



# Integrated Health and Microfinance in India Volume III: Banking on Health

Authors

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**Cover images:**

Front cover: (left) Nosho Hembrum, an SHG member in West Bengal, collects *sa/* leaves for her livelihood activity; (right) Community Nutrition Advocates supported and trained by PRADAN in Rajasthan, pictured here, facilitate health education and linkages to government health and nutrition programmes of SHG members. Credit: RESULTS Educational Fund

Back cover: COPHAM members meet with VimoSEWA's micro-insurance programme participants.  
Credit: RESULTS Educational Fund

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## **RESULTS Educational Fund**

RESULTS Educational Fund supports a movement of passionate, committed everyday people using their voices to influence political decisions that will bring an end to poverty. Volunteers and staff multiply their impact through the enormous power of advocacy. Our movement of volunteers is backed by a staff of researchers, policy analysts, and legislative and media experts. Our shared goal is the end of poverty. We have affiliates and partners across five continents, and a network of volunteers in all 50 states and worldwide. Website: [www.results.org](http://www.results.org).

## **Grameen Foundation**

Grameen Foundation is a global nonprofit whose mission is to enable the poor, especially women, to end poverty and hunger. It uses digital technology and local partner networks to create breakthrough solutions – spanning financial, agricultural and health services – that bring people the tools and opportunities they need to help themselves. In 2016, Grameen Foundation joined forces with Freedom from Hunger, under the Grameen Foundation banner. To learn more visit [www.grameenfoundation.org](http://www.grameenfoundation.org).

## **Freedom from Hunger India Trust**

Established in 2012 as a Public Charitable Trust, Freedom from Hunger India Trust aims to break the cycle of chronic hunger and poverty among women and their families in India by delivering sustainable innovations that combine health protection services, livelihood with the availability of micro credit. Together with local partners, Freedom from Hunger India Trust equips families with resources they need to build futures of health, hope and dignity. It is governed by five trustees with highly relevant professional backgrounds. Freedom from Hunger India Trust plays a pivotal role in designing and disseminating community based integrated services and behaviour-change communication interventions across the country. It supports the self-help efforts of the very poor to achieve food and nutrition security. Please visit: [www.freedomfromhunger-india.org](http://www.freedomfromhunger-india.org).

## **Sa-Dhan**

Sa-Dhan, the oldest and largest association of community development finance institutions, came into being on July 21, 1999 with a mission to support and strengthen the financial inclusion agenda in India. It helps its member institutions to better serve low-income households, particularly women, in both rural and urban India, in their quest for establishing stable livelihoods and improving quality of life. Sa-Dhan has 184 members reaching out to 33 States/Union Territories and 563 districts; it includes SHG promoting institutions, MFIs (For Profit and Not for Profit), Banks, Rating Agencies, Capacity Building Institutions etc. Sa-Dhan's members follow diverse legal forms and operating models to reach out to over 29 million clients with loan outstanding of more than ₹468 billion. The Reserve Bank of India (RBI) has recognized Sa-Dhan as a Self-Regulatory Organization (SRO) for the Microfinance Sector. Sa-Dhan is recognized as National Support Organization (NSO) by National Rural Livelihood Mission (NRLM). Please visit: [www.sa-dhan.net](http://www.sa-dhan.net).

## Acknowledgements

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## Abbreviations

AB-NHPM	Ayushman Bharat – National Health Protection Mission
ADS	Aikyatan Development Society
ANM	Auxiliary Nurse Midwife
APVS	Annapurna Pariwar Vikas Samvardhan
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BPL	Below Poverty Line
CBHI	Community-Based Health Insurance
CHE	Community Health Entrepreneur
CHF	Community Health Facilitators
CHW	Community Health Worker
COPHAM	Community of Practice for Health and Microfinance
CPHC	Comprehensive Primary Health Care
CSR	Corporate Social Responsibility
FLW	Frontline Worker
FSP	Financial Service Provider
GDP	Gross Domestic Product
Gol	Government of India
HBNC	Home Based New-born Care
HCO	Health Community Organiser
HWC	Health and Wellness Centre
LGG	Learning Games for Girls
MAVIM	Mahila Arthik Vikas Mahamandal
MFI	Microfinance Institution
MFIN	Microfinance India Network
MHM	Menstrual Hygiene Management
MIS	Management Information Software
MUAC	Mid-upper arm Circumference
MYRADA	Mysore Resettlement and Development Agency
NABARD	National Bank for Agriculture and Rural Development
NBFC	Non-Banking Financial Company
NCD	Non-communicable Disease
NGO	Non-governmental Organisation
NHM	National Health Mission

NHP-2017	National Health Policy, 2017
NHPS	National Health Protection Scheme
OOP	Out-of-pocket
PAR	Portfolio at Risk
PEM	Protein Energy Malnutrition
PHC	Primary Health Centre
PLC	Pictorial Learning Conversation
PMDS	People's Multipurpose Development Society
RBI	Reserve Bank of India
RSBY	Rashtriya Swasthya Bima Yojana
SAM	Severely Acute Malnourished
SAS-PAP	SAS Poorna Arogya Healthcare Pvt. Ltd.
SCHIS	Senior Citizen Health Insurance Scheme
SDG	Sustainable Development Goal
SFB	Small Finance Bank
SFMC	SIDBI Foundation for Micro Credit
SHG	Self-help Group
SHG-BLP	SHG-Bank Linkage Programme
SHPI	Self-help Promoting Institution
SIDBI	Small Industries Development Bank of India
SRO	Self-regulatory Organisation
SS	Swasthya Sahayika
SSHI	Sampoorna Suraksha Health Insurance
SSP	Swayam Shikshan Prayog
TB	Tuberculosis
TFR	Total fertility Rate
UHC	Universal Health Coverage
VC	Village Committee
VDF	Village Development Fund
VE	Vision Entrepreneur
VHND	Village Health and Nutrition Day
WASH	Water, Sanitation and Hygiene

## Foreword

India is poised for a healthcare revolution. How its citizens access and finance their healthcare is at a turning point.

On 15 August, 2018, Prime Minister Narendra Modi announced his government's decision to launch Ayushman Bharat ('Healthy India'), a universal health coverage scheme, on 25 September. 'It is high time we ensure that the poor of India get access to good quality and affordable healthcare', said the Honourable Prime Minister in his Independence Day address to the nation. Ayushman Bharat aims to reach 500 million Indians, targeting rural families and certain categories of urban workers' families (The Times of India, 2018).

**A letter from  
RESULTS Educational Fund,  
Grameen Foundation and  
Freedom from Hunger India Trust**

This exciting announcement comes at a time when the Government of India has a mammoth challenge. Its healthcare system is strained by an ever-increasing population, low government health spending and a dismal health infrastructure, including unsafe drinking water and poor sanitation. The fragmented services provided by private health practitioners compounded by the poorly staffed and equipped rural clinics have created a rural-urban divide, perpetuating inequity in accessing health services.

Our three organizations, RESULTS Educational Fund, Grameen Foundation and Freedom from Hunger India Trust, believe that the integration of health and microfinance can supplement the government's efforts and help pave the way to universal health coverage. We, along with 28 financial service provider (FSP) partners, have worked in close cooperation since 2010 to facilitate access for microfinance clients to quality and affordable health services. Credit and self-help groups have enormous potential as a platform to deliver health-related education, financing and linkages to providers. We have worked to convince the largest and smallest FSPs of the urgency of this need as well as the financial benefits they will gain. This report points to the massive impact that further coordination between the health and financial service sectors could have.

Twenty-eight is an exciting year for organisations like ours that have worked for more than a decade in India to bring awareness on prevention and management of health and nutrition to microfinance clients, who largely come from rural, poor and marginalized populations. While the government is working to strengthen the health system with initiatives like Ayushman Bharat, we are working to support those most in need to access and utilize those services.

We also celebrate the culmination of three years' work to design, implement and document a holistic integrated health and microfinance model brought to scale and to kick start the Community of Practice for Health and Microfinance (COPHAM) to connect the microfinance and health sectors across India. We wish to thank Sa-Dhan for accepting to host the COPHAM Secretariat and helping move this agenda forward.



The core clientele of the microfinance sector — the poor and the underprivileged — are the most vulnerable to shocks due to ill-health. Experience has shown that even one event of ill health to a family member, especially if they are an income-earning member, can throw that family's finances into disarray.

As such, guarding the health of their clientele by providing suitable services and products makes eminent business sense to microfinance institutions (MFIs) and self-help promoting institutions (SHPIs). COPHAM is aiming to bring together health and microfinance practitioners so that affordable healthcare is made available to the poor and vulnerable. Sa-Dhan is pleased to announce that, henceforth, COPHAM will be part of our regular activities, and we will work towards facilitating more players in the microfinance sector to take up health related services and products.

This report provides an overview of the work that some MFIs and SHPIs are doing in the health sector. It may be observed that a number of institutions have pioneered a variety of health microfinance products successfully. Sa-Dhan calls upon its member institutions to actively take up health microfinance products on the lines of these pioneering institutions. Sa-Dhan would be glad to mobilise necessary capacity building support for the interested institutions. We would be able to leverage the technical expertise of COPHAM members to facilitate our microfinance members to actively go in health microfinance.



Image 1. Bandhan microfinance client, Sipra Roy, and her daughter. (Credit: RESULTS Educational Fund)

## Executive Summary

This, the third volume of the state of practice for integrated health and microfinance, builds on the foundation laid in 2012 and 2014. The first two volumes outlined the rationale for the integrated methodology, documented exemplary programmes in India and identified the challenges to expanding the integrated services effectively on a large scale.<sup>1</sup>

Since 2014, there has been phenomenal progress in both the microfinance and health sectors. Ten large Non-Banking Financial Company (NBFC) microfinance institutions (MFIs) have become Universal Banks and Small Finance Banks, with impressive increase in outreach as well as deepening of financial services. More and more MFIs and self-help promoting institutions (SHPIs)<sup>2</sup> are promoting the health and wellness of their clients, families and communities. They create programmes in-house or through non-governmental organisations (NGOs) promoted by them, and increasingly, they partner with health sector players. MFIs and SHPIs are also mobilizing the local populations, training thousands of local women as community health workers (CHWs) who educate clients/members and link them to existing health services.

While the microfinance sector has grown more robust and responsive in those ways, the health sector in India has struggled to address health challenges such as high disease prevalence, gender inequality, unregulated and fragmented healthcare delivery systems and a dearth of adequate skilled health workforce, among other concerns. India's most vulnerable communities are subject to increasing health costs, which are overwhelmingly paid out of pocket and contribute to sinking families deeper into debt, causing loss of livelihood and perpetuating the poverty cycle.

There is an urgent need to strengthen critical components of the health system such as financing, infrastructure and skilled human resources and to expand access to medicines and vaccines and community participation. The Ayushman Bharat ('Healthy India') scheme<sup>3</sup> launched by Prime Minister Narendra Modi's government aims to provide financial security and improve the quality of healthcare available to poor and vulnerable families. This is the lynchpin of the Government of India's efforts to accelerate the country's progress towards achievement of Sustainable Development Goal 3 (SDG 3), including universal health coverage (UHC, which falls under SDG 3.8).

The design of efforts to strengthen India's health system must ensure health equity (between rural-urban, male-female and rich-poor power divides) and prioritize the poor and marginalized populations, especially mothers and children. Health services are not always affordable and people sometimes do not know how to access them; therefore, the solution must include strengthening local knowledge of preventive measures as well as access to health products and services reinforced by access to financial tools.

This report shows how integration between the robust, pro-poor microfinance sector and the health sector can drive progress on two of the factors most critical to achieving UHC in India: 1) ensuring the poorest and most vulnerable households are effectively reached, enrolled and actively use the coverage and 2) public, private or civil society actors delivering support services that fill the gaps in services and financing.

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<sup>1</sup> Find the first two volumes of the State of Practice report on <http://healthandmicrofinance.org>.

<sup>2</sup> Which we sometimes also refer to, collectively, as financial service providers (FSPs).

<sup>3</sup> Ayushman Bharat will officially start on 25 September, 2018. Website: <https://www.abnhpm.gov.in/>

Volume three of the State of Practice Report illustrates how the development sector — MFIs, health NGOs, health diagnostics entrepreneurs and others — can support India's journey towards UHC. The integrated health and microfinance approach adds value to the government's existing UHC strategy because it provides a platform to deliver health-related services to hard-to-reach populations.

To realise the benefits of this approach, this report makes the following key recommendations:

1. **Adopt and scale-up health promotion interventions:** A healthy client is a good client, so MFIs and SHPIs would benefit by integrating health into their programme or partnering with an institution from the health sector — and aim for scale.
2. **Create complementary health and microfinance packages:** MFIs and SHPIs considering or currently implementing a health programme should create a complementary package — a mix of health education, financial tools and linkages to healthcare — that will address the complex health needs of their clients.
3. **Use technology:** MFIs and SHPIs can leverage their experience integrating technology into their financial operations to extend health-related services.
4. **Leverage CSR funds:** Profit-making microfinance companies can consider allotting part of their CSR funding obligations for the promotion of health-related services, both in their own operations and in partnership with health NGOs and SHPIs.
5. **Grow and support COPHAM:** Practitioners in the health and microfinance sectors would benefit from joining the community of practice and an exchange of experience and expertise among members, and donor support will be invaluable in helping COPHAM promote the expansion of access to health products and services to underserved populations.
6. **Establish public-private partnerships:** Local and state government (e.g., village Panchayats and the Departments of Health and Integrated Child Development Services) may consider a mutually beneficial partnership with health-promoting MFIs and SHPIs.
7. **Expand the evidence base:** Further research is needed to understand the cost and benefit aspects of integrated services and their impact (e.g., on the financial health of the MFI/SHPI or on the health of affected communities).

## 1.0 State of Microfinance in India

The earliest initiative in microfinance in India can be traced to banking services provided to women in Ahmedabad, Gujarat, in the 1970s; these women existed on the margins of society, living in abject poverty and working in the unorganised sector. SEWA Bank, set up as an urban cooperative bank in 1971, organized them and gave them access to financial services. Ever since, SEWA has provided banking and many other urgently needed services to hawkers, vendors and domestic servants, for example. In the mid-1980s, Mysore Resettlement and Development Agency (MYRADA) piloted a project on savings and credit groups with the support of National Bank for Agriculture and Rural Development (NABARD), the apex development bank in India. This emerged as the crucible of NABARD's pilot project for linking banks with self-help groups (SHGs).

What came to be known first as microcredit and then microfinance institutions (MFIs) also grew steadily in the 2000s. Organizations founded by social mission-driven entrepreneurs and philanthropists sprang up across India, such as Bandhan Bank, CASHPOR Micro Credit and ESAF Small Finance Bank. At the same time, the number of SHGs expanded exponentially as the base for state governments' poverty alleviation programmes and evolved into the dominant microfinance programme in India as well as the largest microfinance programme in the world.

### Self Help Group-Bank Linkage Programme

The SHG-Bank Linkage Program (SHG-BLP) currently serves 2.3 million credit-linked SHGs, including roughly 30 million members, 91.8 per cent of them being women (NABARD, 2018b). Under this programme, NABARD supports institutions organizing SHGs, known as self-help promoting institutions (SHPIs), through capacity building and refinancing the loans to SHGs given by commercial banks, cooperative banks and the Regional Rural Banks.

In the initial years, the SHG-BLP was more concentrated in South India, particularly in Andhra Pradesh. Currently, more than 100 Scheduled Banks, 349 District Central Cooperative Banks, 27 State Rural Livelihood Missions (a programme sponsored by the Government of India [GoI] to help SHG member families to create livelihoods) and more than 5,000 non-governmental organisations (NGOs) engage in promoting SHGs across India (see table 1.1). NABARD's experiment in SHG-BLP established the credibility of groups as a bankable proposition and rural poor capable of financial discipline. The wide acceptance and the phenomenal growth of SHG-BLP could be attributed to breakthrough policy innovations introduced by NABARD and India's central bank, the Reserve Bank of India (RBI), in the early 1990s: a) banks to accept informal groups (i.e., SHGs) as clients for both savings and credit linkages and b) banks to provide collateral-free lending and allow groups the flexibility to decide the loan utilization by individual members.

After experiencing a phenomenal growth, the SHG-BLP reached its peak of 4.85 million credit-linked groups (approximately 63 million members) during the 2009-2010 period, which corresponded to the 'Andhra Pradesh Microfinance Crisis'. Since then, the number of savings- and credit-linked SHGs declined until 2014-2015 to 4.2 million (table 1.1). Though the number of groups was reduced during this period, the loan amounts disbursed and loans outstanding to SHGs continued to grow (figure 1.1). The dip in the number of SHGs was

mainly due to banks cleaning up their data and deleting redundant groups from their records (accordingly, NABARD also refined the count). However, the formation and linkage of SHGs regained vigour and grew steadily after 2014–2015, even after ‘demonetisation’<sup>4</sup> in 2016–2017.



Image 2. Pubar women, members of an SHG promoted by Aikayatan Development Society in West Bengal stitch *kantha*. (Credit: RESULTS Educational Fund)

<sup>4</sup> When the GoI rescinded higher denomination notes. More about demonetisation in box 1.

**Table 1.1. Regional share in SHGs with outstanding loans (2008-2018)**

Region	2008-2009		2009-2010		2010-2011		2011-2012		2012-2013		2013-2014		2014-2015		2015-2016		2016-2017		2017-2018	
	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)	No. of SHGs	Share (%)	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	124,569	3.0	123,041	2.8	154,724	3.3	143,905	3.0	144,428	2.90
North-eastern	117,812	2.8	133,785	2.8	150,021	3.1	159,416	3.7	143,660	3.2	183,929	4.4	176,904	4.0	150,860	3.2	143,222	3.0	143,648	2.90
Eastern	933,489	22.1	1,027,570	21.2	1,105,533	23.1	985,329	22.6	1,020,656	22.9	978,960	23.3	1,069,329	23.9	1,130,902	24.3	1,343,296	27.7	1,412,153	28.10
Central	332,116	7.9	497,922	10.3	358,872	7.5	352,452	8.1	362,521	8.1	419,834	10.0	438,216	9.8	434,797	9.3	398,411	8.2	404,378	8.10
Western	393,499	9.3	457,476	9.4	316,821	6.6	289,472	6.6	295,451	6.6	269,008	6.4	270,718	6.0	258,119	5.5	278,097	5.7	276,336	5.50
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	2,221,038	52.9	2,389,972	53.5	2,543,219	54.4	2,541,356	52.4	2,639,415	52.50
<b>Total</b>	<b>4,224,338</b>	<b>100.0</b>	<b>4,851,356</b>	<b>100.0</b>	<b>4,786,763</b>	<b>100.0</b>	<b>4,354,442</b>	<b>100.0</b>	<b>4,451,434</b>	<b>100.0</b>	<b>4,197,338</b>	<b>100.0</b>	<b>4,468,180</b>	<b>100.0</b>	<b>4,672,621</b>	<b>100.0</b>	<b>4,848,287</b>	<b>100.0</b>	<b>5,020,358</b>	<b>100.00</b>

Source: NABARD, 2018b

**Figure 1.1. Growth trends in SHG-Bank Linkage Programme (2008-2018)**



Source: NABARD, 2018b

Inspired by Prime Minister Modi's exhortation to 'move with the dream of electronic digital India', NABARD introduced in 2015 digital technology to ensure a seamless flow of SHG transaction data and other demographic information. The EShakti project, which systematically digitises the SHG data, captures the credit history of SHG members and generates SHG grading reports based on financial and social records (of the SHG and their members), making them available to all important stakeholders. The project envisages mapping the existing SHGs in a district (bank-wise and branch-wise) and uploading the transactions, including minutes of meetings, to a dedicated website through an Android app loaded on tablets and mobile phones. Encouraged by the positive response of the stakeholders in Phase I of EShakti implemented in 2 districts, NABARD has expanded this ambitious project to 100 more districts under Phase II (NABARD, 2018a).

