reporting positive change of behavior and practices. The success of the pilot has encouraged Equitas to scale up education to cover all of Tamil Nadu, Maharashtra, Rajasthan, Gujarat and Madhya Pradesh, and they expect to reach 50,000 clients during 2014.

Equitas has also established partnerships with about 750 hospitals for providing subsidized quality healthcare services to their client families. Members wishing to avail themselves of this service contact the "Health Helpline" established by Equitas. The helpline guides them to the nearest hospital and has benefited more than 16,600 members, resulting in savings in out-of-pocket healthcare costs for families of an estimated Rs. 40 million (more than $655,000).

An example of the benefits from our helpline is a call from a woman who needed gynecological care. Our staff was able to immediately refer her to one of our partner hospitals [Geethanjili Medical Centre] and was told that she was in need of immediate surgery. Since she had no funds to cover the costs, Equitas was able to discuss the situation with the hospital, which agreed to provide the surgery and in-hospital stay at no cost for the woman and her family. Now, she is well and at rest at her home. Through this helpline service she saved Rs. 45,000 towards the surgery.

—Case shared by Equitas

As per an internal study, median value perception of beneficiaries for the health camps and health helpline services were Rs. 850 ($14) and Rs. 9,000 ($147), respectively.

Uplift Mutuals

Uplift Mutuals has pioneered community-owned and -managed risk-protection systems in India. Their model, emerging out of the need to provide access to quality healthcare at reasonable costs, associates thousands of low-income families who come together to share their health risks and access preventive and curative health services at rationalized rates. As Uplift explains, "Unlike in other models of risk protection (insurance), the risk is not

"It was not easy. I had to convince my husband and my in-laws for the need to have a toilet of our own as we were using a community toilet for years, and my family didn't want to invest in constructing a toilet of our own. Also, space was a constraint. But, somehow after attending the sessions on cleanliness and personal hygiene, I decided that for the sake of my two adolescent daughters, I need a small toilet—but [one] of our own," says Rekha from Nagpur.

transferred to a third party but pooled and shared by the contributing members and is very similar to how self-help groups are organized." In other words, by sharing risk, the community guarantees each member's security. The scheme has been in operation for 10 years and has 200,000 members.

Uplift Mutual designs the insurance product in a participatory manner. The community is involved in deciding what the insurance covers and how much each person will contribute. An important aspect of the mutual model established by Uplift is that it puts the claims in the hands of the community. This means that when a claim is made, the head office reviews the validity of the claim just as an insurance company does, but the community decides the final amount of money to be awarded.

When a low-income family enrolls in Uplift Mutuals, they get information on healthcare coverage, prevention of illnesses and how to file a claim, as well as what happens if someone is taken to the hospital. While the health insurance primarily covers hospitalization, Uplift has created a network of OPD doctors with its own OPD beat to act as gatekeepers wherein Mutual members receive primary care and are referred for further medical care. With the guidance center, Uplift makes the benefits of the mutual not only tangible but reduces the incidence of unwanted hospitalization. Uplift has also created a discounted provider network. Under this agreement, Uplift has negotiated up front the fee to be paid to the doctor but without any element of subsidy.

The biggest advantage of a community health mutual is that it drastically reduces the cost of implementation to the company.

ESAF Microfinance

ESAF Microfinance has a client base of 450,000 low-income women in five states of India. ESAF has positively responded to its client needs by developing an array of loan products that can support their livelihood as well as take care of other primary needs of their families. These products include income-generating loan, education loan, loan for improved water and sanitation, clean energy loan, house improvement loan, mobile phone loan, pension, insurance and savings.

ESAF partnered with several states as well as national and international agencies to use microfinance as a platform to deliver health education. ESAF also runs two 50-bed hospitals and two clinics where ESAF's clients as well as other low-income people can access the services at a concessional rate. Community-based health camps are organized where SHG members are motivated to attend and get a checkup so that timely treatment can be initiated before it becomes too late.

ESAF has successfully partnered with the Microcredit Summit Campaign and Freedom from Hunger in delivering health messages to over 10,000 clients in Maharashtra and Madhya Pradesh using the module provided by the Campaign and Freedom from Hunger. These lessons have helped women decide whether to take a water and sanitation loan from ESAF to construct a toilet or to get a water connection.

These lessons have helped several women like Rekha prioritize their health issues and seek appropriate and timely medical aid. Simple tips on proper hand-washing with soap at critical times, ways to keep water clean, and use of clean drinking water has reduced the number of diarrhea episodes. Furthermore, lessons on the appropriate intake of food have helped them improve the nutritional status of family members, especially the children.