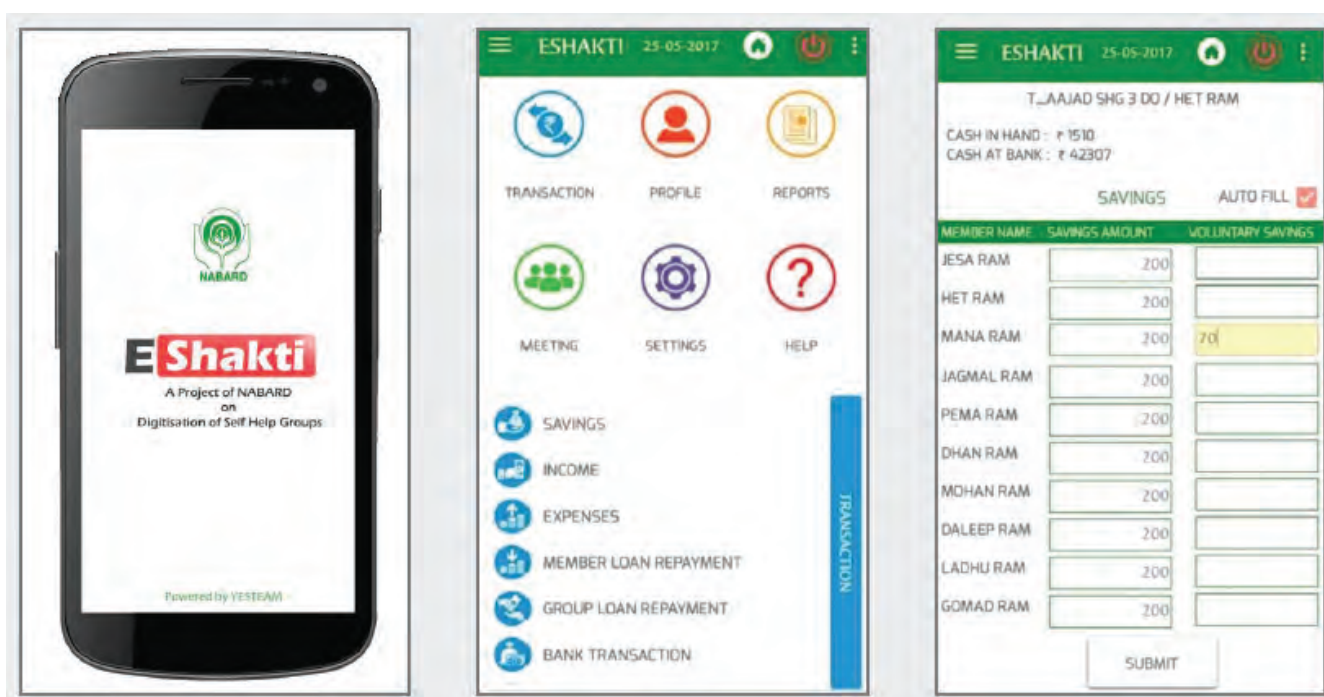


Image 3. The EShakti Android app provides 'one-click' availability to social and financial information of SHGs and individual members. (Credit: NABARD <https://eshakti.nabard.org/>)

## Evolution of Microfinance Institutions

Around the same time that the SHG-Bank Linkage Programme was evolving, many MFIs began their journey as NGOs, registering as Trusts or Societies. Inspired by Muhammad Yunus of Bangladesh and the success of Grameen Bank pioneered by him, Indian promoters almost universally adopted the Grameen Bank model, which laid more credence on lending, as compared to the SHG model, which stressed savings first and placing all the power of decision-making in the hands of the women members.

While these NGOs did well on community building, they lacked experience in financial management. The rapid growth of their operations demanded capacity building and systems improvement to acquire such skills. The Small Industries Development Bank of India (SIDBI) established the SIDBI Foundation for Micro Credit (SFMC) in 1999 to improve the capacity of NGOs in financial management.

As non-profit organisations, the NGO-MFIs could neither borrow from higher financial institutions nor accept deposits from their clients, which hampered their growth. Eventually,

MFIs began to feel pressure to demonstrate that banking with the poor is both profitable and sustainable, and they believed the financial side must function as a distinct, profit-seeking institution. Therefore, many converted into Non-Banking Financial Companies (NBFCs), which allowed them to function as financial institutions regulated by RBI. While the larger MFIs graduated to become NBFCs, an overwhelming majority of the MFIs did not. And, a few NGO-MFIs, such as SKDRDP and CASHPOR, reversed course on converting into NBFCs, prioritising their commitment to the concept of microfinance as a not-for-profit activity.

MFI growth in the early 2000s was painfully slow. Bandhan and SKS Microfinance, the two largest institutions in the country in 2018, had a combined reach of 102,000 active borrowers in December, 2004, even after five years of operation (Daley-Harris, 2005). The growth since 2005, however, has been spectacular, mainly because of overseas investors and the liberal flow of bank lending to the sector. Some MFIs doubled their outreach each year. As institutions scaled up quickly, they ignored many of the safeguards of responsible lending, and the first signs of distress manifested in Krishna district of Andhra Pradesh in 2006, where Government authorities closed branches of a couple of prominent MFIs, alleging usurious interest. Though it could have been a wake-up call, the sector quickly resumed business as usual and continued its growth path till a bigger crisis struck four years later.

## **Crisis and Reform**

The mega success of the SKS initial public offering in 2010 triggered a crisis of monumental proportions. MFIs were attacked for usurious interest rates and exploitation of the poor. Reports in the media linked sporadic suicides of microfinance clients in Andhra Pradesh to reckless lending by MFIs, which included over-lending to women members of Velugu, a State-sponsored SHG programme. Tension escalated, culminating in an ordinance passed by the Andhra Pradesh Government that banned MFI operations in the state, which triggered a precipitous drop in loan repayments. Equity dried up, and banks refused to lend to MFIs across India, fearing a repeat of Andhra Pradesh crisis elsewhere.

In response, the RBI Board set up the Malegam Committee, and its subsequent report, released in January, 2011, issued recommendations relating to the regulation of the sector. Accepting most of these recommendations, RBI established guidelines to streamline operations, bringing much needed credibility. Income minimums and loan limits were put in place for microcredit borrowers. To curb multiple lending, new rules allowed each borrower to borrow from a maximum of two MFIs. Margin caps and lending rate caps compelled MFIs to cut costs and improve operating efficiency. For some MFIs, this regulatory framework would affect their ability to create and expand non-financial programmes using their own resources.

Acting on the Malegam recommendations in 2014-2015, RBI designated Sa-Dhan and Microfinance India Network (MFIN) as self-regulatory organisations (SROs) for NBFC-MFIs. SROs formulate and administer a Code of Conduct, operate a grievance and dispute redressal mechanism for the clients of NBFC-MFIs, ensure borrower protection and education, monitor compliance by NBFC-MFI practitioners with the regulatory framework put in place by RBI, scrutinize the microfinance sector and run training and awareness programmes.

RBI has now made it mandatory to report the credit data of MFI borrowers to all four credit bureaus. Every MFI reviews the borrower's credit report before sanctioning a loan to ensure that the client has not crossed the two-lender limit. The Lenders' Forum and Responsible Finance Forum exert pressure on microfinance players to adhere to the norms stipulated by RBI.

Hitherto, there was no authentic data on the number of MFIs operating in India. The estimates by various sources ranged anywhere from 300 to 800. To overcome this issue, Sa-Dhan began publishing the annual 'MFI Directory' in 2014, which verified data on each MFI. The latest version of this directory verified that 225 MFIs function in the country under a variety of legal forms (table 1.2).



**Table 1.2. Number of MFIs in India in 2018**

Legal form	No. of MFIs	Note
Society	64	Non-profit
Trust	19	Non-profit
Section 8 (Sec 25) Company	32	Non-profit
Mutually Aided Cooperative Society (MACS) / Cooperative	11	Non-profit or for-profit
NBFC	18	For-profit
NBFC-MFI	81	For-profit
<b>Total</b>	<b>225</b>	

Source: Sa-Dhan

### Box 1. Demonetisation and Microfinance Sector

The country experienced a massive, unexpected and disruptive financial sector reform in November, 2016. Commonly referred to as demonetisation, the Government of India rescinded higher denomination notes, which accounted for 86 per cent of currency in circulation. This reform had a profound negative impact on loan repayment and, consequently, loan disbursement, devastating the microfinance sector for nearly a year.

MFI clients and SHG members witnessed disruption to their businesses in the immediate aftermath of demonetisation, affecting their ability to repay loans. Thanks to the pro-active role played by several SHG-BLP stakeholders (i.e., RBI, NABARD, banks, SHPIs, National Rural Livelihoods Mission and other Government agencies), the programme recovered fast and regained its growth trajectory. Formation and linkage of new SHGs continued, with a net addition of 673,000 SHGs during 2016–2017, and SHG savings with banks reached an all-time

high of ₹161 billion. The gross non-performing assets (NPAs) of bank loans to SHGs increased only marginally from 6.45 per cent to 6.50 per cent during 2016–2017. This was achieved in a year when there was overall deterioration in quality of assets and mounting NPAs in the banking sector (NABARD, 2017).

Demonetisation affected MFIs more severely than SHGs. Rumours that the government would waive loans availed by the poor, including loans from MFIs, encouraged clients to default on loans. MFIs witnessed a sharp decline in repayment rates, with several leading players reporting portfolio at risk (PAR) more than 10 per cent.

However, demonetisation has encouraged MFIs to promote cashless transactions among their clients. This will have a positive impact on the operating efficiency and risk profile of MFIs by reducing losses from theft and frauds, the two major operational risks for MFIs.

### A Resilient Sector

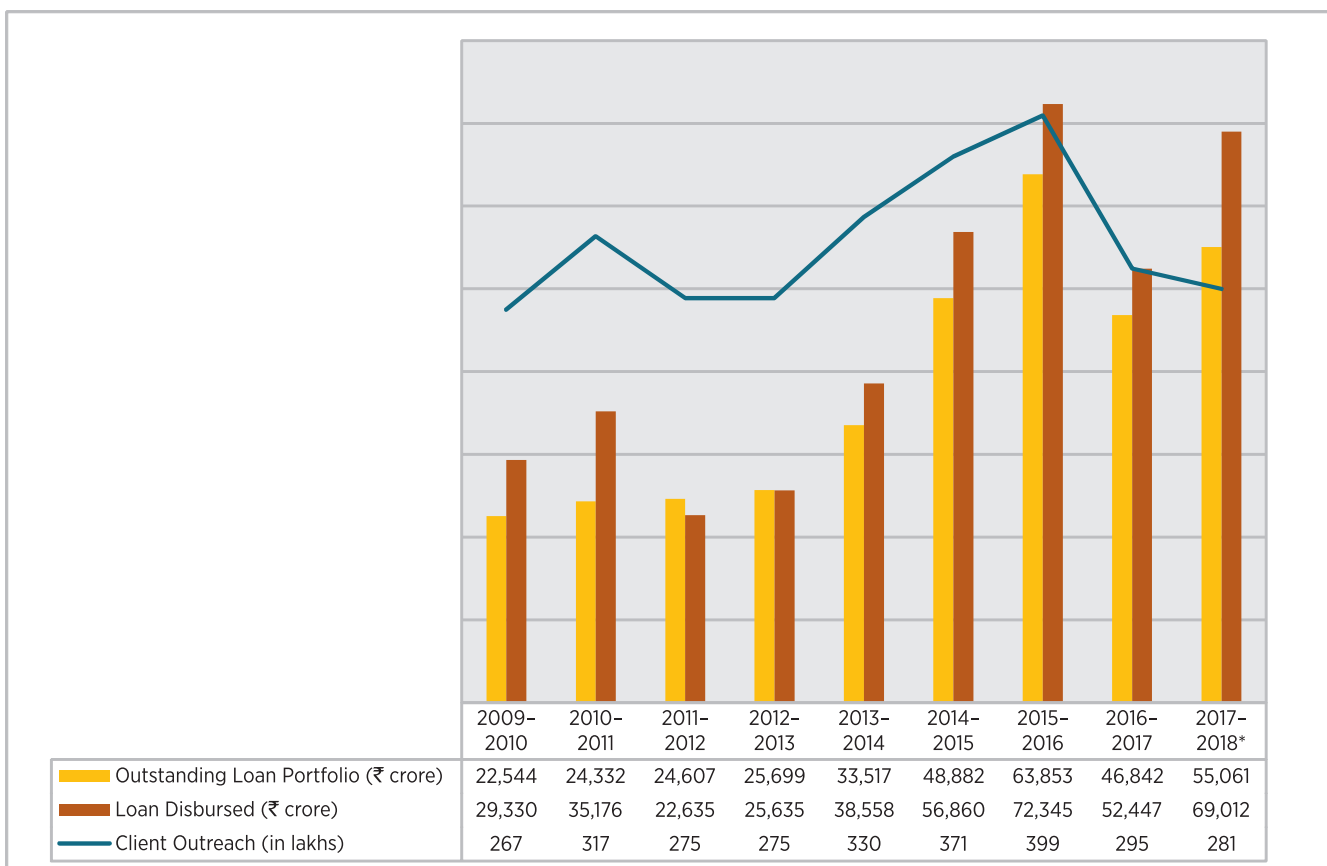
The Indian microfinance sector has shown great resilience over the years, surviving many setbacks and renewing its growth trajectory, while also emerging as aspirationally client-centred. The last five years witnessed the emergence of ‘client’ as the protagonist. Multiple instruments – code of conduct, client-protection principles and fair practices code, for example – promote responsible microfinance. Moreover, although MFIs faced severe disruption in their cash flows after demonetisation, the improved risk management practices MFIs had already adopted buffered them from its potentially catastrophic impact.

Tighter regulatory oversight and operational guidelines framed by RBI has stabilised the sector. The impact of the Andhra Pradesh Microfinance Crisis was undoubtedly felt across India, and the sector did experience a slower growth and contraction in loans outstanding between 2010–2011 and 2012–2013. However, by 2013–2014, the MFI sector was largely up and running again, with growth rates reaching 45.8 per cent for loans outstanding and 55.2 per cent for disbursements in 2014–2015 (figure 1.2). If Bandhan Bank is excluded (for ceasing to

be an MFI when it became an Universal Bank), the sector grew at 62.2 per cent and 61.2 per cent in terms of loans outstanding and disbursement, respectively, for 2015–2016.

The data for 2016–2017 reflects two developments: a) demonetisation disrupted the credit flow in the sector and b) Small Finance Banks exited the MFI space. The growth trends as indicated in figure 1.2, including the provisional data for 2017–2018, confirm that the sector is bouncing back.

**Figure 1.2. Growth in MFI sector (2009–2018)**



Source: Sa-Dhan, various years; \*Provisional data: Sa-Dhan, 2018

## The New Players on the Scene

For the last several years, MFIs have demanded persistently to convert to full-fledged banks or limited banks. The Rajan Committee opined in 2008 that there was sufficient change in environment to warrant experimentation with licensing of Small Finance Banks (SFBs), and in 2013, RBI decided to expand the banking space to ensure greater financial inclusion.

The new category of SFBs undertakes basic banking activities that include accepting deposits and lending to under-served sections, particularly to small and marginal farmers, micro and small enterprises, unorganised sector entities and small business units. While the statutory provisions and reserve requirements are similar to other commercial banks, they must extend 75 per cent of credit to priority sectors compared to 40 per cent prescribed for commercial banks. Further, to ensure that the bank extends loans primarily to small borrowers, at least 50 per cent of its loan portfolio should constitute loans and advances of up to ₹2.5 million.

NBFC-MFIs accounted for 8 of the 10 institutions granted in-principle approval by RBI in 2015. The performance of the sector in extending financial services to the marginalised and neglected sections of the society enabled it to be the frontrunner in the SFB race and show that SFB is a natural graduation process.

Since the SFBs continue with their erstwhile microfinance portfolio, they are still major purveyors of microcredit. Even Bandhan Bank, as a universal bank, is maintaining its microfinance wing. In addition, at least half a dozen private sector banks have microfinance verticals whose operations are structured on the lines of an MFI. These two sets of institutions together have a microcredit loan portfolio of ₹804 billion as of 31 March, 2018, of which microfinance verticals of banks account for ₹504 billion and SFBs account for ₹300 billion (Sa-Dhan, 2018).

In 2015, a different sort of initiative emerged in India. RESULTS Educational Fund, Grameen Foundation and Freedom from Hunger India Trust (FFHIT) jointly formed the Community of Practice for Health and Microfinance (COPHAM), an experiment to bring together stakeholders in the health and microfinance sectors to promote universal health coverage. Starting in April, 2018, Sa-Dhan became the host of the COPHAM Secretariat.

Practitioners of health and microfinance largely work in silos, but with more meaningful collaboration, both will benefit: microfinance providers have access to innovations in the health sector and healthcare actors can more easily reach millions of healthcare consumers. COPHAM's mission is to ensure access to comprehensive, high quality and affordable healthcare and sustainable management of water and sanitation, particularly for women, adolescent girls and children, by aligning the strategies of microfinance and health sectors and catalysing collective action. COPHAM members leave behind the imperatives of competition to exchange knowledge (lessons, tools and expertise) and potentially collaborate on joint projects. In 2018, COPHAM counted 49 members across India and included MFIs/SHPs, representatives from the health sector, donors, academia, government and social entrepreneurs (e.g., technology, medical devices, etc.).<sup>5</sup>



Image 4. Members of COPHAM attended the 2nd Annual Stakeholder Meet in Ahmedabad in 2017. (Credit: RESULTS Educational Fund)

<sup>5</sup> Visit <http://healthandmicrofinance.org/> to view the full list.

## 2.0 State of Health in India

All the markers of a healthy population have improved significantly since India gained independence in 1947. Life expectancy at birth has improved from 36 years in 1951 to 66 years in 2013 – though this is 4 years fewer than the global average and 17 years fewer than the average of high-income countries (Jeemon & Stephen, 2009). While the infant mortality rate has declined at an even faster rate of more than 70 per cent, from 140 per 1,000 live births in the 1970s to 41 per 1,000 in 2013 (Registrar General of India, 2014).

Despite these improvements plus the eradication of smallpox and guinea worm and now being a polio-free country, India still has an unacceptably high level of morbidity and mortality. Compared to its neighbours Sri Lanka, Bangladesh, Nepal and Bhutan, India has the highest neonatal risk in the world with approximately 750,000 newborn deaths every year (Scroll Staff, 2018). Within the country, disparities are highly significant, which is evident between the Western and Eastern regions of India. In Kerala and Goa, neonatal mortality rates are 10 per 1,000 live births, while the figure for Bihar and Uttarakhand stands at 44 per 1,000 (The Wire Staff, 2018). Nevertheless, under-five mortality in India dropped below one million for the first time in 2016, resulting in close to 120,000 fewer children below the age of five dying in India than in the previous year (Scroll Staff, 2018).

Furthermore, India suffers the highest rate of tuberculosis (TB) in the world with 211 per 100,000 people, the second highest total number of estimated multi-drug resistant TB cases (99,000 in 2008; behind China with 100,000) and 2.8 million incidences TB-HIV coinfection (Institute of Medicine [US], 2012; WHO, 2017). Though the government has tripled the domestic budget for TB prevention, diagnosis and treatment, India's health system continues to struggle with the epidemic and other disease burdens.

Today, India is experiencing an epidemiological transition, moving from a phase of high burden of infectious disease to a phase of double burden – infectious disease and chronic non-communicable diseases – as well as nutritional and environmental changes (Bloom, 2011; Jeemon & Stephen, 2009). Diarrhoeal diseases and respiratory infections continue to affect children and the poor disproportionately. Prevalence of chronic conditions such as cancers, diabetes, mental illness and cardiovascular diseases are on the rise with people from low socio-economic groups severely affected due to poor access to healthcare and to the low quality of healthcare delivered.

India's healthcare system is stressed and over-burdened, and India's poorest and most vulnerable communities remain the most excluded from the system. When they do seek treatment, only 1 in 3 households have at least 1 member with health insurance coverage (though, it is a vast improvement from 1 in 20 households the previous decade), and out-of-pocket (OOP) costs account for 69 per cent of health expenditures (IIPS, 2017a; Gupta & Bhatia, 2017). Solutions are coming from all sides, whether private or public, for-profit or not-for-profit, bottom-up or top-down, without coordination. This has led to not only innovative solutions, but also chaos. See box 2 for one such innovative solution and box 3 for insights into how much household income is spent out of pocket for healthcare expenditures related to pregnancy.

## Box 2: Vajpayee Arogyashree Scheme

Several state governments have initiated social health protection schemes to cover the poor against tertiary care expenses: Rajiv Aarogyasri scheme in Andhra Pradesh, Vajpayee Arogyashree scheme in Karnataka, Kalaignar in Tamil Nadu and the Mukhyamantri Amrutum Yojana in Gujarat. These schemes cover, on a cashless basis, higher-end tertiary care for people living below the poverty line.

Karnataka State Government set up Vajpayee Arogyashree in 2010 to deliver universal coverage to families living below the poverty line (BPL) and provide financial protection against catastrophic costs of hospital treatment for major ailments. Vajpayee Arogyashree is fully funded by the government — with subscription fees paid on behalf of beneficiaries — and applies across the state.

The scheme envisions reaching 7.8 million families (5 members per family) in rural and urban BPL populations. Members use their BPL card issued by the Department of Food and Civil Supplies as identification. Vajpayee Arogyashree covers cardiovascular, neurological and renal diseases; cancer treatment (surgery, chemotherapy and radiology); burns; poly trauma cases; and neonatal cases.

A management information system (MIS) stores and reports out data on a real-time basis as collected by *Arogya Mithras* (frontline workers), regional coordinators, district coordinators, etc. Each family can receive up to ₹150,000 cashless service (with an additional ₹50,000 buffer approved on a case-by-case basis), and the MIS system ensures swift pre-authorization approval. *Arogya Mithras* provide client services to beneficiaries and will assist if a hospital refuses treatment or demands extra payment.

As most hospitals are in urban centres in southern Karnataka and beneficiaries (during the first phases of the scheme) were located as far as hundreds of kilometres away in northern Karnataka, empanelled hospitals were required to organize health camps in rural northern areas to screen patients for tertiary care and transport eligible patients to hospitals. Hospitals signed an agreement to conduct these health camps during the empanelment process and receive a fixed payment per health camp conducted. Most rural patients receiving care were identified through these health camps.

## The Government Response

The Government of India (GoI) under Prime Minister Narendra Modi recently undertook a review of the national health policy, which was last formulated in 2002. In early 2017, the Union Cabinet approved the National Health Policy, 2017 (NHP-2017), which aims to provide high-quality healthcare for all by increasing access, improving quality and lowering the cost of healthcare delivery. The NHP-2017 recognizes four major changes in the context of healthcare in India that influenced the formulation of this policy:

1. **Health priorities:** While maternal and child mortality have rapidly declined, non-communicable diseases (NCDs) and some infectious diseases constitute a growing burden.
2. **Health infrastructure:** A robust healthcare industry has emerged with double-digit growth.
3. **Health costs:** The incidence of catastrophic OOP expenditure, one of the major contributors to poverty, continues to grow due to healthcare costs and over reliance on fee-for-service models.
4. **Economic growth:** Rising economic growth enables enhanced fiscal capacity.

The NHP-2017 has set out quantitative goals and objectives in three categories: a) health status and programme impact (11 objectives), b) health systems performance (10 objectives) and c) health system strengthening (9 objectives). For example, by 2025, India will increase the expenditure on health to 2.5 per cent of gross domestic product (GDP) and decrease the proportion of households facing catastrophic health expenditure from current levels by 25 per

cent. A total of 30 objectives cover the following areas: life expectancy; mortality (maternal and child); reduction of diseases such as HIV/AIDS, TB and NCDs; the rate of certain health services accessed (e.g., use of public health facilities and antenatal care coverage); improvement of cross sectoral health issues such as tobacco use, stunting and water, sanitation and hygiene (WASH); health financing (e.g., increasing health spending in state and national budgets); building health infrastructure and human resources, from medical staff and volunteers to care facilities in high priority districts; and finally, health information management (e.g., an e-database of health system components and health surveillance system). Each of these objectives has a defined deadline of completion by 2025 or earlier (Ministry of Health and Family Welfare, 2017).

While the NHP-2017 aligns with the Sustainable Development Goals (SDGs), including the objective to 'progressively achieve universal health coverage' (SDG 3.8), critics argue that certain pieces of the proposed initiatives might increase the cost of healthcare. For example, relying on the private sector for 'strategic purchasing' of services, weak commitment to regulations such as of drug licensing and over-reliance on secondary and tertiary care each could incentivize profiteering and escalate healthcare costs. Moreover, the GoI healthcare expenditure target of 2.5 per cent of GDP is well below the global average of 6 percent of GDP (Gupta & Kumari, 2017; Pahwa, Dhar, & Godinho, 2017).



Image 5. An SHG member brought her infant to the Sub-Centre for weighing by the ANM and ASHA. (Credit: RESULTS Educational Fund)

## Maternal and Child Health Programmes

Interventions addressing reduction in neonatal mortality will serve to further reduce under-five child and infant mortality. A global- and national-level systematic analysis suggests that preterm and low birth weight (less than 2500g) contribute more than 40 per cent in neonatal mortality (Sankar et al, 2016). The GoI has several interventions to address reduction in neonatal mortality rate such as Facility Based New-born Care, Navajati Shishu Shuraksha Karyakram and Home Based New-born Care (HBNC). Evidence suggests that community-based newborn care can significantly improve child survival, including newborn survival (Prost et al, 2013).

The GoI adapted HBNC as a policy in 2011 under the National Health Mission (NHM), training frontline workers (FLWs) called Accredited Social Health Activists (ASHAs) across the country. While its guidelines to operationalize HBNC indicate care of low birth weight and preterm babies, these are often ignored. Yet, around 20 per cent of newborns in India have birth weights of less than 2,500g, and 13 per cent are born prematurely, or before 37 weeks of pregnancy (Black et al, 2013). Periodic reviews of the programme and independent evaluation at every level with ASHAs will be necessary to maintain quality care, and HBNC guidelines should focus on care of low birth weight and preterm babies to effectively reduce the neonatal mortality further.

## Universal Health Coverage

In 2018, the GoI announced Ayushman Bharat under the National Health Agency to fulfil its commitment to achieve universal health coverage (UHC) as laid out in the NHP-2017 and ‘move from sectoral and segmented approach of health service delivery to a comprehensive need-based healthcare service’ (Ministry of Finance, 2018). The scheme has two components:

- A. **Comprehensive primary healthcare:** Health and Wellness Centres (HWCs) will subsume the existing infrastructure of Sub-Centres and Primary Health Centres, expanding coverage to include non-communicable diseases, mental and dental health, etc.
- B. **Financial protection:** The National Health Protection Scheme (NHPS) aims to protect families living in poverty in rural and urban areas from falling deeper into poverty as a result of catastrophic OOP healthcare costs.

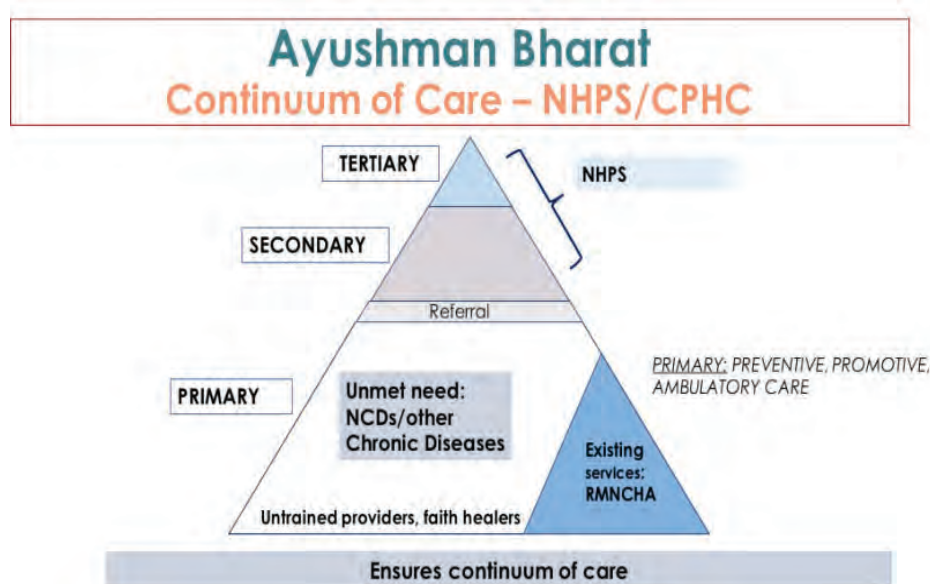


Image 6. The Ayushman Bharat continuum of care. HWCs form the base of the triangle, Comprehensive Primary Health Care (CPHC); and the NHPS provides coverage to the top of the triangle, secondary and tertiary care. (Source: <https://www.abnhpm.gov.in/>)

The planned 150,000 HWCs can provide basic medical services to a population cluster of 5,000 to 15,000 people in rural, sub-urban and urban setup. These establishments will act as a comprehensive primary healthcare package and help take care of 80 per cent of the healthcare needs with zero cost to the patient.

Under Ayushman Bharat, the National Health Protection Mission (AB-NHPM) proposes to cover 100 million poor and vulnerable families (approximately 500 million beneficiaries) and will provide coverage up to ₹500,000 per family per year for secondary and tertiary care hospitalization. AB-NHPM will subsume the centrally sponsored Rashtriya Swasthya Bima

Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). Patients can avail the benefits from any empanelled hospital across the country, and the benefits are not limited to individual hospital or branch. Cashless treatment facilities are available for the patients.

An important challenge for AB-NHPM will be covering out-patient treatment and prescription medicine, which is known to have the greatest impact on the cost of care. Civil society and community organizations with a large beneficiary base, such as MFIs and SHPIs, can fill this gap by promoting awareness about entitlement and develop a system to expand the base through a contributory mechanism from the less poor.

### **Box 3. What ‘Health Diaries’ tell us about managing healthcare and costs among women in West Bengal and Jharkhand**

Grameen Foundation conducted a research project\* in West Bengal and Jharkhand to understand how much of their income women were spending for healthcare expenditures related to pregnancy. For seven months in 2017, 45 low-income women (30 in West Bengal and 15 in Jharkhand) belonging to Aikyatan Development Society (ADS) and Bandhan-Konnagar were interviewed every three to four weeks with a series of frequent household surveys, or ‘Health Diaries’, to capture ‘health events’ (e.g., illnesses or accidents). Grameen Foundation selected pregnant women, women with young children and mothers or mothers-in-law of pregnant women to participate.

#### **The following is an excerpt of key findings from the health diaries research:**

How these households are managing health costs:

1. Low-income households may lack awareness and understanding of how to use and enrol in insurance programs for which they may be eligible.
2. Low-income households are incurring possibly catastrophic OOP health

expenses, despite available government programs meant to mitigate these costs.

3. Households seek care most often from ‘quacks’, followed by the public health sector; however, for the most severe illnesses, they report that they seek treatment from medical providers followed by quacks.
4. Financial products designed to assist women in preparing for and covering health costs will have to be designed in such a way that they respond to the urgency in which women feel they have to respond to these costs. Most prefer to use any savings they have that they keep at home because, in their words, *‘I keep money at home, because when I need money, I get it instantly’*.

To learn more about the integrated health and microfinance programme connected to this study, see case study A in the annex.

\*Read the three research briefs on Grameen Foundation’s website: <https://grameenfoundation.org/resources/publications?keys=health+diaries>.

## **Financial Inclusion for Health Inclusion**

The Gol has made a commitment to SDG 3, which strives to ensure healthy lives with the ultimate goal of UHC, which in turn contributes towards reduction in inequality (SDG 10). Crucial to the success of these SDGs is enhancing the financial health of India’s low-income population, mostly in the informal sector, through improving access to healthcare and reducing related OOP expenditure. While several health protection schemes such as RSBY and other state-sponsored health insurance schemes have provided some relief, such schemes failed to address the systematic and structural social exclusion within the healthcare delivery system.

One of the most substantial challenges in achieving UHC is the extension of benefits to the vulnerable and resource-constrained groups such as the urban poor, women in the informal sector, migrant workers or those working in specific sectors such as the garment industry, quarry workers, salt pan workers or tea garden workers. This extension is what one would call ‘product distribution’ in the financial inclusion world and ‘expanding enrolment’ in public insurance.



Financial inclusion can go a long way towards helping low-income families improve access to healthcare and reduce OOP expenditure. While AB-NHPM can cover a substantial tranche of expected healthcare costs, the balance can be supplemented through innovative financial products that relieve financial risk during times of hardship, especially for vulnerable women, and avert their economic burden owing to healthcare access and utilization. If seeking treatment were to result in little to no economic burden, poor women will not only be economically empowered but will not hesitate to access care during a health crisis or emergency to promote their health and well-being.

To achieve UHC, the poor need access to both financial and health services. Given today's digital advances, there are more opportunities than ever for financial inclusion and health agendas to intersect, exploring innovative models that combine public and private sector resources. As described in chapter 1.0, the microfinance sector — MFIs and SHPIs — has a vast reach of some of the most vulnerable and hard-to-reach populations, and they possess intimate knowledge of the communities within which they operate.

The GoI can engage microfinance institutions, informal networks such as self-help groups and women's groups, producers' cooperatives such as dairy cooperatives and farmers' cooperatives, mobile network operators and other financial sector players to extend social protection floors. They can distribute healthcare coverage to workers in the informal economy and supplement the benefits with simple health micro-insurance, health mutual products or other health financing products (e.g., savings and loans) as well as non-financial value-added services. These will be explored in chapters 3.0 and 4.0. Leveraging this strength, there is an underlying potential to not only transform the social health protection system in India, but also promote social and gender equity in health access.

## **Innovations in the Health Sector**

India is often criticized for low utilization of public healthcare facilities attributed to various reasons, including poor accessibility, non-availability of trained health workers and a resulting reluctance to use the existing facilities. A healthy infrastructure is a key determinant of health and well-being, and the private sector has developed tools that could be used in rural areas.

Technology is transforming India. Through NITI Aayog (a government think tank) and the Department of Science & Technology, the GoI has invested in creating an ecosystem for innovations in healthcare. Techno-business incubators have been established to promote and nurture innovations in healthcare from idea to market access. Conclaves and workshops are organized to promote innovations in healthcare, and global industry leaders such as GE, Philips and Medtronic are increasingly investing in low-cost innovations to improve access to healthcare.

Listed below are a few interesting examples of tools available to those interested in integrated health and microfinance programming, including low-cost medical devices, micronutrient products and mHealth. There is a vast array of innovations into the market, and these are a representative sample, selected using two criteria: a) cost effective to the ultimate user and b) user friendly to the field staff of an FSP or the CHWs promoted by them. It is not an exhaustive list, nor does inclusion imply endorsement.

### **Anaemia-Related Innovations**

Anaemia is a condition marked by an iron deficiency; if left untreated its ill effects can cause serious health dangers, especially for pregnant women. Anaemia can be checked by identifying the presence of pallor in conjunctiva (the mucous membrane that covers the front of the eye and lines the inside of the eyelids), tongue (though the tongue pallor can be affected by oral hygiene) and the nail beds. Perfusion, which determines the flow of blood to the extremities, affects the colour in the nail bed.

## 'Lucky Iron Fish' by LIFE

**Type of innovation:** Nutritional supplement.

**How it works:** The 'Lucky Iron Fish' is made from natural ferrous iron, which is safe and easily absorbed by the body. As the Fish is boiled in water or broth, it releases safe, non-toxic doses of iron that is then ingested and absorbed by the body. Though a nursing mother can use the fish without negative impacts to the baby, infants 0–6 months should not be given water cooked with the iron fish.

Research found that using the Fish every day increased the iron levels of users, reducing iron deficiency and iron deficiency-related anaemia (Lucky Iron Fish, 2018). The Fish provides a family with up to 75 per cent of their daily iron intake and lasts for up to 5 years.

**Cost:** If purchased in bulk by a local vendor (e.g., an MFI or SHPI), each Fish costs US\$12.50 to \$17 (min. 8 Fish), or approx. ₹850 to ₹1,200, plus costs of shipping. LIFE works with local partners to distribute donated fish as well.

**Headquarters:** LIFE is based in Ontario, Canada.

**Website:** <http://www.luckyironfish.com/>

## Micronutrient Powder (Sprinkles) by Maternova

**Type of innovation:** Nutritional supplement.

**How it works:** Sprinkles are a micronutrient powder of encapsulated vitamins and minerals used to fortify foods. They come in sachets and contain various vitamins and minerals (see image 8). It is flavourless and is sprinkled over homemade food. A study in Cambodia showed Sprinkles reduce anaemia and iron deficiency and increase the mean serum zinc in infants (Jack et al, 2012).

**Cost:** Approximately \$0.10–0.15 (approx. ₹7–10).

**Headquarters:** Rhode Island, United States.

**Website:** <https://maternova.net/products/micronutrient-powder>

## TouchHb by Biosense

**Type of innovation:** Medical device.

**How it works:** Biosense promotes TouchHb, a non-invasive anaemia screener that measures haemoglobin content (in grams per decilitre) without drawing blood. The TouchHb device captures the presence of pallor in conjunctiva by scanning the eye with the light, handheld device; results will display within 60 seconds.



Image 7. Lucky Iron Fish can provide a portion of the daily required iron intake. (Source: <https://luckyironfish.com/products>)

Table 1. Nutrient Composition of Sprinkles

Nutrient	Study Composition
Iron, microencapsulated ferrous fumarate	12.5 mg
Zinc gluconate	10 mg
Vitamin A, retinol acetate	300 µg
Iodine	90 µg
Vitamin B <sub>1</sub>	0.5 mg
Vitamin B <sub>2</sub>	0.5 mg
Vitamin B <sub>6</sub>	0.5 mg
Vitamin B <sub>12</sub>	0.9 µg
Niacin	6 mg
Folate, folic acid	160 µg
Vitamin C, ascorbic acid	30 mg
Copper	0.3 mg
Vitamin D	5 µg
Vitamin E	6 IU

Image 8. Nutrient composition of Sprinkles. (Source: Jack et al, 2012)

**Cost:** You must contact Biosense for a price quote. There are no recurring costs once purchased.

**Headquarters:** Thane, Maharashtra.

**Website:** <http://www.biosense.in/touchb.php>

### *Haemospect® by MBR Optical Systems*

**Type of innovation:** Medical device.

**How it works:** Haemospect® is a non-invasive device that measures haemoglobin levels by projecting a white light through the skin and measuring the frequency of the light reflecting from within. It is battery-powered, produces 250 measurements per charge and displays the results within 30 seconds.

**Cost:** The cost of the product is not available, though MBR claims it is 'economically highly attractive, pays for itself in a short time'.

**Headquarters:** Wuppertal, Germany. (They do not have an India distributor, but you can contact the company directly.)

**Website:** <http://www.mbr-optical-systems.com/en/>



Image 9. MBR claims that Haemospect® pays for itself. (Source: <https://www.mbr-optical-systems.com/en/>)

### *Insta ECG by Tricog*

**Type of innovation:** Medical device.

**How it works:** In severe cases of anaemia, blood oxygen levels can be so low that they cause a heart attack (a blood circulation problem). The Insta ECG device provides instant analysis of heart attack using 'technology, artificial intelligence and an expert medical team that works 24\*7 to provide the fastest and most accurate real time diagnosis for heart patients'. This device helps save lives by cutting down the average time between symptoms and treatment. Healthcare start-up Tricog introduced InstaECG to respond to India's over-burdened system and under-served communities, where there is approximately 1 doctor for every 2,000 people (or more).

**Cost:** Request a quote from Tricog.

**Headquarters:** Bangalore, Karnataka.

**Website:** <https://tricog.com/insta-ecg.html>

## **Community Health Innovations**

Community engagement is a cornerstone of primary healthcare, yet rural and poor communities are the most difficult to serve because people are the hardest to reach. Mobile technology offers a solution to bridging these problems created by distance.

### *ImTeCHO by Government of Gujarat*

**Type of innovation:** mHealth platform.

**How it works:** ImTeCHO (TeCHO+) is a mobile phone application developed by the Department of Health and Family Welfare, Gujarat state, and field tested by SEWA Rural. It is similar to Mother and Child Tracking System (MCTS) run by the Gov. ASHAs use the app to check their daily schedule, guide home visitations, record services provided, track high-risk cases, record births and deaths and more. Clinic staff use the web interface to track real-time data on high-risk cases, obtain information about critical indicators and manage incentives and supplies. ImTeCHO has shown to improve the performance of ASHAs: e.g., 90 per cent improvement in counselling and 61 per cent increase in post-natal care. The State Health Department has scaled up the programme across Gujarat.