Client Impact Story

Alpana Mahish lives in a small village in Shyampur, India. She is married with one son and two daughters, and has been a client of Bandhan for five years. Alpana was first interviewed in 2009 after she had taken her first loan from Bandhan, and she and her husband were on their way to becoming successful small entrepreneurs but her family remained vulnerable to health challenges. When Alpana's grandson was hospitalized with diarrhea, Alpana paid the $100 cost out of her hard-earned savings.

When Alpana was interviewed four years later in 2013, she had taken a total of eight loans. The loans were used to grow the family business that makes car batteries, to further her son's education to become a computer engineer, and for the marriage of her daughters. The family's small plot of land grows enough rice and vegetables selected for their nutritional value, to feed their family.

Alpana attends monthly meetings featuring an educational message in her village, and her first stop for advice on minor illnesses or medicines is Bandhan's SS. For more serious illnesses, or if first-line treatment does not work, she consults a doctor. She perceives her family's health to be quite good and that they have enough savings to manage most minor or even major health needs.

Alpana was happy to hear about recent efforts by Bandhan to promote hygiene and sanitation, and although her family already has a toilet, she is looking forward to assistance from her son to arrange for a better water supply for their home.

Bandhan

Bandhan[2] is a pro-poor development organization set up in 2001 to meet the twin objectives of women's empowerment and poverty alleviation. Bandhan works in the unbanked areas across 22 Indian States and Union Territory through a strong network of 2,013 branches catering to more than 5 million poor women.

Bandhan's health initiative started in 2007 to create health awareness among mothers and their adolescent daughters and to help reduce health expenditures for poor families. Bandhan developed their local health volunteer program by selecting interested underprivileged women from the community and training them. Bandhan's health program is operational in 14 districts with 1,906 health volunteers (called Swasthya Sahayikas) and covers 463,700 families.

Bandhan has developed and implemented a health program that includes the following:

- Health education provided in local community forums (open to clients and all community members) with a focus on child and maternal health.
- Health loans made available to MFI clients with two years of loan experience.
- Local community health volunteers, called Swasthya Sahayikas (SS), visit homes and distribute health products.
- Linkages to local healthcare services done through referrals from the SS.

Freedom from Hunger worked with Bandhan to design and conduct mixed-methods research to evaluate the impact of the program on key indicators of health knowledge and behaviors known to be important to improve the health of mothers and very young children. Quantitative pre- and post-tests with Bandhan clients participating in the health program were completed in 2008 just after the introduction of the health program and in 2009 after

[2]Source for this section: (Johnson et al, 2014)

one full year. In 2013, an additional follow-up survey was completed with many of the same participants of the prior two surveys.

The results from the three surveys show significant improvements that have been sustained over time in infant feeding, treatment of diarrhea, maternal care and advice-seeking among other indicators related to child and maternal health. These findings also show an increase in the number of clients who report sharing information on maternal and child health with others in their communities, suggesting that the positive impact for clients may also accrue to the broader community.

SKDRDP

Shri Kshetra Dharmasthala Rural Development Project (SKDRDP) concentrates on empowering rural women by organizing SHGs along the lines of the Joint Liability Groups (JLBs) of Bangladesh and provides infrastructure and finance through microcredit for the rural populations. It operates in Karnataka and had 1.9 million active borrowers in 2012.

SKDRDP realized that health shocks could be devastating to their SHG members, pushing them into poverty. SKDRDP introduced a health insurance scheme called Sampoorna Suraksha in 2003. Under this scheme, an insurance premium of Rs. 190 ($3) per member is collected, which gives clients protection for Rs. 5,000 ($82) in medical expenses. The scheme covers hospitalization, maternity care, life insurance, natural disasters and damages to property.

Target beneficiaries, those 70 percent below poverty line, are able to obtain cashless treatment in the scheme partner hospitals. SKDRDP also assists with a loan to meet any hospitalization expenses that exceed the sum insured under the Sampoorna Suraksha scheme, as well as a special loan to pay the insurance premium. During 2013, SKDRDP mobilized 1.3 million members for the scheme, collecting a premium of Rs. 364 million ($6 million) and settling 62,281 claims.

According to Dr. Divakar [of SKS NGO], "the ultra poor spend their meager income on food that barely meets their nutritional requirements. Malnutrition and sickness result, forcing the poor to contend with health expenses—when they are able to even meet with a doctor—thereby reducing familial income. With this vicious cycle of meager income, malnutrition, sickness, health expenses, and reduction in income, it is impossible to escape the clutches of poverty. Poor health is one of the biggest contributors to poverty," and members needed a local and affordable healthcare option.