**Cost:** ₹4,500 per GPRS-enabled smartphone; ₹15-20 monthly cost.

**Headquarters:** Ahmedabad, Gujarat.

**Website:** <http://sewarural.org/community-health-project/>

### *MOTECH by Dimagi*

**Type of innovation:** mHealth platform.

**How it works:** The MOTECH Platform, developed by Grameen Foundation and now managed by Dimagi, is an open-source software that connects eHealth systems, frontline worker systems, and communication systems to expand the capabilities of each. The phone-based innovation has two primary components: 'Mobile Midwife' and 'Nurse Application'. Mobile Midwife pushes SMS or pre-recorded voice messages that reinforce 'well-child care' practices and vaccination schedules to pregnant women throughout their pregnancy into the first year of life for the newborn. The Nurse Application allows community health nurses to track the care pregnant women and newborns receive. MOTECH links these applications, so when Mobile Midwife sends a reminder to the patient for a visit to the clinic, it sends a message to medical staff informing her of the service.

The Open Smart Register Platform (OpenSRP) also uses MOTECH to enable organizations to send reminders to patients and frontline workers; mPower Social Enterprises Ltd., based in Bangladesh, supports OpenSRP in India (<http://www.mpower-social.com/>).

**Cost:** Contact Dimagi.

**Headquarters:** New Delhi (and Massachusetts, USA).

**Website:** <https://motechproject.org/>

### *Wireless Health Incident Monitoring System (WHIMS) by iKureTechsoft*

**Type of innovation:** mHealth platform.

**How it works:** iKureTechsoft created WHIMS, a cloud-based technology using patent-pending software on a tablet or smartphone, to improve the efficiency of their network of rural health centres. WHIMS gives health workers in rural and remote areas access to their patient's health information, enabling them to provide quality and affordable primary healthcare. The application integrates the following features: patient management, billing rules engine, medical information, patient escalation, materials and inventory management and pharmacy management. It also provides accurate and timely information about pregnancy and child birth, generates alerts in real-time and tertiary link to a hospital.

**Cost:** Contact iKure.

**Headquarters:** Kolkata, West Bengal.

**Website:** <http://www.ikuretechsoft.com/>

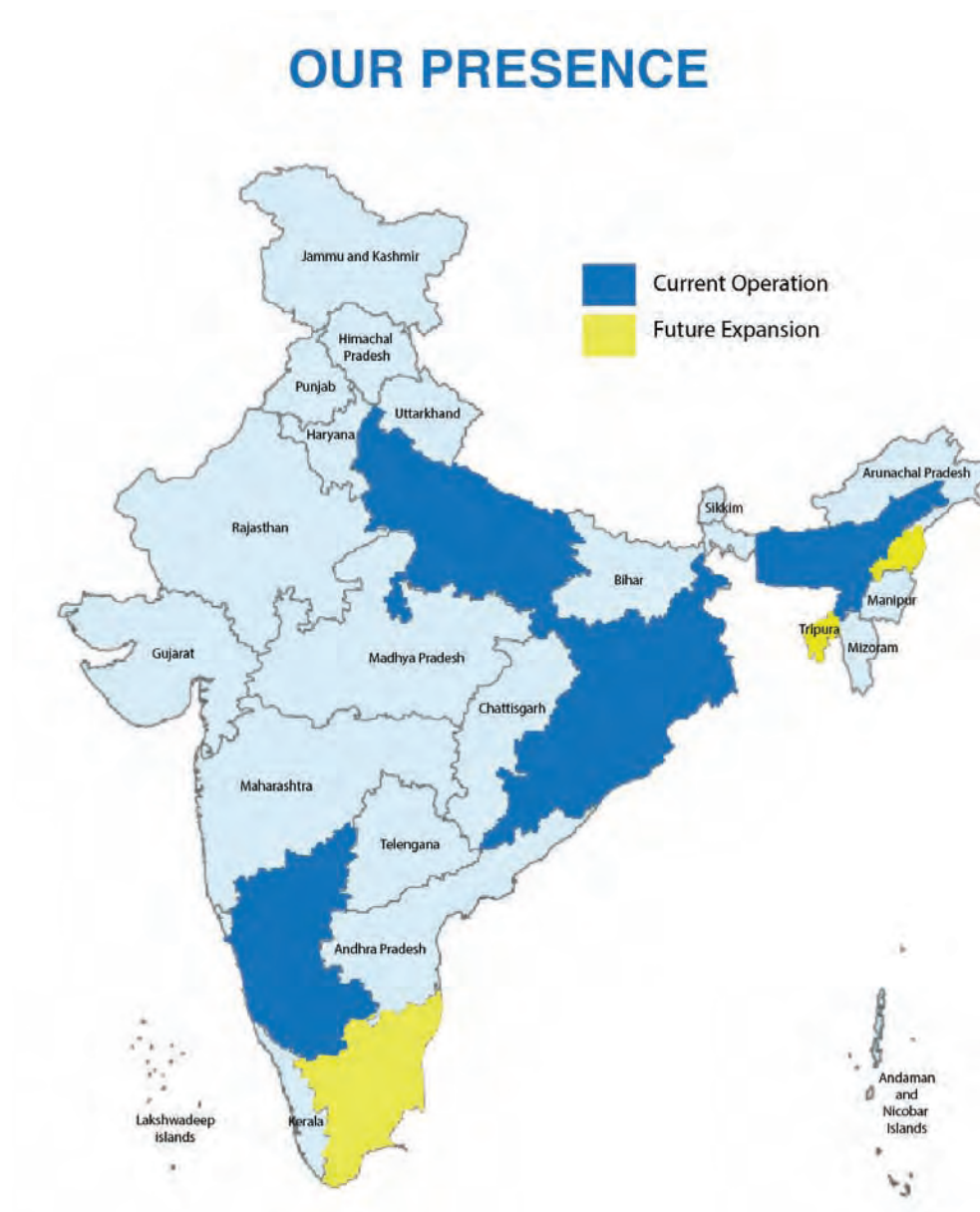


Image 10. Current and future operations of iKureTechsoft.  
(Source: <http://www.ikuretechsoft.com/>).

### 3.0 Health Promotion by Microfinance Practitioners

Those microfinance providers in India that strongly identify with their social missions, believe strongly that their clients must develop in a holistic manner. They understand poverty alleviation requires more than financial services. They also realise that their clientele have difficulty in accessing affordable and quality education and health services. Moreover, financial service providers have compelling business reasons to attend to their clients' health needs with a unique opportunity to deliver health-related services and many are keen to address the non-financial needs of their clients, particularly their health needs. The most common interventions implemented by MFIs include educating microfinance clients on health and nutrition, disease prevention and providing access to basic health products and services. While health financing was previously identified as a means to address the likely gap that will continue in covering OOP health expenses, it is still not as common an intervention compared to other interventions.

To quote Ela Bhat, the illustrious figure of Indian microfinance and promoter of SEWA Bank:

*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 which is a crucial element of social security. 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.*

#### The Evidence for Integration

India has a wide variety of microfinance institutions operating in India, differentiated by legal status, geographic distribution, delivery model and offering of products and services. Mega sized institutions such as Bandhan Bank serve nearly eight million active borrowers, small NBFCs and NGO MFIs have a few thousand clients, and SFBs fall somewhere in between. Additionally, hundreds of SHPIs form SHGs and link them to banks in India's largest microfinance programme, the SHG-BLP.

Together, the microfinance sector has changed the face of financial services in poor, rural and underserved communities. In equal measure, evidence shows that microfinance institutions can bring measurable health improvements to these communities on a national scale with reduced cost (Baum, Elize, & Jean-Lou, 2017). Meta-analysis published in The Lancet covering evidence in South Asia and sub-Saharan Africa found that involvement in a women's group was associated with a 23 per cent reduction in newborn deaths and a 37 per cent reduction in maternal deaths (Prost et al, 2013). The Bill & Melinda Gates Foundation has supported 'health layering' into SHGs in Bihar and Uttar Pradesh since 2012 (Raza et al, 2016). The programs add participatory learning and behaviour change communication in five areas: maternal health, newborn health, family planning, nutrition and sanitation. Evaluation of these efforts show that SHGs can significantly improve women's empowerment and health outcomes, as shown below:

- **Promote life-saving newborn (first 28 days) care behaviours.** In both states, SHG programs have improved immediate breastfeeding (14 per cent difference over one year), skin-to-skin care (up to 24 per cent difference) and clean cord care (up to 20 per cent difference) among members of SHGs or in households of members.

- **Increase women's use of modern contraceptives.** In Bihar, SHG programs increased members' use of modern contraceptives by 9 per cent.
- **Empower women.** SHG membership is associated with greater participation by women in decision making and greater influence. Group members reported an 8 per cent increase in empowerment (decision making, confidence and efficacy) and a 13 per cent increase in group cohesion and cooperation. Women in SHGs are three times more likely than non-members to participate in *Gram Sabha* meetings, a meeting of all adults (18 years and above) who live in the village.

Experience shows that group-based lending provides a good forum for education. The borrowers' meetings provide an opportunity for regular face-to-face contact with an educator, and the solidarity structure and joint guarantee mechanism fosters a supportive atmosphere of collective self-interest. Women's successful management of the loans is likely to boost their confidence and, thereby, their willingness to try new practices for better health and other benefits (Dunford, 2001).

## The State of Integrated Services in India

The number of microfinance providers in India implementing integrated microfinance and health programs continues to increase and spread across the country. SEWA, Bandhan, Equitas, SKDRDP and CASHPOR are early adopters. SHG-promoting state government agencies such as Mahila Arthik Vikas Mahamandal (MAVIM) of Maharashtra State have long run integrated health and microfinance programmes, and SHPIs such as ADS in West Bengal promote health on the platform of SHGs.

Data collected from 60 institutions, 37 of them COPHAM members, shows that health education to enhance knowledge and awareness about various diseases, particularly those afflicting women and children, is the most common service delivered by the surveyed organizations at 38. The most common healthcare interventions utilized by COPHAM members are health camps (13) and linkages to health services (16). Microfinance providers most commonly offered health loans (16) and health insurance (6) as health financing solutions (table 3.1).

'Health education' consists of modules designed with adult learning principles and delivered during credit group meetings or community events. 'Linkages' to health services means the encouragement and guidance by field staff or community health workers (CHWs) of the community women to avail public healthcare providers. Financial service providers (FSPs, encompassing MFIs and SHPIs) create access to health-related products such as sanitary pads or over-the-counter medicines, often at subsidized rates and as a means to support volunteer CHWs trained by the organisation. 'Health financing' includes health micro-insurance, savings or loans; as seen in table 3.1, ADS in West Bengal is the lone organisation to promote health savings to its SHG members (see case study A in the annex). Equitas Small Finance Bank provides tele-medicine services in partnership with Apollo Hospitals in four microfinance branches of Chennai city. SAS Poorna Arogya Healthcare Pvt. Ltd. operates a 'hub and spoke' model to provide healthcare assisted by tele-medicine services in Mysore area of Karnataka state.

Table 3.2 shows that health promoting microfinance service providers, health NGOs and health entrepreneurs operate in every state in the country, with more concentration in the northern and north-eastern states, which are comparatively less developed.

In table 3.1, the services are split into three categories (the number of organizations offering that type of service in parenthesis):

- A) Awareness: health education (38);
- B) Health products and services: health camps (17), tele-medicine (2), providing health services (3), linking with health services (16), sale of health products/services (10) and linking to government subsidy (4);

C) Health financing: loans (16), saving (1) and insurance (6); and

D) Other: training/technical service support (9) and program funding (4).

The types of institutions are abbreviated as follows: healthcare organization as 'HO', for-profit MFI as 'MFI', non-profit MFI as 'NGO MFI', Small Finance Bank as 'SFB', Universal Bank as 'UB', State Agency as 'SA', investor/funder as 'I/F', self-help promoting institution as 'SHPI' and technical service provider as 'TSP'.

**Table 3.1. Types of health services provided (2016–2018)**

Organisation	COPHAM	Type	Health education	Health camps	Tele-medicine	Providing health services	Linking with health services	Sale of health products/ services	Linking to government subsidy	Loans	Saving	Insurance	Training/ technical service	Program funding
Total organizations offering each:			38	17	2	3	16	10	4	16	1	6	9	4
Aatapi Seva	Y	SHPI												
Adhikar Microfinance Pvt. Ltd.		MFI												
Aikyatan Development Society	Y	SHPI												
Annapurna Pariwar	Y	NGO MFI												
Arohan Financial Services Pvt. Ltd.		MFI												
Asomi Finance Pvt. Ltd.		MFI												
Bandhan-Konnagar	Y	HO												
Banka Bioloo	Y	HO												
Biosense	Y	HO												
Blaze Trust		HO												
BWDA Finance Ltd.		MFI												
CASHPOR Micro Credit	Y	NGO MFI												
CHEटना	Y	HO												
Child In Need Institute (CINI)	Y	HO												
CROSS	Y	SHPI												
Dakshin Buddhakali Improvement Society		SHPI												
Destiny Finco Pvt. Ltd.		MFI												
Dia Vikas	Y	I/F												
Equitas Small Finance Bank	Y	SFB												
ESAF Small Finance Bank	Y	SFB												
Freedom from Hunger India Trust	Y	TSP												
Grama Vidiyal (IDFC Bank)	Y	UB												
Grameen Development and Finance Pvt. Ltd.		MFI												
Grameen Financial Services Ltd.		MFI												
Grameen Foundation	Y	TSP												
Grameen Shakti Microfinance Services Pvt. Ltd.		MFI												
GU Financial Service Pvt. Ltd.		MFI												
Guardian	Y	MFI												
Jan Sahas	Y	SHPI												
Lok Swastya SEWA Trust	Y	HO												
Mahasemam Trust		HO												



Organisation	COPHAM	Type	Health education	Health camps	Tele-medicine	Providing health services	Linking with health services	Sale of health products/ services	Linking to government subsidy	Loans	Saving	Insurance	Training/ technical service	Program funding
Total organizations offering each:			38	17	2	3	16	10	4	16	1	6	9	4
MAVIM	Y	SA												
National Insurance VimoSEWA Cooperative	Y	HO												
Nav Bharat Jagriti Kendra		SHPI												
Opportunity International	Y	I/F												
PEDO	Y	SHPI												
People's Action for Transformation		SHPI												
Pioneer Trad	Y	SHPI												
PMDS	Y	SHPI												
Prayas	Y	SHPI												
Prochesta Thrift and Credit Cooperative Society Asom Ltd.		SHPI												
Rajasthan Shram Sarathi Association		SHPI												
RESULTS Educational Fund	Y	TSP												
Sahara Utsarga Welfare Society		SHPI												
Samhita	Y	MFI												
SAS Poorna Arogya Healthcare Pvt. Ltd.	Y	HO												
Sesame Workshop	Y	HO												
Seva Mandir	Y	HO												
Shikhar Microfinance Pvt. Ltd.		MFI												
SKDRDP	Y	NGO MFI												
SMILE Microfinance Ltd.		MFI												
South India Finvest Pvt. Ltd.		MFI												
Sukarya	Y	HO												
Swayam Micro Services		NGO MFI (Sec. 8)												
Swayam Shikshan Prayog	Y	SHPI												
Swayamshree Mahila Sambaya Samiti Ltd.		SHPI												
UE Life Sciences	Y	HO												
Uplift Mutuals	Y	HO												
Vaagdhara	Y	SHPI												
Welfare Services Ernakulam		SHPI												

Source: Survey conducted by Sa-Dhan in 2018 and data collected from COPHAM members (2016-2018).

**Table 3.2. The geographic spread of providers (2016–2018)**

Organisation	COPHAM	All India	Assam	Bihar	Chhattisgarh	Delhi	Gujarat	Haryana	Jharkhand	Karnataka	Kerala	Madhya Pradesh	Maharashtra	Odisha	Rajasthan	Tamil Nadu	Uttar Pradesh	Uttarakhand	W Bengal	NE states
<b>Total organizations:</b>		7	8	9	7	6	6	3	8	8	3	10	7	7	13	14	7	3	10	3
Aatapi Seva	Y																			
Adhikar Microfinance Pvt. Ltd.																				
Aikyatan Development Society	Y																			
Annapurna Pariwar	Y																			
Arohan Financial Services Pvt. Ltd.																				
Asomi Finance Pvt. Ltd.																				
Bandhan-Konnagar	Y																			
Banka Bioloo	Y																			
Biosense	Y																			
Blaze Trust																				
BWDA Finance Limited																				
CASHPOR Micro Credit	Y																			
Child In Need Institute (CINI)	Y																			
CROSS	Y																			
Dakshin Buddhakali Improvement Society																				
Destiny Finco Pvt. Ltd.																				
Dia Vikas	Y																			
Equitas Small Finance Bank	Y																			
ESAF Small Finance Bank	Y																			
Freedom from Hunger India Trust	Y																			
Grama Vidiyal	Y																			
Grameen Development and Finance Pvt. Ltd.																				
Grameen Financial Services																				
Grameen Foundation	Y																			
Grameen Shakti Microfinance Services Pvt. Ltd.																				
GU Financial Service Pvt. Ltd.																				
Guardian	Y																			
Jan Sahas	Y																			
Lok Swastya SEWA Trust	Y																			
Mahasemam Trust																				
MAVIM	Y																			
National Insurance VimoSewa Cooperative	Y																			
Nav Bharat Jagriti Kendra																				
Opportunity International	Y																			
PEDO	Y																			
People's Action for Transformation																				
Pioneer Trad	Y																			
PMDS	Y																			

Organisation	COPHAM	All India	Assam	Bihar	Chhattisgarh	Delhi	Gujarat	Haryana	Jharkhand	Karnataka	Kerala	Madhya Pradesh	Maharashtra	Odisha	Rajasthan	Tamil Nadu	Uttar Pradesh	Uttarakhand	W Bengal	NE states	
<b>Total organizations:</b>		7	8	9	7	6	6	3	8	8	3	10	7	7	13	14	7	3	10	3	
Prayas	Y																				
Prochesta Thrift and Credit Cooperative Society Asom Ltd.																					
Rajasthan Shram Sarathi Association																					
RESULTS Educational Fund	Y																				
Sahara Utsarga Welfare Society																					
Samhita	Y																				
SAS Poorna Arogya Healthcare Pvt. Ltd.	Y																				
Sesame Workshop	Y																				
Seva Mandir	Y																				
Shikhar Microfinance Pvt. Ltd.																					
SKDRDP	Y																				
SMILE Microfinance Ltd.																					
South India Finvest Pvt. Ltd.																					
Sukarya	Y																				
Swayam Micro Services																					
Swayam Shikshan Prayog	Y																				
Swayamshree Mahila Sambaya Samiti Ltd.																					
UE Life Sciences	Y																				
Uplift Mutual	Y																				
Vaagdhara	Y																				
Welfare Services Ernakulam																					

Source: Survey conducted by Sa-Dhan in 2018 and data collected from COPHAM members (2016-2018).

## Knowledge and Behaviour-Change Education

While an additional service such as health education imposes additional delivery costs on group-based lending, the marginal cost can be reduced when the regular (weekly, biweekly or monthly) repayment meetings serve as the forum for the education. Moreover, the marginal cost can be made quite small when the same field staff deliver both financial and educational services at the same regular meetings, known as the 'unified model' (Dunford, 2001).

In the last two decades, Grameen Foundation,<sup>6</sup> has developed education modules on various health topics targeted to credit and savings group women and youth in Africa, Asia and Latin America. The alliance of Grameen Foundation, Freedom from Hunger India Trust and RESULTS Educational Fund has adapted those modules to Indian conditions and partnered with local FSPs to deliver to 169,100 women and girls (as of September, 2017). They have designed new modules on gender and food security, anaemia, WASH, menstrual hygiene and NCDs, and they have developed Learning Games for Girls (LGG), a new game-based methodology targeting adolescent girls.

<sup>6</sup> In 2016, Grameen Foundation and Freedom from Hunger integrated under the Grameen banner. The work described here originated with Freedom from Hunger and continues now with Grameen Foundation.