[The SKS team decided to select members] who showed interest and enthusiasm, and train them to serve as health professionals within the village. The health professional's role was to provide primary care, so they were trained to identify common, non-critical ailments such as a cough, cold, body aches, etc. and dispense medicine accordingly. Since most of the beneficiaries, including the health professionals, were illiterate, the professional was trained to recognize a particular drug by the colour of the packet it was wrapped in… This activity not only created new livelihood options, but also proved extremely beneficial for the villagers who previously had to travel long distances, even to procure basic medication. The availability of medication within the village also meant instant relief of many symptoms and hence, improved productivity within the community.

Source: (Gutta, 2012)

A total of 200,000 sanitation units (toilets) have been constructed since 2000 by SHG members of SKDRDP with the help of motivation and sanitation loans. As an additional incentive, a cash subsidy of Rs. 1,000 ($16) was given to deserving members. Members were also encouraged to construct a small cement water tank in the toilet for storing water so that the toilet is put to use continuously.

SKDRDP also facilitates health education to members of Jnanavikasa Kendras (JVKs), centers of socio-economic empowerment for uneducated, unemployed rural women with no land. The modules, developed with supported from Freedom from Hunger and the Microcredit Summit Campaign, include topics on women's health and Integrated Management of Childhood Illnesses. In 2012, a pre and post-test survey found a noticeable increase in women and child health indicators—some increases as much as 96 percentage points.

SKS NGO

Swayam Krishi Sangam (SKS) NGO, the non-profit affiliate of SKS Microfinance, promotes and coordinates integrated rural development programs that benefit the rural poor—especially women and other disadvantaged groups—by addressing their basic needs such as livelihoods, shelter, medical care, education and adult literacy.

In "Building Bridges to Self-Reliance," Sriram Gutta analyzed the Sorenson/Unitus Ultra Poor Initiative (UPI) in which Unitus Labs and SKS adapted the graduation model in for the ultra-poor in Odisha.

Grameen Koota

Grameen Koota, an MFI based in the State of Karnataka offers a voluntary health insurance program (SAS Poorna Arogya Healthcare) for its clients. A study by Microinsurance Learning and Knowledge (MILK) found that…

…the insurance alleviated pressures on direct hospitalization costs, but indirect costs were still high, especially opportunity costs for women clients of Grameen Koota who did not own their land but worked as laborers or in trade…As of January 2012, 106,500 clients had enrolled in the program. These represent nearly a third of Grameen Koota's 350,000 borrowers. Clients pay annual premiums ranging from US$ 3.20 for an individual to $32 for a family of ten. Clients and covered family members can access coverage up to a single overall limit; this ranges from $102 to $1,015 depending on the number of lives enrolled. One of the key features of the scheme is a 20% discount on outpatient consultations from networked hospitals.

—Source: (MILK, 2012)

Health providers taking innovative approaches in delivering services to the poor

As MFIs, SHGs and savings groups mobilize demand for health services, local health innovators also stand to benefit. Health innovators are designing new products that can be adopted by MFIs and SHGs for tracking health indicators and providing service access. Products such as CommTrack, an open-source turnkey product, are designed to strengthen logistics management through the use of mobile technology. This mobile health platform is used and developed by Dimagi, a privately held social enterprise, to communicate and seamlessly gather data related to nutrition, antenatal care, neonatal care, family planning, and case management of child illness, as well as in processes for improving accountability and supervision.

Biosense Technologies Pvt. Ltd.'s uChek adopts an application that turns an iPhone into a mobile urine laboratory. Using the powerful camera and processing of smart phones, uCheck runs an inexpensive urine analysis. The technology is essentially in the strips that change color and can be compared against the pre-existing chart provided.

Neurosynaptic Communications Pvt. Ltd. (NSCPL) has the mission of enabling access to quality and affordable health care in the rural and remote areas through adoption of technology. NSCPL's comprehensive ReMeDi™ e-healthcare solution makes affordable rural healthcare delivery possible by connecting mobile health workers, stationary telemedicine centers, pharmacies, diagnostic labs, doctors at the clinics, central medical facilities and tertiary care, as well as the ground service-delivery teams. ReMeDi makes tele-consultations possible from the villages by allowing diagnostics such as BP, ECG (EKG), heart, and lung sounds to be carried out by the operator who has a minimal skill set, video-audio conferencing at very low bandwidths, and the availability of medical records.