A survey of 60 institutions (including 39 FSPs) carried out for this report shows that two-thirds deliver health education, and half of those use education modules developed by Grameen Foundation/RESULTS Education Fund. Careful market research to determine learners' needs, existing knowledge and resources available in the community form the basis of these modules. The research is used to identify knowledge, skills and attitude gaps that education can address. Education modules developed by these institutions reflect the following attributes:

- **Relevance for the poor:** Content reflects and is determined by the needs and concerns of the target group; participants are encouraged to share personal experiences.
- **Focus on change in practice or behaviour:** Content is simple yet essential; the desired practices and behaviours are attainable and measurable.
- **Fun and enjoyable:** Methods use familiar, safe techniques and encourage discussions, stories and games; learning process is enjoyable and fun. Even illiterate participants can engage fully.
- **Ease of use:** Materials needed are minimal and available in the immediate environment; sessions are simple and facilitators have all the instructions they need in the facilitator guide.

The health education modules are divided into five to six sessions, each taking about 30 minutes to deliver. However, it is possible to adapt them — without sacrificing quality — into longer sessions (one hour each) delivered over fewer total sessions or into shorter sessions of 15 to 20 minutes each (Gray et al, 2012).

FSPs using Grameen Foundation modules have adopted different approaches in the delivery. People's Multipurpose Development Society (PMDS) in Tamil Nadu provides health education to their SHGs by deploying their field staff and has covered more than 60,000 members (2007–2018) with awareness building on HIV/AIDS, childhood illness, women's reproductive health, healthy habits for life and anaemia. However, none of the large MFIs wishes to deploy their credit staff for delivering the health lessons, though such unified approach could be highly cost-effective. In addition to their own staff of Health Community Organisers (HCOs), Bandhan Bank-sponsored NGO Bandhan-Konnagar deploys CHWs they train and promote called *Swasthya Sahayikas* (SSes; learn more in case study C). Equitas Small Finance Bank incorporates health education into the lessons a cadre of paid vocational trainers delivers to tens of thousands of women each year in fee-based courses. CASHPOR Micro Credit promotes health education through Community Health Facilitators (CHFs), whom they prefer to call entrepreneurs; CHFs are local women trained by their partner, Healing Fields Foundation (see case study B). Swayam Shikshan Prayog (SSP), Maharashtra-based NGO, also trains local women (*Arogya Sakhis*) to deliver health education and to provide health services such as monitoring blood pressure, blood sugar or growth parameters of children (see case study D).

FSPs using Grameen Foundation modules measure the impact of health education by administering a simple questionnaire before and after delivering the module. The findings from this minimal monitoring and evaluation yield very impressive results in terms of enhancement of knowledge and awareness, besides behaviour change. For example, MAVIM used the module 'Healthy Habits for Life to Prevent Non-Communicable Diseases' to achieve great results as seen in table 3.3, where the sample size (N) is 513 and 506 women for the baseline and end line, respectively.

**Table 3.3. Consumption of seasonal fruits and vegetables (2014)**

Characteristic	Baseline		End line		
	No. respondents	%	No. respondents	%	
<b>Awareness about importance of consumption of fruits and vegetables</b>					
Green vegetables	416	83%	498	98%	
Fruits	238	46%	496	98%	
<b>Awareness that extra nutrition is required for :</b>					
Pregnant and lactating women	237	46%	495	98%	
Adolescent girls	167	33%	493	97%	
<b>Awareness about health complications of diabetes</b>					
Risk of heart disease	166	32%	412	81%	
Risk of blindness	115	22%	399	79%	
Risk of losing toes	114	22%	398	79%	
<b>Awareness about health complications of hypertension</b>					
Risk of heart disease	110	21%	341	67%	
Risk of kidney problems	158	31%	306	60%	
Risk of paralysis	143	28%	322	64%	
<b>Awareness about factors contributing to hypertension and diabetes</b>					
Consuming high amounts of salt, sugar and oil	221	43%	439	87%	
Not doing enough exercise	3	1%	395	78%	
Consuming tobacco and/or alcohol	255	50%	463	92%	
Not eating enough fruits and vegetables	72	14%	219	43%	
<b>Change of behaviour (Consumption of sugar with coffee/tea and pickles)</b>					
Half a spoon of sugar with each cup of coffee/tea	33	6%	198	39%	
One spoon of sugar with each cup of coffee/tea	174	34%	248	49%	
Two spoons and more	288	56%	43	9%	
Eating salty pickles every day	147	29%	17	3%	
Eating salty pickles very rarely	177	35%	414	82%	
<b>Percentage of rice in the staple food</b>					
Behaviour	100%	22	4%	4	1%
	75%	46	9%	17	3%
	50%	228	44%	413	82%
	25%	207	40%	72	14%
<b>Consumption pattern of fruits</b>					
Are you eating fruits at least once in two days? ("YES" responses)	215	42%	410	81%	

Bandhan-Konnagar also used extensively the Grameen Foundation and Freedom from Hunger India Trust maternal and child health modules and recorded impressive results in terms of enhanced awareness and change of practices. When they revisited the original sample five years after the pre-test, the beneficiaries not only retained their knowledge and behaviour but had improved upon it (Johnson et al, 2014).

**Table 3.4. Bandhan-Konnagar results over four years (2008–2013)**

Characteristics	Pre-Test 2008 (N=240)	Post-Test 2009 (N=180)	Follow-up 2013 (N=181)
<b>Infant Feeding and Nutrition</b>			
Knew how soon after birth a child should be breastfed	71%	97%*	92%*
Knew to add oil, protein or vegetables to first foods for baby to make them more nutritious	93%	96%	98%
The child in their care was breastfed immediately or within one hour of birth (women with children <12 months)	61%	93%*	75%
Reported introducing complementary foods at age 6 months or older (with children <12 months)	60%	88%*	100%*
<b>Diarrhoea Treatment</b>			
Had a child in their household or care who had diarrhoea in the last three months who treated that child with ORS	60%	88%*	100%*
<b>Prenatal and Maternal Health</b>			
Pregnant within the prior 18 months and received a referral from the MFI community health worker for prenatal care	31%	38%	64%*
Gave birth during the past 12 months and were visited by an MFI community health worker within 48 hours of birth	16%	36%*	54%*
Pregnant within prior 18 months and made at least three visits to a medical professional	87%	86%	95%

\*Statistically significant change with at least  $p \leq 0.05$ .

Grameen Foundation's Microfinance and Health Protection (MAHP) methodology has proven highly cost-effective. A comparison of the cost incurred by Bandhan, CARD-MRI in the Philippines and CRECER in Bolivia found that CARD-MRI could provide health-related services to their clients for \$0.27 per client per year, as compared to \$1.01 and \$0.80 incurred by Bandhan and CRECER, respectively (see table 3.5). CARD-MRI achieved cost efficiency by deploying their credit staff to deliver health lessons during group meetings (Metcalf, Hollingworth, Stack, & Sinclair, 2014).

**Table 3.5. Programs are low-cost and sustainable (2009 and 2013)**

MFI Partner	2009		2013	
	Total annual cost/client (US\$)	Outreach	Total annual cost/client (US\$)	Outreach
Bandhan (India)	1.73	51,900	1.01	437,015
CARD-MRI (Philippines)	0.74	152,334	0.27	1,636,409
CRECER (Bolivia)	0.88	26,287	0.80	124,006
<b>Average</b>	<b>1.12</b>		<b>0.69</b>	

Source: Metcalfe, Hollingworth, Stack, & Sinclair, 2014

## Access to Health Products and Services

Many FSPs go beyond health education and provide access to cost-effective health products and services to their clients. PMDS runs a primary hospital in Viluppuram district, Tamil Nadu, to provide pre-and post-natal care of pregnant mothers. ADS works closely with members of the local *Gram Panchayat* (local village council) and government FLWs to encourage and facilitate optimal utilisation by their SHG member families of the facilities available at the government-run Primary Health Centre (PHCs), Service Centres and *Anganwadi* centres.<sup>7</sup> ESAF Small Finance Bank, CASHPOR Micro Credit and SSP train SHG members to be entrepreneurs

<sup>7</sup> Anganwadis are government run pre-schools for children of 3-6 years. These run for 4 hours a day.

monitoring vital statistics such as blood pressure, blood sugar and haemoglobin in rural communities by charging a modest fee, potentially earning a modest income.

Equitas Small Finance Bank believes in promoting health through partnerships. They have partnered with Apollo Group of Hospitals to run tele-medicine centres in Chennai city and partners with VisionSpring, a global eyecare company, to run eye screening camps and provide spectacles at a very reasonable cost (see case study E). Equitas has tie up with some 900 private hospitals in eight states where their clients receive preferential and concessional consultation and treatment.

Using credit and savings groups for providing essential health interventions has important policy implications for India, which from an acute shortage of qualified doctors and para-medical staff, particularly in the rural areas, where the majority of the poor live. By March, 2017, FSPs reached 141 million households (Sa-Dhan, 2017). Even after discounting for duplication of clients (some clients being serviced by more than one institution), FSP outreach in India is very significant. If FSPs use the existing supply chain – credit and savings groups – to deliver health-related services alongside financial services, they could supplement the country’s efforts to strengthen the healthcare system in rural areas and for the urban poor.

### Community Health Workers

Promoting access to health products and services by creating a cadre of CHWs is an additional strategy adopted by both MFIs and SHPIs. Drawn from the community, SHG members or microfinance clients work as volunteers or with a modest incentive-based income – unlike government FLWs, who receive regular emoluments – to increase community access to medicines, health products and services.

**Table 3.6. COPHAM members promoting CHWs (2018)**

Organisation	No. CHWs	CHW Roles and Programme Details
<b>Bandhan-Konnagar</b>	5,500	Drawn from among microfinance clients of Bandhan Bank, Swasthya Sahayikas deliver health education, supply health products and give advice on linkages to health services. They earn a modest income of ₹200–300 per month through the sale of health products (e.g., sanitary pads) and over-the-counter medicines. Bandhan-Konnagar supports these workers by providing training and maintaining inventory of health products. After three years, SSeS are mostly on their own, though Bandhan-Konnagar provides counselling and retraining.
<b>CASHPOR Micro Credit</b>	2,600	Drawn from among clients of CASHPOR, Community Health Facilitators earn a modest income by sale of sanitary napkins, delivery of health lessons and facilitating CASHPOR loans for construction of toilets and water connections.
<b>Seva Mandir</b>	98	Each <i>Bal Sakhi</i> operates in one village, covering a population of about 500. They make home visits to identify pregnant women and malnourished children. They monitor weight of children and prepare their growth charts. <i>Bal Sakhis</i> recommend the course of action to the parents for malnourished children and, in extreme cases, refer children to the Malnourishment Treatment Centre at the district hospital (learn more in case study F).
<b>SSP</b>	380	Selected from among SHG members, <i>Arogya Sakhis</i> are trained to deliver health education and monitor the growth parameters of children. Additionally, they collect a small fee to monitor blood pressure, blood sugar, haemoglobin and weight of community members. They are trained to use a tablet to enter the above health parameters, along with personal data of individuals, which is transmitted to a doctor, who issues a prescription to those needing treatment.
<b>Vaagdhara</b>	1,243	Community Nutrition Advocates (CNAs) deliver behaviour-changing health and nutrition education to SHG members. CNAs work in close coordination with ASHAs and Anganwadi workers (AWWs).
<b>Pradan</b>	80	<i>Shakti Bais</i> deliver behaviour-changing health and nutrition education to SHG members and work in close coordination with ASHAs and AWWs.
<b>TOTAL</b>	<b>9,901 CHWs</b>	

Interactions with groups of CHWs engaged by Bandhan-Konnagar, Seva Mandir, SSP, PRADAN and Vaagdhara revealed interesting facts about their attitude and work ethic. They are proud of their work and immensely value the appreciation they receive. They cherish the attention and respect for their work from their own family members and the community. Jharna Rabi

Das, an SS with Bandhan-Konnagar, stated that she has saved lives of several pregnant women by insisting that deliveries should take place in the hospital. Initially, the families of pregnant women loathe her intervention, but after successful deliveries, they are grateful to her. Their gratitude is the main driving force for Jharna to work harder.

CHWs interviewed fondly remember the trainings they received. For many of them, these trainings were the first of its kind in their life. Arogya Sakhis of SSP said they loved the quizzes and games that formed a part of the trainings they received. They also feel extremely proud, with their self-esteem boosted, when they go around their village with the health kit, measuring and recording the blood pressure and blood sugar of the beneficiaries.

Though they welcome better emoluments, the lack of it has not dampened their spirit or involvement. They look at their work as long-term, value the knowledge gained during training and are keen to have fresh trainings on newer health topics. Though they felt extremely nervous initially during the health education trainings and delivery of health sessions, over time, they became comfortable and started enjoying it.

However, considering the large number of CHWs (9,901 as seen in table 3.6), questions arise about their relevance, acceptability and sustainability. With 1 million ASHAs (1.5 per village) and 1.3 million AWWs (2 per village) working in the field, can CHWs play any useful role? How long can CHWs work as volunteers? Can they earn a decent income for the work they do so selflessly?

Mukti Bosco, executive director of Healing Fields Foundation, the technical partner of CASHPOR, says that CHWs make the healthcare system more effective:

*Though ASHA workers and Anganwadi workers are working in the field, they belong to different departments of the government and, therefore, lack coordination. They are loaded with diverse responsibilities but lack adequate infrastructure and facilities to work. Unless these functionaries come together to achieve convergence of their services, the community will not be benefited. Community Health Facilitators, promoted by CASHPOR/Healing Fields Foundation, are envisioned and trained to be the convergence point.*

*Our evaluations show that the CHW is the first point of contact in the community because she is a trusted peer who is able to coordinate with ASHAs/AWWs for achieving the desired results. She adds value to the existing government services.*

The important role CHWs are playing is evident in the field areas of Bandhan-Konnagar. Bandhan Bank clients and the village community appreciate the contribution of SSeS, finding the health information useful and health products available for purchase convenient. Suchitra Sarkar, an SS in Pakur area, recounted that one of the pregnant women in her neighbourhood had a ruptured membrane, which led to heavy bleeding at 4am in the morning. Suchitra called for the ambulance and accompanied the pregnant woman to the hospital; along the way, Suchitra helped the mother deliver in the ambulance. Suchitra was thrilled seeing the happiness of the woman and her family upon the positive results.

When asked about the sustainability of the SSeS, Chandra Shekhar Ghosh, managing director of Bandhan Bank, was emphatic that even after the support of Bandhan is withdrawn after three years, many of the SSeS promoted by Bandhan-Konnagar continue to work on their own. He opined that a passion to help others and the spirit of volunteerism are the driving forces behind the SSeS (read the interview with Ghosh in the annex). But Mukti has a different argument.

Healing Fields Foundation trains a CHF to be entrepreneurial. CASHPOR CHFs convince clients to avail CASHPOR loans for construction of a toilet. After the toilet is constructed, the CHF persuades the families during their routine home visits to use the toilet and sells them toilet cleaning supplies. Thus, in addition to earning a small fee from CASHPOR on toilet loans,



the CHFs have sales income from cleaning supplies, supplementary food and pregnancy kits.

SHPs and MFIs are uniquely placed to promote CHWs. Years of work promoting microfinance groups and nurturing them has made their job of identifying women suitable to be CHWs rather easy. Once the right person is selected, the job of training and deploying them is not difficult. The field staff of microfinance providers could routinely monitor the performance of these workers. Find case studies of CHW programmes in the annex.



Image 11. A Bandhan healthcare officer visits the home of a microfinance client for a health check-up and weighing. (Credit: RESULTS Educational Fund)

## 4.0 Promoting Financial Security Through Micro Health Insurance

Existing publicly funded social health protection schemes for the poor, such as RSBY, have had a limited effect on out-of-pocket expenditure due to a range of factors, including limited awareness of entitlements that hinder the benefit of such schemes for those who need them most. This leaves an opportunity for health micro-insurance, mutuals and other community-based health insurance schemes to complement government-sponsored schemes.

Unlike credit, the concept of insurance is complex, and it takes time to create the proper understanding among poor members for whom insurance is not a priority. A comprehensive education campaign to understand the product and claim servicing in detail is required before enrolling and paying a premium. Micro-insurance programme management is more about doing several small things properly and iterative learning and tweaking, rather than taking a major initiative to scale. Several organizations have promoted financial security for low-income populations, and such programmes take different form, scope and scale. We discuss several such experiences in this section.

### Annapurna Pariwar Vikas Samvardhan

Annapurna Pariwar, a Section 8 non-profit company headquartered in Pune, Maharashtra State, set up a community-based health mutual fund in 2003 for its microfinance members, who belong to the bottom 20 per cent and low-middle income (20 to 40 per cent) populations in terms of income. While Annapurna Mahila Cooperative Credit Society lends to its members, Annapurna Pariwar Vikas Samvardhan (APVS) company enrolls families of the microfinance clients in the community-based insurance. They saw this as a solution to the desperately felt need of its microfinance clientele as early as 2000.

As of 2018, 205,537 members in urban and peri-urban slums participated in the Community-Based Health Insurance (CBHI) scheme and received, to some extent, financial protection from catastrophic health costs.

The health mutual fund is owned by its members, who have representation in the management committee as well. Members pay an insurance premium, ranging from ₹155 to ₹205 per person per year, in proportion to the microcredit loan availed (the maximum micro loan is ₹100,000). This is the only source of revenue for CBHI. CBHI provides a 50 to 100 per cent reimbursement of hospitalisation expenditure with a ceiling of ₹18,000 for each episode. The maximum benefit ranges from ₹20,000 to ₹28,000 per head per annum. The total claims reimbursed during 2017-18 was ₹18,172,037.

APVS created a tailor-made specialized management information software (MIS) that helps in claim settlement, keeping medical history of the clients for better actuarial design and fund management.

#### Costs and Benefits

**Premium:** ₹155–205/year/person

**Benefits:** 50–100% refund for hospitalization, guidance to quality providers, health card, health education, 24x7 helpline

#### Insurance Design

**Model:** Health mutual

**Payment:** Reimbursement

**Enrolment:** Mandatory

**Additional Support:** None

**Insurer:** Community through company funds

**Providers:** Discounted provider network

## What we can learn from APVS

Mandatory enrolment takes care of adverse selection, which describes when participation is affected by asymmetric information, as well as supplier induced demand as beneficiaries form a large pool of clients and may opt out of services if not offered in a competitive manner.

Primary and preventive health services provided by a discounted provider network keep claim ratio low by preventing poor health or catching illness early.

Health guidance and education is an important component of community-based financial protection interventions.

Community involvement in insurance governance and claim management is very important to control delinquencies from clients.

A strong MIS system is needed for monitoring scheme progress.

Scale is saturated once all members of the organization (microfinance borrowers) are covered; the challenge is to attract non-member households to the health mutual.

## National Insurance VimoSEWA Cooperative Ltd.

VimoSEWA started in 1992 to provide financial protection to SEWA Bank borrowers in Ahmedabad. Gradually, VimoSEWA evolved to serve all SEWA members, protecting them from different types of catastrophes such as illness, death and loss of assets. Over several years, VimoSEWA developed a stand-alone, voluntary micro-insurance model managed by community-leaders and women workers. It is managed by a democratically elected board comprising of women workers and professionals from the insurance sector.

Registered in 2009 under the Government of India's Multi-State Cooperative Act, the National Insurance VimoSEWA Cooperative Ltd. has 12,000 women share-holders across five states (Bihar, Delhi, Gujarat, Madhya Pradesh and Rajasthan). VimoSEWA has 13 institutional members, including SEWA Bank, SEWA Bihar and SEWA Cooperative Federation of 106 women's cooperatives.

In 2017, VimoSEWA had 79,899 members, and their premiums make up the sole source of revenue. The premium has increased over time from ₹175 to ₹1,350 per year per family in response to increased demand for higher coverage amounts, which grew from ₹2,000 to ₹50,000.

VimoSEWA has four different health and health-plus insurance products, offering from ₹2,000 in coverage, a wage-loss allowance for hospitalization (₹200 per day up to 15 days per year), pay-outs for accidental death and more. Family plans can cover four to six persons, and one may be availed by individuals. Between 1992 and 2017, VimoSEWA disbursed ₹203 million to 94,000 claimants.

VimoSEWA promotes insurance uptake through a direct sales team, community-based insurance promoters and partner organisations such as MFIs. Implementation includes health education, financial literacy, and their *Agewans*, women deployed by VimoSEWA to provide doorstep facilitation and support.

### Costs and Benefits

**Premium:** ₹225 per person up to ₹1,350 per family per year

**Benefits:** Coverage varies by product (coverage of ₹15,000–50,000 per year per family), daily allowance for hospitalization (up to ₹200 x 15 days), other types of insurance coverage, bundled options

### Insurance Design

**Model:** Health micro-insurance

**Payment:** Cashless

**Enrolment:** Voluntary and monthly

**Additional Support:** *Agewans* provide doorstep facilitation and support

**Risk carrier:** Public sector insurer and mutual model

**Providers:** Network hospitals, low-cost medicine providers

## What we can learn from VimoSEWA

Products need to be designed in consultation with members and as per their need and demand to ensure better compliance.

Designing products with simple features and an easy claim servicing process along with trained human resource are some of the critical components of VimoSEWA's success.

A stand-alone and voluntary micro-insurance distribution model requires a comprehensive sales and marketing strategy to provide timely servicing and maintaining renewals year-on-year.

Insurance is a data-driven business, and technology has helped VimoSEWA manage it effectively. Technology increases efficiency and reduces the chance of bias or variance in decision making in claim settlement. Several years' data analysis and vigilant claims processing led VimoSEWA to change their claims policy from 'zero rejection' to 'zero pendency' (meaning zero delay in processing).

Balancing the social objective of covering the risk of the poor while running the operation in a financially sustainable way is a challenge. Constant engagement with members helps in higher renewals regardless of whether a member submits claims over the years.



Image 12. Aagewans provide doorstep facilitation and support to VimoSEWA's micro-insurance programme members. (Credit: RESULTS Educational Fund)

## SKDRDP: Sampoorna Suraksha Health Insurance

SKDRDP, a charitable trust headquartered in Dakshina Kannada district of Karnataka State, formed the subsidiary Sampoorna Suraksha Health Insurance (SSHI) in 2004. SKDRDP previously offered a small contributory welfare fund (maximum ₹5,000 health benefits), and its SHGs members, who are among the bottom 20 per cent income group, agitated for a more comprehensive insurance product.

SSHI finances health costs for 926,581 members (265,028 families) in rural areas of Karnataka state through health micro-insurance, covering accident, maternity and hospitalization.

SKDRDP funds its insurance operations through subscription fees and donor funds; subscription fees are ₹500 per year per person. SSHI provides ₹10,000 per person for hospitalization expenses (up to 6 family members) on a floater basis, ₹5,000–10,000 for partial or permanent disability compensation and ₹3,500–8,500 for the first two institutional deliveries. In 2017–2018, it disbursed ₹380 million, settling 43,515 claims.

Beneficiaries can obtain additional financial assistance from *Pragathinidhi* (a microfinancing scheme), if hospitalization expenses exceed the sum insured.

### What we can learn from SSHI

The micro-insurance programme is built upon the goodwill that SKDRDP already had in the community. They provide high client value services, for example, helping to cover hospitalization costs that exceed the ensured coverage by providing loans through *Pragathinidhi*.

SKDRDP offers a cashless system where hospitals seek permission for admissions with a preauthorized request. SKDRDP uses its own advanced online technology to process pre-authorization requests and claims, collect insurance premiums from members and make payments to the hospitals.

SSHI operates under a principle of ‘zero rejection’ (compared to VemoSEWA’s zero pendency, or delay).

## Grameen Koota – SAS-PAP Healthcare Partnership Model

Two organisations from Karnataka State, Grameen Koota Services Pvt. Ltd. (Grameen Koota) and SAS Poorna Arogya Healthcare Pvt. Ltd. (SAS-PAP) partnered in 2014 to provide affordable healthcare services. SAS-PAP, founded in 2010, has grown to more than 650,000 clients of 10 MFIs/NGOs in Karnataka and Assam as of March, 2016, with a network of more than 120 partner hospitals. SAS-PAP fully funds its operations through revenue generated from membership fees.

Grameen Koota, founded in 1999, has 1.6 million active borrowers (April, 2017), and feedback from clients revealed an acute need for quality medical consultation and cashless inpatient treatment. The Grameen Koota – SAS-PAP partnership provides its clients access to 45 hospitals in Karnataka. Grameen Koota enrolls its clients at select branches, collects the membership fee of ₹250 per year per person and offers loan support to clients who cannot afford the fee.

### Costs and Benefits

**Premium:** ₹500/year/person collected weekly

**Benefits:** Hospitalization (₹10,000 per person), permanent disability (max. ₹10,000), partial disability for up to 2 childbirths (₹3,500–8,500)

### Insurance provision

**Model:** Health micro-insurance

**Payment:** Cashless (providers bill the insurance programme)

**Enrolment:** Voluntary

**Additional Support:** *Pragathinidhi* financial assistance

**Insurer:** Formal insurance companies

**Providers:** Discounted provider network

Members have access to unlimited consultations for ₹25 per visit, and their coverage provides ₹6,000 per person for cashless inpatient treatment (up to 10 family members). By December, 2016, it disbursed ₹64.3 million on nearly 11,000 claims, and more than 84,000 beneficiaries availed outpatient consultations.

SAS-PAP runs a help desk at partner hospitals staffed by *Sakhis*, who guide clients through the healthcare process. They also offer a mobile app and web-based software to manage the system.

### Costs and Benefits

**Membership Fees:** ₹250/year/person collected weekly

**Benefits:** Inpatient treatment (₹6,000), unlimited consultations for ₹25/visit

### Health Mutual provision

**Model:** Health micro-insurance

**Payment:** Cashless

**Enrolment:** Voluntary

**Additional Support:** Sakhis

**Insurer:** Grameen Koota-SAS-Poorna Arogya Healthcare

**Providers:** Hospital network

## What we can learn from the Healthcare Partnership Model

Health mutual coverage for outpatient consultation is very important because it facilitates early detection of diseases.

MFIs can provide health coverage to their client families in a sustainable manner through partnerships with insurance companies and private hospitals.

Early challenges included the following:

- Convincing MFIs to go beyond financial services and introduce healthcare for their client families.
- Developing a seamless and efficient turn-around time claim process.
- Nurturing partnerships with network hospitals.
- Ensuring Integration of SAS team with MFI team.
- Designing most suitable healthcare products to benefit the clients.

## DHAN Foundation

DHAN Foundation, headquartered in Madurai in Tamil Nadu State, was founded in 1997 and its institutions form the DHAN Collective. Its mission is to build people and institutions that enable the poor communities for poverty reduction and self-reliance. It targets the bottom 20 to 40 per cent (by income) in rural and urban populations.

In 2000, an SHG federation promoted by DHAN initiated a pilot with 3,000 families to establish a health scheme, creating a primary care clinic and providing ₹10,000

### Costs and Benefits

**Premium:** ₹200/year/person (in 2014)

**Benefits:** Hospitalization benefits (₹2,500–20,000 per family per year); provider-owned hospitals and clinics; discount on medicines, lab, X-ray and diagnosis

### Insurance Design

**Model:** Provider insurance

**Enrolment:** Voluntary

**Additional Support:** Free specialist consultations

**Insurer:** Insurance companies

**Providers:** SUHAM Hospitals promoted by Kalanjams and primary care clinics

coverage for a contribution of ₹150 per member (up to 5 people). The programme reimbursed up to 75 per cent of expenses at select hospitals. DHAN took this success and, with the help of National Insurance Company, designed a tailor-made provider insurance model in 2006.

In 2016, 54,570 families (up to 5 members) subscribed to DHAN's insurance coverage, and 28,156 members claimed healthcare benefits. Under the universal health insurance scheme, insurance customers receive hospitalisation healthcare at the SUHAM Hospitals promoted by Kalanjiam Foundation. DHAN has also entered into a partnership to provide affordable medicines to communities living in poverty, and their SHG federations also own four primary care clinics in Andhra Pradesh.

### **What we can learn from DHAN Foundation**

The viability and sustainability of its provider insurance model rely on strong social capital and community-run clinics and hospitals.

Their experimentation with insurance evolved into a provider model of community health insurance through community hospitals set up by DHAN. Inherent issues in getting hospitalization benefits at the private hospitals paved the way for establishment of three community hospitals and clinics in Tamil Nadu and Andhra Pradesh; the SUHAM Hospitals provide primary and secondary care to insurance members.

Risk management means more than risk financing and insurance; risk avoidance, risk prevention and risk reduction are equally important. DHAN implements community health programmes on a variety of health issues to mitigate risks. It also analyses benefits data to identify health risks in coverage communities.

## Conclusions and Recommendations

Microfinance in India is practiced by a variety of institutions, ranging from NGOs, banks, NBFCs, SHPIs and government departments. The sector is vibrant, registering a robust growth despite occasional setbacks. The sector currently reaches 100 million households, the majority of them poor and rural. Though initially concentrated in South India, the outreach of the sector has become more evenly distributed to include the poorer states of North and Eastern India.

Microfinance practitioners are interested to go beyond financial services and promote holistic development of their client families, making a priority of education and health. They most commonly report providing health education and organising health camps, though the implementation model varies, with the distinction largely between MFIs and SHPIs. Bandhan Bank, Equitas Small Finance Bank and other MFIs prefer to promote health by sponsoring separate NGOs whereas SHPIs are more comfortable with having their field staff also implement the health programme.

Experience shows that designing complementary packages best enable successful uptake, and health education is essential when introducing health products and services such as health finance tools, linkages or diagnostic services. Understanding what is being offered by the MFI or SHPI and how to use it helps clients to more effectively use these products and services. They can better understand risk and how the product such as insurance or a health loan works, how to utilize it, what to expect and where to go.

Several institutions also promote CHWs to deliver health-related services. Six institutions have trained nearly 10,000 CHWs, proving that this model is feasible and an attractive programme to achieve health-related goals each has set for their institution. Several affordable, innovative health devices have entered the market, which MFIs and SHPIs can and do purchase; they deploy either field staff or CHWs to provide their clients cost-effective monitoring of vital health parameters such as blood pressure and blood sugar.

Health financing products (e.g., savings, loans and insurance) are a crucial need of the poor in India. There are several successful models of community health insurance presently implemented by microfinance practitioners. These schemes are community-managed in which, for example, members have a role in claim settlement. Health savings SHGs and health loans they make available provide another useful product to vulnerable populations, who can have easy access to quick cash to meet the cost of small but urgent health needs such as medication and transportation. This will continue to be useful with the roll-out of Ayushman Bharat as such expenses are not covered by the scheme.

The Ayushman Bharat initiative has opened up new opportunities for India to move towards achieving Sustainable Development Goal 3, including universal health coverage. It seeks to address the most pressing healthcare challenges for an estimated 500 million citizens, the 40 per cent most vulnerable Indians, by strengthening primary healthcare and protecting more people against costly secondary and tertiary care hospitalization-related spending.

Achieving the lofty targets of Ayushman Bharat will require the participation of community-based organizations, including the microfinance sector. There are more opportunities than ever for financial inclusion and health agendas to intersect, exploring innovative models that combine public and private sector resources. They can extend social protection floors by



distributing coverage to workers in the informal economy and supplementing the benefits with simple health micro-insurance or health mutual products and value-added services.

The Community of Practice for Health and Microfinance (COPHAM), initiated by RESULTS Educational Fund, Grameen Foundation and Freedom from Hunger India Trust, offers a vibrant platform for health and microfinance players to share and learn from each other. With Sa-Dhan serving as host of the Secretariat, this exciting venture has even greater potential.

## **Recommendations**

Given that a healthy client is a good client, MFIs may consider promoting the health of clients and their families if only for business reasons. Those who have already integrated health into their activities may consider scaling up.

MFIs and SHPIs considering or currently implementing a health programme should design a complementary package: a mix of health education, financial tools and linkages to healthcare providers. The sum of the different health components in a program are much greater than their separate parts.

Microfinance practitioners have adopted digital platforms to improve operational efficiency of their financial services, and this expertise could be leveraged to extend health-related services. Such programmes include mHealth for knowledge or behaviour change and to connect clients to healthcare providers through tele-medicine.

NBFC-MFIs and SFBs can consider allotting part of their CSR funding for the promotion of health-related services — both in their own operations and in partnership with health NGOs and SHPIs. Such partnerships would bolster the resources of NGOs, help MFIs to promote the health of their own client families and keep focus of their core function of financial services while achieving their social mission.

COPHAM is uniquely positioned to bring together the siloed sectors of health and microfinance and promote the expansion of access to health products and services to underserved populations. It gives members a valuable platform to share their experiences and learn from others, so more health and microfinance stakeholders would benefit from joining this platform and liberally sharing their expertise. Donor support will be invaluable in helping COPHAM develop new training modules of health education, manuals for practicing integrated health and microfinance and conducting research to build the social and financial case for the strategy.

Local and state government (e.g., village Panchayats and the departments of health and ICDS) may consider partnering with health-promoting MFIs and SHPIs. Such partnerships would be mutually beneficial: client families will have better access to frontline workers and the government will be better positioned to market their programs and facilities to the poor and vulnerable sections of the population.

Further research is needed to understand the cost and benefit aspects of integrated services and their impact (e.g., on the financial health of the MFI/SHPI or on the health of affected communities).



Image 13. Members of a Pradan-promoted SHG in Rajasthan discuss health and nutrition issues that their CNA has raised in their group meeting. (Credit: RESULTS Educational Fund)

## Annex

### Interview of Chandra Shekhar Ghosh, MD and CEO, Bandhan Bank

Chandra Shekhar Ghosh started Bandhan-Konnagar in 2001 with a modest capital of ₹200,000 (\$3,200) and three employees in Kolkata. The NGO provided finance to small women entrepreneurs at a time when most established banks were wary about lending to poor borrowers without a credit history. Bandhan expanded its outreach steadily to reach 2 million active borrowers by 2009, in which year Mr. Ghosh registered Bandhan as an NBFC. In 2014, the Reserve Bank of India granted the approval for a banking license to Bandhan, and the very next year, Bandhan Bank started its operations as a universal bank and by March, 2018, had reached 13 million clients, including 7.8 million microcredit borrowers.

Deservedly, Bandhan and its founder have won more than two dozen awards, including the Microfinance India awards in the category 'Institution of the Year' from HSBC-ACCESS Development Services in October, 2009, and the Genius HR 'Entrepreneur of the Year' Award from the AIMA Managing India Awards 2014. Bandhan was recognised as a Global Growth Company by the World Economic Forum in 2014.

#### Interaction

**Q: How do you define successful microfinance?**

Mr. Ghosh: Successful microfinance should result in financial growth and well-being of client families. However, financial growth is not sustainable if the poor lack access to affordable and quality education and healthcare. Therefore, in order to achieve successful microfinance, microfinance institutions should go beyond financial services and work for holistic growth of their client families.

**Q: Bandhan attached much importance to health promotion, right from the beginning of its operations. As a microfinance institution, why did you pursue with health promotion?**

Mr. Ghosh: Successful microfinance depends on the entrepreneurship of the clients. If the client family suffers from health problems, the entrepreneurship suffers, impeding financial growth. If the entrepreneur's health is not good, her business will not be good. If business is not good, she cannot repay loans promptly and be a good microfinance client.

**Q: Microfinance institutions are already enjoying more than 99 per cent repayments. In that context, is it necessary for them to strive on promoting the health?**

Mr. Ghosh: Impact of poor health on loan repayments is not significant when the loan sizes are small. However, as clients become entrepreneurs and avail bigger loans, the impact of poor health will be more conspicuous. Good health and entrepreneurship go hand in hand. It is important that there is inclusive growth of the client family, which cannot take place through financial growth alone. Health and education become an integral part of inclusive growth.

**Q: In health promotion work by MFIs, how important is education to build awareness on health?**

Mr. Ghosh: Health education is the crucial first step. Health education creates awareness, which, in turn, creates demand for health services. For example, Bandhan's education on the importance of institutional deliveries has encouraged pregnant women to go to hospitals for their delivery. But, the primary health centres (PHCs) are in poor shape. In a written report

recently submitted to Rajya Sabha by the Union Minister of State for Health and Family Welfare, it was mentioned that, out of 25,650 PHCs in the country, 15,700 (61.2 per cent) function with only one doctor each. And 7.69 per cent of PHCs do not have even a single doctor (Yasmeen, 2018).

Thanks to the demand created through health awareness, the government is compelled to employ doctors in their PHCs. And, with improved economic condition of the poor, thanks mostly due to microfinance, they also go to private clinics, thus creating more business opportunities for medical professionals.

Microfinance is contributing to improved schooling and health by changing the mindset and spending patterns of the poor families. After the second or third loan cycle, with their confidence bolstered and economic condition slightly improved, the poor people, even in rural areas, start spending on nutrition and health. They start sending their children to private schools where the medium of instruction is English.

**Q: Bandhan-Konnagar, the NGO sponsored by Bandhan Bank, has nearly 6,000 Swasthya Sahayikas (community health workers) for health promotion work. What are your plans for these grass-root volunteers? If they have to continue as volunteers for long, their interest might wane...**

Mr. Ghosh: As a policy, Bandhan-Konnagar health staff exits after three years of capacity building and supportive supervision of Swasthya Sahayikas, expecting them to carry on with their work beyond that. Bandhan-Konnagar is keen that, in the long run, Swasthya Sahayikas graduate from volunteers to health entrepreneurs. We train them to be socially empowered and financially benefited.

Bandhan-Konnagar maintains the inventory of health products, such as over-the-counter drugs and sanitary napkins, and supplies them to Swasthya Sahayikas. They are earning small amounts through the sale of these products. We further incentivise them through WASH promotion work: they are paid fees for facilitating construction of toilets through loans from Bandhan Bank and ensuring their utilisation by the client families.

**Q: The government of India is introducing the National Health Protection Scheme (NHPS), which will cover 100 million households. Do MFIs have any role in the implementation of this scheme?**

Mr. Ghosh: No doubt NHPS is a very ambitious scheme. But, financial institutions like Bandhan may not like to be involved in its implementation because of the inherent risks. If the service providers falter, the beneficiaries will be disappointed and that will affect repayment of microfinance loans. However, MFIs might play an active role in promoting this scheme among their clients and the community.

**Q: There are many SHG-promoting NGOs working for health. But, unfortunately, they do not have adequate resources. Is it possible for MFIs, particularly those which are profitable, to partner with such NGOs and support them with resources for health promotion work?**

Mr. Ghosh: I am aware of the good work done by some NGOs. But, small is beautiful and big is challenging. NGOs' contribution will be significant when operating on a small scale. But, scaling up calls for professional management, which only very few large NGOs could provide. As far as Bandhan is concerned, we have promoted our own NGO, Bandhan-Konnagar, which is implementing all our non-financial services.

**Q: Several innovations have been introduced in health diagnostics. Communication technology has improved so much and opened the doors for innovations such as tele-medicine. Will Bandhan be interested to introduce any such technologies, with their branch as an active hub?**

Mr. Ghosh: Innovative technologies for easy and cost-effective measurement of haemoglobin, blood sugar, etc. are good, and we welcome them. However, we do not like our bank branches to be distracted from financial intermediation. Otherwise, confusing signals go to investors and clients. Bandhan-Konnagar is mandated for all non-financial activities, and their contributions stupendous. If we identify suitable technologies, we will promote them through our NGO.

## **Case Study A. Comprehensive Integrated Health and Microfinance**

Partnership of Aikyatan Development Society, Freedom from Hunger India Trust, Grameen Foundation and RESULTS Educational Fund

### **About Aikyatan Development Society**

Aikyatan Development Society (ADS) started its operations as a non-profit organisation in 1999 in Burdwan district of West Bengal engaged in the self-help groups (SHGs) movement. ADS implements integrated and sustainable village development programs. Because it believes women to be the real change makers, ADS insists on their active participation in all programs, namely promotion of SHGs, healthcare, WASH and livelihoods.

#### *Participatory Management Style in ADS*

ADS has adopted unique practices to help to foster excellent interpersonal relationships between management and staff. Sudhir Dutta, the CEO of ADS, is a firm believer in team work and believes in being transparent. To promote camaraderie among the staff and management, all staff (including the CEO) and their families go on a long trip to different places in the country each year; staff and ADS share the cost of the trip.