School Health Annual Report Program (SHARP) is an NGO working to improve the health of school children across the country. SHARP operates in 20 states covering 10,000 schools and 2.5 million children and has established partnerships with 600 hospitals across the country. SHARP's program envisages early detection of health problems in children, regular follow-up and low-cost treatment. Its focus is to make people understand the services that already exist. In addition, SHARP conducts awareness programs for children in schools; the themes range from water and sanitation to menstrual health and young mothers. SHARP charges higher fees to elite schools, thus cross-subsidizing many government schools where poorer children study. SHARP employs mostly women staff because they connect with children much better. The model can be replicated by MFIs that are organizing school health clinics in villages or urban slums as well as those organizing healthcare camps.

Agenda for Moving Forward

While a section of the microfinance sector is still emerging from the financial services sector crisis, scores of MFIs and SHGs are offering programs and services that use their microfinance platform to 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 are also going further by providing a range of programs that link clients to health services and health products and, in some cases, are financing health care to help assure timely access and greater capacity for managing health expenses.

The group structures that remain a part of many MFIs are instrumental in expanding healthcare access. A systematic review of randomized trials in Bangladesh, India, Malawi, and Nepal shows that exposure to women's groups was associated with a 37 percent reduction in maternal mortality, a 23 percent reduction in neonatal mortality, and a 9 percent reduction in stillbirths. The intervention was cost-effective by World Health Organization (WHO) standards and could save an estimated 283,000 newborn infants and 41,100 mothers per year if implemented in rural areas of 74 Countdown countries (where more than 95 percent of all maternal and child deaths occur, including the 49 lowest-income countries) (Prost et al., 2013). A global study by Freedom from Hunger with five MFIs found that the average cost of different types of integrated health and microfinance programs was $1.59 per client per year with only a minor impact on MFI profit margins. However, costs depend on the health-protection package provided, the way in which services are provided, the efficiency of the organization generally and the local heath market context (Reinsch, 2011).

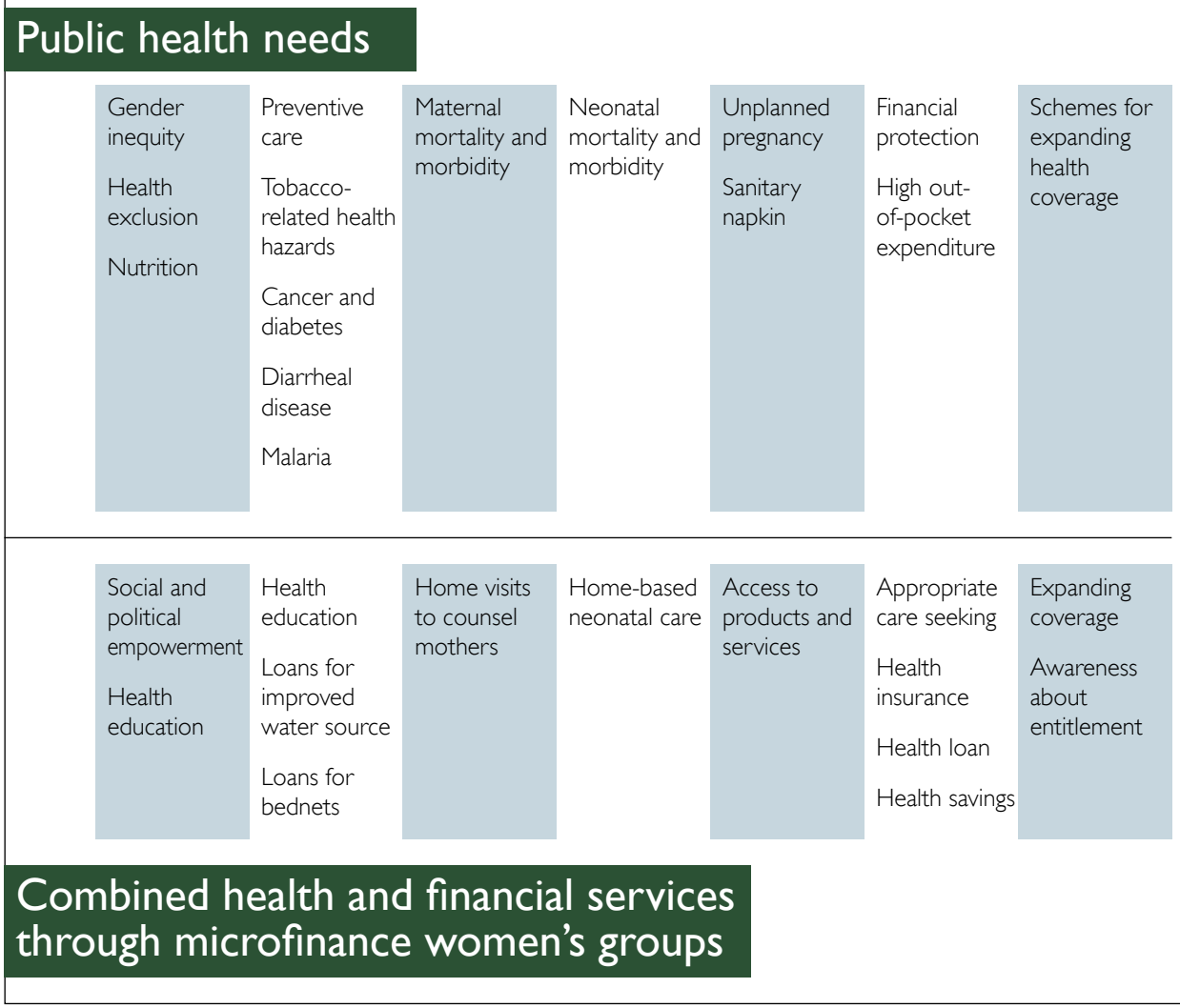
However, most MFIs and other institutions seeking to add health programs do require funds for initial development as they lack support for planning, program piloting and internal capacity-building, which remains a barrier to expansion. Evidence of the costs per beneficiary and cost-effectiveness of the programs is thin. Poor health infrastructure, lack of trained human resources and lack of health awareness are other key challenges reported. Respondents also cited lack of support from public health systems and sustaining community participation as challenges in ultimately sustaining the health programs.

Apex development banks in India such as NABARD should continue to play its proactive role in restoring the past glory of SHGs. NABARD may also work to strengthen the SHG federations by laying down policies which would help to improve the quality, self-management and sustainability of these institutions. APMAS, a technical resource organization for promoting the self-help movement in India, has estimated that as of March 2013, there were 178,664 federations in the country, including 171,511 primary federations, 7,087 secondary-level federations and 66 tertiary-level federations. The southern region is home to 52 percent of the federations.

In its endeavor to expand universal health care in India, public health planners stand to benefit from the membership-based structures and social capital that already exist through microfinance and SHGs in India. By linking microfinance to national programs, such as the National Rural Health Mission (NRHM), Indian policymakers could increase the impact of these proven interventions designed to provide improved access to health care, promote gender equity in service delivery, and address poverty, thereby addressing multiple social determinants of health. Such programs could effectively use the existing community structures to promote awareness and generate increased demand for services.

The NRHM would benefit from the linkage to the range of services provided in the community by both the individual SHGs and their federated structure. These services include creating community awareness, promoting institutional delivery, childhood immunization, preventive care and lay counseling through village health and sanitation committees, community monitoring, emergency health loans and health savings funds, and the provision of low-cost health products (such as sanitary napkins,

FIGURE 2: PUBLIC HEALTH NEEDS AND AREAS THAT LINKED HEALTH AND MICROFINANCE SUPPORTS



contraceptives and first-aid care at the community level). **Figure 2** presents a framework of important health needs that can be addressed by combining health and financial services through microfinance women's groups.

Areas for future research

While NGOs promoting SHGs and large MFIs are involved in adding health programs as part of their portfolio, wider uptake of these program require large-scale effectiveness studies with active support and involvement of Indian public health policy planners, particularly the Department of Health Research. Such studies should assess the impact of integrated products on access to health care of members, spill-over effect among non-members and the scalability of interventions; they should also establish contextual factors that affect the work of MFIs and SHPIs on health knowledge, behavior and service-use related measures, including both process and outcome indicators of maternal and infant health, child nutrition and health, and water and sanitation. In addition to impact evaluation, factors influencing uptake at both the individual and institutional levels, including costs and client satisfaction are key research priority areas.

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About the Health and Microfinance Alliance

The Health and Microfinance Alliance, established by the Microcredit Summit Campaign and Freedom from Hunger, was established in 2012 to work globally on several levels to create a more enabling environment for integrating microfinance and health programs. In India, the Alliance is helping financial service providers (MFIs and SHG-serving NGOs) add health-related services to what they offer clients and members. Using India as a demonstration of what can be achieved globally, the Alliance is currently working with more than 30 microfinance organizations to reach some 600,000 households with health-related services. These services include:

- Health education on prevention of HIV and AIDS, TB, malaria, and on basic nutrition and treatments for childhood illnesses;
- Linkages to health care providers and products; and
- Health financing such as health loans, health savings, and health microinsurance.

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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

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

Microcredit Summit Campaign

The Microcredit Summit Campaign (the "Campaign"), a project of RESULTS Educational Fund, 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

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