Additionally, every important decision is discussed in staff meetings, and the views of the staff are obtained and given due weight. Recently, Sudhir was keen to convert into an NBFC-MFI, which he thought would help to raise loan funds smoothly facilitating rapid growth. However, upon discussing the matter, his field and head office staff expressed resistance. They were concerned that two separate teams, one for the NGO and the other for the MFI, would lead to unhealthy competition. Though consultants and auditors had highly favoured the idea, Sudhir dropped the idea.

When a donor offered to fund ADS for starting a mobile clinic, the staff argued that it would be very difficult to get a qualified doctor to work in their remote area unless they pay very high salary. This would make the service unaffordable to their community, so though Sudhir was keen to accept the donor's offer, he politely declined.

### **Maa aur Shishu Swasthya Project**

#### *The Health Problem*

Health access in India has not greatly improved despite efforts on the national and state level. Rates of access to subsidized healthcare schemes are dismally low even though household out-of-pocket expenditures account for two-thirds of total healthcare expenditures. One concern is the anaemia prevalence in women and children, which affects more than half the population; West Bengal and Jharkhand had seen no improvement in the past decade despite strong economic growth. Success in lowering prevalence plateaued around 2005–2006, particularly in rural areas. Women and children suffer nearly twice the rate of anaemia compared to their male relatives. Families in rural and poor communities confront three main barriers to health: i) insufficient knowledge about how to prevent and manage disease, ii) inadequate access to effective and appropriate health services and products and iii) inability to afford services when needed.

#### *The Solution*

In 2015, Freedom from Hunger India Trust, Grameen Foundation and RESULTS Educational



Image 14. An auxiliary nurse midwife conducts a pre-natal exam on a client of ADS in West Bengal. (Credit: RESULTS Educational Fund)

Fund launched the 'Maa aur Shishu Swasthya' (MASS, or Mother and Child Health) project in partnership with ADS and Bandhan-Konnagar. The program seeks to promote maternal and child health indicators by building awareness of key health issues for preventive care, linking to affordable health services and creating health financing products that make healthcare more affordable.

ADS rolled out the project to its SHGs in two blocks in Burdwan District of West Bengal, targeting some 30,000 women SHG members. They offered an integrated package of financial services, health education sessions and linkages to local health services aiming to improve health outcomes of women and their families of the credit group member families, and the community at large.

## **Project Implementation Model**

### *Health Education*

ADS used Grameen Foundation health education modules for providing vital information about anaemia control, care during pregnancy, safe birth, correct breastfeeding practices and infant and child nutrition. These education modules adopt adult learning principles, with participatory learning processes and active engagement of the learners.

Considering the high prevalence of anaemia in their operational area of Burdwan district, ADS focused on prevention and management of anaemia in the initial phase of the program. Pictorial learning conversations (PLCs) were used to build awareness and bring about change of behaviour and practices. The PLC methodology is designed to be delivered by facilitators with modest education (at least 8th Standard). Each session focuses on one key concept and consisted four steps to engage the participants, as shown below:

1. participants encouraged to share what they knew about the session topic;
2. new information delivered to participants;

3. participants seek clarifications about the new information;
4. participants apply the new information.

The anaemia PLC included seven sessions of 15 to 20 minutes each, which were delivered during the weekly SHG meetings. The contents of the module include information on causes and symptoms of anaemia, food items high in iron and vitamin C and the importance of blood test to diagnose anaemia. Good hygiene practices to be followed to prevent diarrhoea and anaemia are also included in the module.

### *Health Linkages*

ADS went beyond awareness building by creating linkages with primary care providers and government health and nutrition agencies. In West Bengal, the *Gram Panchayat* (local village council) has the responsibility of coordinating all the development activities, including health and Integrated Child Development Services (ICDS). ADS worked closely with the Gram Panchayat to ensure cooperation of government frontline health workers, namely, Auxiliary Nurse Midwife (ANMs), ASHAs and AWWs in extending the facilities to which the women and children are entitled.

### *Health Savings*

Even though poor people know how to access the healthcare they need, they often delay seeking it or purchasing medicines because they often do not readily have the needed money. Ultimately, it is only when they are in critical health condition that they go to a hospital. Such delays lead, at times, to serious health repercussions and expenses. To assuage this problem, ADS encourages the SHG members to save for health and to become Health SHGs. By end of March, 2018, more than 15,000 women members of 1,555 SHGs (out of the total 2,060 promoted by ADS), were saving for health, in addition to regular SHG savings. The main objective of this initiative is to create immediate access to small amount of cash. The idea of meeting their emergent health needs with their own efforts appealed to the members, and they agreed to save small amounts, ranging from ₹20 to ₹50 per month for health. Loans availed from out of health savings are typically small, in the range of ₹500 to ₹1,500. These loans are mostly used to cover the cost of transport to hospital and purchase of medicines.



Image 15. Inside of health savings box. (Credit: RESULTS Educational Fund)

The health saving amount is kept in a small box with two locks, kept in the possession of one of the SHG members. The box could be opened only when both keys are used, which are kept in the custody of two other members of the group. The health loans accrue interest, set by the SHG members, of 24 per cent per annum and are to be repaid in three months. A health SHG cycle consists of 12 months, and after completion of each cycle, the group pays out either 50 per cent or 100 per cent of the accrued amount and then starts the next cycle. These rules are set by the SHG members at the beginning of a cycle.

The health saving boxes make it much easier to respond to emergency health needs even in the dead of night if allowed by the Health SHG's rules. The dedicated health saving boxes are popular among ADS SHG members, which is evidenced from the fact that one year after introducing this product, the number of groups adopting health savings increased tenfold from 146 to 1,409, covering 70 per cent of ADS promoted SHGs.

### *Adolescent Girls*

It is important that healthy behaviour and practices are introduced at a young age. This prompted ADS to educate adolescent girls, most of them children of SHG members, about menstrual hygiene, reproductive health and the importance of nutrition and diarrhoea management. They used an education methodology known as Learning Games for Girls (LGG) that provides opportunities for the girls to learn new knowledge and skills through games. ADS staff deliver LGG at Anganwadi centres, which also supply weekly iron capsule supplementation to the girls. By March, 2018, ADS had covered 1,084 adolescent girls with education.



Image 16. Adolescent girls play a game to learn important information about menstrual hygiene and reproductive health in a group convened by ADS. (Credit: Soumitra Dutta)



## Impact

### *Knowledge and Behaviour Change*

The study conducted by Freedom from Hunger India Trust and Grameen Foundation in 2017 revealed very impressive impact of anaemia education delivered by ADS under the MASS project. In Ausgram II block, before receiving anaemia education, only 11 per cent of women knew that children were more vulnerable to anaemia; after the education, 99 per cent knew this fact. There was an 86 per cent improvement in the knowledge that the most common cause of anaemia is iron deficiency. Similar increase in knowledge was also recorded in respect of the following parameters: symptoms of anaemia, blood test as the best way to diagnose anaemia, iron rich food items, treatment of severe anaemia and hygienic practices to be adopted for preventing anaemia.

Discussion with SHG members, AWWs, ASHAs, ANMs and ADS staff revealed great improvements in knowledge and behaviour. Almost all the adolescent girls (and their mothers) now use sanitary pads, as compared to pre-program period when the usage of cloth was the most common mode. Green vegetables and foods rich in vitamin C are now routinely consumed. Clients seek out the anaemia test when they visit a health facility, and almost all the deliveries now occur in the hospitals, mostly in the PHCs, as compared to pre-programme period, when nearly half the deliveries were at home.

### *Conclusions*

ADS has proved that the social infrastructure in the form of SHGs created for financial intermediation could also be used very effectively for promoting health. The SHG meeting platform is ideally suited for building awareness on preventive healthcare and to induce positive changes in health seeking behaviour. ADS work under the MASS project also lays the road map for working closely with the local governments to build an eco-system conducive for accessing the facilities offered by the government health system. ADS has also proved that poor women are willing to help themselves to meet the cost of small and emergent health expenses by saving additional amounts from out of their meagre earnings and capable of managing the savings effectively.

### **Stories of Change**

**Salma Khatun** is an ANM in charge of the Sub-Centre in Noda village of Aushgram I block. The Sub-Centre caters to a population of 7,500. She is responsible for monitoring the health of pregnant women, lactating mothers and children. In addition to her duties at the Sub-Centre, she conducts two Village Health and Nutrition Days (VHNDs) each month. In each VHND, she monitors 25 to 30 pregnant women and lactating mothers for their blood pressure, haemoglobin and the growth parameters of children. ADS field staff actively support the ANM by encouraging pregnant women and lactating mothers among the SHG members and the community, to avail the facilities at the VHNDs.



Image 17. Salman Khatun, ANM measuring blood pressure of a pregnant woman at a VHND where ASHAs, AWWs and ADS field staff are also present to assist her. (Credit: DSK Rao for RESULTS Educational Fund)

**Mr. Tapakesh**, an *Upa Pradhan* (elected member) of Billogram Gram Panchayat in Ausgram I block, attended one of the health education sessions facilitated by ADS staff. He was greatly impressed with the content of the sessions, facilitating methodology and the enthusiastic participation of the members. He realised the critical role ADS staff and the SHG leaders were playing in promoting health.

Every fourth Saturday, the *Upa Pradhan* convenes a meeting of the ANMs, AWWs and ASHAs to discuss the health issues in his Panchayat. After his exposure to ADS's work, he started inviting the cluster leaders of SHGs to these monthly meetings. With the participation of SHG leaders, these meetings became very lively and vibrant, with several problems of access to health services discussed and solutions arrived at. The government frontline health workers, ADS field staff and SHG leaders started working collaboratively. As a result, attendance of pregnant/lactating women and children in the VHNDs improved, pregnant women take iron-folic acid tablets regularly, practically all the deliveries in the village take place in hospitals and all the adolescent girls and their mothers use sanitary napkins.

All the 14 Panchayats in Ausgram I and II blocks have instructed their health frontline



workers to collaborate with ADS field staff and SHGs in extending health services to the village community, particularly their children, adolescent girls, pregnant women and lactating mothers.

There is a need for more elective representatives like Tapakesh to bring about positive changes in the attitude and work ethic of grass-root frontline workers of the health bureaucracy in India. Involvement of the Panchayats enhances the accountability of the frontline workers and creates a collaborative interface between the community and the service providers.

## Case study B. Community Health Facilitators

Partnership Between CASHPOR Micro Credit and Healing Fields Foundation

### About CASHPOR and Healing Fields Foundation

Set up by Professor David Gibbons, CASHPOR Micro Credit provides microfinance services in Uttar Pradesh, Bihar and Chhattisgarh, adopting the Grameen Bank model of lending. CASHPOR is a poverty-focused, not-for-profit company that provides microfinance exclusively to BPL women. CASHPOR follows a dual lending model: direct lending and lending under the banking correspondence model. CASHPOR operates in some of the poorest parts of India, with 12 districts in their operational area ranked among the poorest districts in the country. Within such poor districts, CASHPOR targets very poor households, ensuring that at least 90 per cent of their clients belong to below poverty line. CASHPOR's products and services are specially designed to meet the needs of the poor. CASHPOR is a partner of the Opportunity International Network.

Mukti Bosco, an Ashoka Fellow, founded Healing Fields Foundation (HFF) in 2000 as a non-profit organization, with headquarters at Hyderabad, Telangana. HFF is a pioneer in the areas of health financing and community health education and entrepreneurship. HFF has a rigorous and well-established programme for training women as Community Health Facilitators (CHFs) who function as change agents for healthcare and hygiene practices in their communities. HFF have refined this model over the years by collaborating with CASHPOR and other MFI members of the Opportunity International Network. HFF also partners with other NGOs, the private healthcare sector and government to improve the access of the poor and the underprivileged to basic healthcare products and services in the 'backward' regions of the country.

## **The Community Health Facilitator (CHF) programme**

### *The Health Problem*

Uttar Pradesh and Bihar, which are the first and the third largest states of India respectively in terms of population, are characterised by very poor health status and health infrastructure. A combination of several factors accounts for the states' poor healthcare record, including shortage of healthcare professionals, inadequate funding for public health by successive governments and increasing cost of healthcare.

Uttar Pradesh, where CASHPOR has been working for the last two decades, has the highest child mortality in the country. Of those children who survive, 50.4 per cent are stunted. About half of the state's children are not vaccinated. The inaccessibility of institutional care is evident from the fact that around 42 per cent pregnant women deliver babies at home. As a result, the state has India's second-highest maternal mortality rate of 285 for every 100,000 live births, with 62 per cent of pregnant women unable to access minimum ante-natal care (IIPS, 2017d). In Uttar Pradesh, private health providers, including unrecognised doctors and quacks, meet 85 per cent of medical needs, and most of the expenses are out-of-pocket.

The situation in Bihar is no better: 11 per cent, or about 2.2 million, of Bihar's 20 million households have faced 'catastrophic' health expenditure, pushing them towards impoverishment (Ravi & Kapoor, 2017). Thirty-six per cent of deliveries take place at home. Only 3.3 per cent of pregnant women in Bihar received the recommended level of antenatal care, as compared to 21 per cent at all-India level. Bihar has the highest total fertility rate (TFR) of 3.4 against the average TFR of 2.18 at all-India level. Bihar has the highest proportion of OOP expenditure in health of 82.3 per cent, as compared to all-India average of 70 per cent. Only 6 per cent of Bihar's population is covered by health insurance compared with India's 15 per cent (IIPS, 2017b).

### *Their Solution*

As CASHPOR chooses its clients from among the poor, we may safely assume that the health status of their client families could in no way be better than the status recorded for the states of Bihar and Uttar Pradesh. Realising the need for tackling the health problems of their client families to derive optimum benefit from the financial services being provided by them, CASHPOR launched the CHF programme in 2009 in partnership with HFF. CASHPOR seeks to create health awareness among its one million clients while providing them with access to health products and services. HFF provides training in health education and, together with CASHPOR, empowers CHFs with income-generation opportunities so that they graduate to be entrepreneurs from being volunteers.

### *The Target Beneficiaries*

CASHPOR selected 2,600 women, based on criteria from HFF, from among its microcredit clients to be CHFs. HFF trained these women, who have a minimum educational qualification of 8th Standard, to be CHFs. HFF trained CHFs for six months, covering topics related to nutrition, child health care from 0 to 3 years with national immunization, puberty and adolescence, pregnancy and women's health, menstrual hygiene, prevention of illnesses, first aid, government programmes and health financing. After the training, CHFs participated in a six-month internship providing health education to CASHPOR clients, conducting community mobilisation programs in which they conducted 10 health awareness sessions per month, earning a stipend of ₹50 per session. During these sessions, the CHFs promoted other healthy habits such as the use of sanitary napkins; construction and use of toilets, handpumps and soak pits; and growing kitchen gardens. CHFs also earn additional income by selling health-related products, such as sanitary napkins.

### *Benefits and Challenges*

The CHFs saw an opportunity for learning more about health-related matters and imparting that knowledge to their family members, as well as the community at large. Many of them

stated that they became CHF's not only for monetary benefits, but also to challenge the social system and break stereotypes. They were keen to create an identity for themselves.

However, CHF's had to overcome many challenges during the training period and subsequently in their work. Some cited inadequate stipends and the high transport costs to reach the training sessions as a big challenge; others mentioned the difficulty of balancing household work and professional commitments. CHF's also initially found it difficult to mobilise women in the community to attend health education sessions. However, with their credibility established over time, community women started flocking to the health sessions. CHF's worked in the communities with great dedication and commitment, and third-party evaluations have shown that it has paid off. By March, 2018, the CHF's have created access of sanitary napkins to 176,000 women and formed 3,000 health savings groups. Nearly 1,000 CHF's have become financially sustainable, earning a monthly income of up to ₹2,000 per month. The work of CHF's has impacted 1,059,000 families.

## Impact

Deloitte India, Tata Institute of Social Sciences and Dr JP Muliylil from Christian Medical College (CMC) Vellore each completed evaluations on the CHF's and their performance, between 2012 and 2017, drawing on quantitative and qualitative data collected from over 3,000 households using random sampling methods. The study confirmed a positive impact of the project and concluded that the strategy of CASHPOR and HFF in promoting health through community workers has yielded desired results.

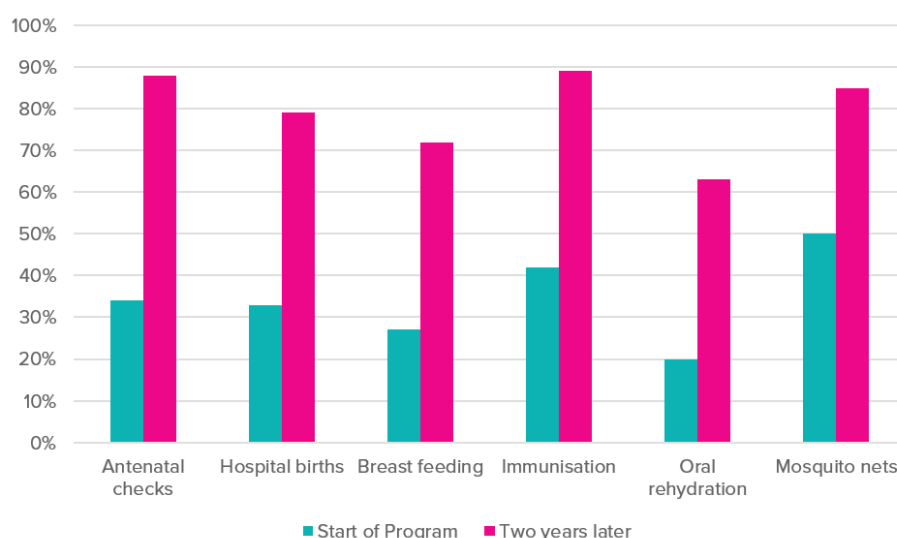
### *Knowledge and Behaviour Change*

Health education vastly improved health knowledge, leading to better health practices and behaviour. Among those surveyed,

- 98 per cent of community members improved their health knowledge.
- 71 per cent regularly practiced the improved health behaviours they learned, including using soap, purifying drinking water and using mosquito nets.

The study noted very significant changes in health-seeking behaviour within two years after the start of the program, such as number of antenatal checks, institutional deliveries, breast feeding practices, immunisation, use of oral rehydration and use of mosquito nets (see figure A.1).

**Figure A.1. Improved health seeking behaviours**



## Increased Income

The study also revealed that 66 per cent of CHFs increased their income by selling health-related products such as sanitary napkins. Further, thanks to improved health practices, families receiving health education recorded 50 to 60 per cent reduction in household health expenses.

## Busting Gender Norms

The role played by CHFs as health leaders enhances their position in the community and harnesses local relationships to improve gender equality. The impact of this is seen at the household and community level. Among those surveyed,

- 98 per cent have increased autonomy to leave their homes; previously, 85 per cent were not free to move outside their homes.
- CHFs reported that HFF training and work with CASHPOR has made them more confident. They also stated that after joining the program, they are being treated with more respect by their own family and the community members.

Given the success of the programme, HFF is continuing its work with CASHPOR and other organisations to strengthen the model further. Opportunity International is supporting the growth and expansion of the model not only in India, but also in Indonesia, where HFF is implementing this program in partnership with Koperasi Mitra Dhuafa (KOMIDA), an Indonesian cooperative providing microfinance services to low-income women who have no access to the formal financial sector.

### Stories of Change

**Ruby Devi**, a CHF since October, 2017, lives in Chillari, Uttar Pradesh; she used her CHF training to ensure the healthy delivery of a child in her village. An important part of the training is pre-natal care and knowledge of health services. A woman in her village, also named Ruby, lost her first child in a stillbirth. When Ruby became pregnant again, Ruby Devi referred her to a doctor in Gogadi for check-up and delivery. She taught pregnant Ruby and her husband, Mukesh Paswan, about the importance of regular pre-natal check-ups and nutrition, and she encouraged an institutional delivery.

Ruby gave birth to a beautiful healthy girl child on 13 June, 2018, through C-section, and both mother and the child are safe and sound. Ruby Devi visits them on a regular basis in their home to check on them. She also advised the family to get mother and child regularly checked by the doctor.



**Nasima Vijaypur** is a hard-working CHF from Mirzapur, Uttar Pradesh, who underwent training in 2018 to become a Community Health Entrepreneur (CHE), CHFs with an additional focus on selling health-related products such as sanitary napkins. During the community interviews she reflected on the positive impact of the CHE training.

‘After the CHF programme, the training can be used in more ways. With the CHE training, we are putting the previous CHF training to good use. I can sell goods to my village women at an affordable price. Therefore, it becomes an earning for me, which I need. It’s very useful. I was thinking about training that we took from HFF a few days back. If I am able to sell these products in my village, women will come and buy their sanitary napkins without any hesitation ... [both] ... because I am a woman and I explain clearly about the dangers of using cloth’.



Photo credit: Healing Fields Foundation

## Case study C. Healthy Baby Wealthy Nation

Project of Bandhan-Konnagar in West Bengal

### About Bandhan-Konnagar

In 2001, Chandra Shekhar Ghosh founded Bandhan-Konnagar, a microcredit NGO, with the mission of alleviating poverty and empowering women. In 2006, Bandhan-Konnagar added social sector programmes in health and education to its financial services. Microcredit outreach grew steadily to reach 2 million active borrowers by 2009, when Bandhan-Konnagar split its financial and non-financial services by establishing an NBFC for financial services (Bandhan Financial Services Pvt. Ltd.), which later became Bandhan Bank. Development work of creating employment for the unemployed, financial literacy, education and health continued under Bandhan-Konnagar.

### *Bandhan-Konnagar's Health Program*

Bandhan-Konnagar implements the health programme through 165 health branches, spread over six states (West Bengal, Bihar, Jharkhand, Assam, Odisha and Chhattisgarh), serving 1 million households. The health programme is implemented by 550 committed staff, including Health Community Organisers (HCOs) and assisted by 5,500 *Swasthya Sahayikas* (SSes) selected from among Bandhan Bank's microfinance clients. The programme emphasises maternal and child health, with a special focus on prenatal and new-born care; primary immunization; and water, sanitation and hygiene (WASH) issues.

### Healthy Baby and Wealthy Nation Project

According to a World Health Organisation report, 0.9 million children under 5 died in India during 2016, and 50 per cent of these deaths were due to malnutrition and its underlying causes. As a result of malnutrition, 19.8 per cent of children in India suffer from wasting (low weight for height), 42.5 per cent are underweight (low weight for age) and 48 per cent are stunted (low height for age). Frequent diarrhoea, mostly due to lack of sanitation and safe drinking water, exacerbates the malnutrition problem.

Protein energy malnutrition (PEM), measured in terms of underweight, stunting and wasting, is a major public health problem in West Bengal, as in most other parts of India. PEM affects the child at the most crucial period of development, which often leads to permanent impairment in later life. India is home to the highest number of stunted, wasted and underweight children in the world; faulty infant and child feeding practices, poor nutritional status of the mother resulting in a low birth weight child and environmental factors such as lack of sanitation contribute heavily to PEM.

**The Project Area:** Bandhan-Konnagar implemented the project 'Healthy Baby Wealthy Nation' (HBWN) from February, 2015, to January, 2018, in 24 Gram Panchayats with funding support from HDFC Life, a life insurance company. The objective of HBWN was to reduce PEM among under-5 children in six 'backward' districts of West Bengal (Alipurduar, Coochbehar, Maldah, Birbhum, Purulia and South 24 Parganas). The project covered 113,182 households, targeting pregnant women, lactating mothers and under-5 children, besides households without sanitary latrines. Bandhan-Konnagar selected only those Gram Panchayats where Bandhan Bank's microfinance programme operates and avoided Panchayats wherein Bandhan-Konnagar's health programme already operated.

The HBWN project sought to address the major causes of child malnutrition, i.e., poor nutrition, improper infant and child feeding practices and diarrhoea management.

## **Project Implementation Model**

Dr Uttam Kumar Ghosh, a qualified physician and head of Bandhan-Konnagar's health programme, was the director of HBWN project. HBWN was implemented through 24 health branches of Bandhan-Konnagar. Each health branch was staffed by three HCOs, who were well-educated women (most of them are college graduates, selected through a competitive screening process). The senior-most HCO was in charge of the health branch, and one Area Coordinator supervised the work of five health branches.

Under HBWN project, each HCO was assisted by 9 to 10 SSeS. The SSeS were women who lived in the same village and had a minimum educational qualification of 8th Standard; soon after joining as SSeS, they received orientation training of six days from Bandhan-Konnagar staff as well as from outside faculty of qualified medical doctors. The orientation training was followed by routine refresher trainings once a month. Each SS covered around 150 households and provided handholding support to pregnant women by accompanying them to the Health and Nutrition Days for monitoring health parameters and Anganwadi centres for receiving fortified food. They also guided the pregnant women to cook nutritious food and kept reiterating the key health messages delivered at the health education sessions.

SSeS were also selling basic health products, such as sanitary napkins, over-the-counter drugs and oral rehydration salts in addition to creating linkages/referrals to existing public healthcare services. Occasionally, SSeS also referred cases to private clinics that offered services at a reasonable price. Such references were, however, informal, without Bandhan-Konnagar entering into any Memorandum of Understanding.

### ***Health Forums***

HCOs and SSeS organised monthly 'Health Forums' to deliver health education. The health forum is designed for community participation and attended mainly by pregnant and lactating women. It is typically a one-hour meeting during which the HCO discusses issues related to safe pregnancy, new-born care, immunization, exclusive breast feeding during the first six months, complimentary feeding (after six months) and WASH. These health forums are attended by about 25 to 30 pregnant and lactating women, adolescent girls and children.

### ***Linkages***

The HBWN team, including HCOs and Area Coordinators, established strong linkages with the government service providers to ensure that the project beneficiaries have access to institutional services such as antenatal care, immunization, delivery and treatment for illnesses.

### ***Health Education***

Under the HBWN project, Bandhan-Konnagar deployed HCOs to deliver education on various health topics. HCOs used the education modules developed by Freedom from Hunger India Trust and Grameen Foundation, specifically designed for group learning, incorporating adult learning principles and aiming for change of behaviour and practices.

The HBWN project covered the following health topics under its education program: planning for better health, healthy pregnancy, safe delivery, new born care, danger sign of a sick child, immunization, breastfeeding, complimentary feeding, diarrhoea, family planning, nutrition and WASH.

### ***Home Visits***

HCOs and SSeS visited the homes of the targeted beneficiaries (e.g., pregnant women, lactating mothers and care givers of malnourished children). In these visits, target women were taught preparation of complementary food like khichri (dish made from rice and lentils) and sattu (flour of pulses and cereals). Support was also provided for antenatal care and immunization. While carrying out these visits, HCOs and SSeS also took the MUAC (mid-

upper arm circumference) measurement of malnourished children. They also reiterated the key health messages taught in the health education sessions.

### *Observing Special Events*

Bandhan-Konnagar organised special events in the project area for World Health Day (7 April), World Toilet Day (19 November) and World Breastfeeding Week (first week of August). These events were organised to create awareness and generate interest in the community. Primary school children campaigns were organised once in six months to promote WASH. The project functionaries also networked with Gram Panchayats and facilitated construction of sanitary latrines.

### **Impact**

At the beginning of the project, a baseline survey was conducted in all the 24 Gram Panchayats of the project area to know the health status, particularly the status of wasting among under-5 children and in the households lacking sanitary latrines. The end line survey showed the following changes:

- Wasting among under-5 children reduced from 19 per cent to 4 per cent.
- Households without sanitary latrine decreased from 61 per cent to 19 per cent.

Education delivered during the health forums, followed by reiteration of key health messages during home visits by HCOs and SSeS, built awareness on the importance of nutrition for pregnant women and lactating mothers. Awareness building on breastfeeding and supplementary feeding of infants contributed to reducing child malnutrition. Similarly, Bandhan-Konnagar's efforts to educate the community on the significance of hygiene and prevention and management of diarrhoea, followed by motivation to construct toilets, have yielded impressive results. It is significant that some of the borrowers have constructed toilets with their own resources, even without waiting for government subsidy.

### **Stories of Change**

**Sulekha Mondal** lived in Rangiladih village of Kashipur Gram Panchayat, along with her husband, three children and in-laws. Their family eked out a living by selling milk. In the baseline survey of HBWN project, Bandhan-Konnagar's staff noticed that Srabanti, Sulekha's youngest daughter, suffered from severe malnutrition (wasting) as her MUAC was only 12.3 cm. The staff advised the mother to supplement Srabanti's diet with *sattu*.

Sulekha regularly attended Bandhan-Konnagar's monthly health forums and learnt a lot about the best practices to be followed for a balanced diet, nutrition for pregnant and lactating women, proper breastfeeding practices, supplementary feeding, hygiene, etc. Having learnt many new things in the forum sessions, she started putting her knowledge to practice at home. Bandhan-Konnagar's SS visited her home regularly to measure the MUAC of the child, which gradually improved to 13.8 cm in a few months. Realising the importance of sanitary hygiene, Sulekha constructed a toilet at home and made sure that all her family members used it regularly.



Sulekha said, 'I have learnt so much and benefitted so much from the HCOs and SSeS of Bandhan-Konnagar. I wanted to share my knowledge and experience with the community. So, I have now become a Swasthya Sahayika myself. I am so grateful to Bandhan-Konnagar for giving me this opportunity'.

Photo credit: Bandhan-Konnagar



## Case Study D. Arogya Sakhis to Empower Women

Project of Swayam Shikshan Prayog

### About Swayam Shikshan Prayog

Focusing on women's empowerment, Prema Gopalan, an alumna of Tata Institute of Social Sciences, promoted Swayam Shikshan Prayog (SSP) in 1996. SSP's strategy was to make grass-roots women to be self-reliant before attempting their sustainable and inclusive development. SSP's focus areas are women's entrepreneurship and leadership, clean energy, food security, agriculture, health and water and sanitation. SSP's work, by choice, is centred on low-income and climate-threatened areas across Maharashtra, Gujarat, Tamil Nadu, Bihar, Assam and Odisha.

### Arogya Sakhi Model for Health Promotion

SSP selects local women interested in community service and possessing an entrepreneurial streak as *Arogya Sakhis* (Friends of Health) and trains them to reach out to young girls, pregnant women and lactating mothers. Arogya Sakhis conduct door-to-door visits and organize group awareness meetings on preventive healthcare and nutrition, besides ensuring high institutional deliveries for pregnant women.

SSP equips Arogya Sakhis with a health kit that includes diagnostic devices such as an Hb meter, glucometer, blood pressure monitor and weighing scale. They are also provided a tablet pre-installed with customized Arogya Sakhi mobile app, which enables them to record basic information of the beneficiary, including a personal medical profile, history of medical conditions, test results, health background, etc.

Arogya Sakhis conduct basic medical tests and upload the test results to the cloud server using the tablet. The physician reviews the uploaded data of each beneficiary and then provides feedback (if necessary after consulting specialists). The Arogya Sakhis hand over the report to the beneficiaries, providing a basic understanding of the report and conveying the necessary care and precautions that need to be taken based on the report. Those beneficiaries who are detected to be at high risk for any diseases are referred to SSP's local hospital network.

The Arogya Sakhis proudly proclaim, *'Our work just does not end at collecting the necessary data. Apart from conducting door-to-door visits, we also organize community meetings, SHG group meetings, adolescent girls' meetings, village health check-up camps and health talks with health experts from government health department and private hospitals'.*

SSP maintains an inventory of health products such as Medi-Chlor drops (for severe bacterial infection), sanitary napkins, pain relieving balms, Himalaya products (Ayurveda medicines) and oral rehydration salts (ORS). Arogya Sakhis sell these supplies to earn a modest income of about ₹1,000 per month in addition to the ₹1,500 per month paid by SSP.

### Menstrual Hygiene Management

Menstrual hygiene management (MHM) is a flagship program of SSP. Under MHM, the Arogya Sakhis mobilize adolescent girls into groups of 10 to 15 and provide information on nutrition, hygiene, sanitation and preventive healthcare practices. The group meetings provide a platform for adolescent girls to freely discuss menstrual health problems with the Sakhis and among themselves, reducing the myths and taboos associated with menstrual health and hygiene. The Arogya Sakhis sensitize the adolescent girls on the usefulness and hygienic benefits of sanitary napkins and also sell them at an affordable price.

The Arogya Sakhis not only educate the young girls on MHM but also provide life skills training to enhance their abilities to cope with daily life situations. This training includes topics on

self-awareness, problem solving, creative thinking, decision making, coping with emotions and effective communication. Since 2010, SSP has trained more than 380 women as Arogya Sakhis in the villages of Maharashtra, and they reach out to 30,000 women and adolescent girls.

## Stories of Change

**Priyanka Pasle**, in her late twenties, is an Arogya Sakhi of SSP. She completed 11th class in school before her marriage at the age of 18. Her husband was a driver by profession and had a modest income. Priyanka was happy as a housewife, looking after her husband and two children. Unfortunately, her husband met with a road accident and died, and within a few months, her 10-year-old son died of rabies. The unexpected, untimely and violent deaths of her husband and son shattered Priyanka. She went into a deep depression.

Knowing her plight, members of her SHG encouraged Priyanka to train as an Arogya Sakhi. Priyanka joined and excelled in the training and very soon proved to be an outstanding Arogya Sakhi. She was so engrossed in her work that she could overcome her grief to some extent, and while working as an Arogya Sakhi, she is pursuing a degree in Arts in an Open University.

When asked to recount the most memorable experience of her professional life, Priyanka mentioned the 12-year-old girl she diagnosed as severely anaemic (Hb of 4 g/dcl). Priyanka accompanied the child and her parents to the PHC, where Priyanka's diagnosis was



Image 18. Priyanka Pasle checking the haemoglobin of school children. (Credit: SSP)

confirmed. The child was given a blood transfusion followed by an iron-rich diet. Gradually, the child recovered, and after two years, she is presently enjoying normal health, with her haemoglobin rising to 10.

When asked for the source of her inspiration, Priyanka says, 'SSP has changed my life, and I want to change the lives of the poor in my village'.

## Sakhis promoting WASH

SSP has another cadre of community workers for promoting WASH. Known as Sakhis, they build awareness on WASH practices among underserved communities and promote safe and affordable household drinking water solutions and custom-built, prefabricated toilets for individual households. Sakhis lead customized community group meetings for women, girls and men, apart from campaigns in schools to build awareness on good sanitation practices.

SSP has designed and developed affordable, pre-fabricated toilets for the rural communities that are easy to install. These toilets have the dimensions of 4'X4'X7' and cost about ₹25,000. Sakhis facilitate access to government subsidies for toilet construction. Through the work of Sakhis, SSP has been able to render 108 villages in Maharashtra State free of open defecation as of March, 2018.

SSP is implementing the 'Healthy Household' project since 2014 in partnership with PATH (an international NGO),



Image 19. Pre-fabricated toilets with twin pits. (Credit: SSP)

bundling a number of products: a ready-to-use toilet, water filter, smoke-free cook stove, solar lanterns and biomass pellet bags along with a consumer finance scheme. The highlight of the package is the convenient credit option and easy repayment schedule made available to the poor rural households. SSP has so far installed 1,550 prefabricated toilets across 30 villages in Latur, Osmanabad and Solapur districts in Maharashtra state. More than 30,000 community members across 6,000 households know about hygiene practices, access to toilets and safe drinking water.

## Case Study E. Improved Sight Is Empowered Life

VisionSpring and Equitas Partnership

*‘Of all the senses, sight must be the most delightful’ – Helen Keller*

### About VisionSpring and Equitas

VisionSpring, a global non-profit organization, believes that correcting vision problems with eye glasses improves daily functioning, productivity and earning potential. With the right manufacturing and distribution partnerships, VisionSpring has sourced quality reading glasses for as little as \$1 per pair; such a model has the potential to radically transform the lives of poor families. For the last 16 years, VisionSpring has created affordable access to eyewear, everywhere. As of April, 2017, VisionSpring has provided eyeglasses to more than 3.7 million people in 18 developing countries, including Bangladesh and India. They are constantly seeking out new, mutually beneficial partnerships with a wide variety of organizations.

Equitas Group’s mission is to improve the quality of life of the low-income families it serves, and it has developed a wide range of initiatives to do so — many of which are designed and run by Equitas Development Initiatives Trust (Equitas Trust). Equitas Small Finance Bank (Equitas SFB) contributes 5 per cent of its annual profits to Equitas Trust, a public charitable trust, to promote education and health among people living in ultra-poverty. Equitas Trust builds awareness on disease prevention and links Equitas SFB’s client families to health services.

For the last 10 years, Equitas Trust has partnered with more than 900 private hospitals located across 400 branch locations in eight states (Tamil Nadu, Karnataka, Chhattisgarh, Madhya Pradesh, Maharashtra, Gujarat, Rajasthan and Pondicherry). Equitas SFB clients and their families receive consultation and treatment in these hospitals at discounted rates. Equitas Trust also organises regular health camps in partnership with these hospitals and other healthcare providers. As of March, 2018, 5 million people attended a health camp.

### The Ujjwal Drishtee Abhiyan (Bright Vision Campaign)

Ujjwal Drishtee Abhiyan seeks to increase access to radically affordable, high quality eyeglasses to people earning less than \$4 per day in India. By the end of 2018, VisionSpring aims to screen 1 million people and provide 500,000 pairs of eyeglasses to increase the household income of earners and learning outcomes of students. As part of the Ujjwal Drishtee Abhiyan, VisionSpring launched a multi-year program in 2016 to foster micro-entrepreneurship and financial inclusion in India. The Ujjwal Drishtee Abhiyan was launched in Pune, Maharashtra, in collaboration with Equitas.

**The Project Scope:** As part of VisionSpring’s strategy to accelerate the uptake of glasses among earners, they developed and rolled out a targeted approach to reach micro-entrepreneurs in India, beginning in impoverished districts of Maharashtra. The goal of the pilot initiative was to provide micro-entrepreneurs with corrective eyewear so that they may enhance productivity and increase income earning potential, leading to improved microloan repayments. Additionally, the pilot period was used to develop a cadre of women micro-entrepreneurs with skills for

basic eye screening and sale of eyeglasses. These Vision Entrepreneurs helped to enhance access to eye glasses to the poor in their community.

The Ujjwal Drishtee Abhyan has the following goals:

- Screening 50,000 people in identified districts of Maharashtra. Approximately 40 per cent of all people screened should belong to Equitas client families. Based on the screening results, presbyopia glasses were provided on the spot (for people with far-sightedness caused by loss of elasticity of the lens of the eye, occurring typically in middle and old age), while prescription eyeglasses were delivered to a contact person on a monthly basis.
- Collecting data to assess the impact of the program and generating an impact evaluation report.

## **Project Implementation Model**

### *The Health Problem*

Millions of people living in poverty in developing countries are robbed off this 'most delightful' sense of which Helen Keller spoke. Sight is more than just the ability to see: it is the ability to earn, to learn, to be safe and lead a meaningful life; it is critical to livelihoods, educational opportunities and workplace and roadside safety. An estimated 125.2 million people live with visual impairment, blindness or low vision in India (WHO, 2012). Despite these massive numbers, traditional optical companies have shown little interest in the base of the pyramid market for eyeglasses due to perceptions of poor consumers' ability and willingness to pay.

### *The Market Problem*

In the last decade, VisionSpring launched in India a Vision Entrepreneur (VE) distribution model, which involves training and empowering local people, mostly women, who are school educated. These VEs conduct basic eye exams in low-resource settings and sell low-cost, durable reading glasses. Under this model, customers pay ₹150 for glasses, leaving a profit of ₹50 for the VEs. In Yeotmal district of Maharashtra State, 50 VEs have sold about 10,000 glasses. While this model has been very successful in Bangladesh, selling 1 million pairs of glasses in a period of five years since 2011, it is plagued with challenges, too. VEs find it hard to mobilise people for a camp, and rural people found VEs to be inadequately qualified to prescribe spectacles.

### *Their Solution*

Since 2017, VisionSpring and Equitas have brought together their complementary expertise in manufacturing and distribution. Equitas uses the convening power of their bank field staff and Equitas Trust CSR staff to organise eye vision camps, arranging the venue and creating the necessary infrastructure. Microfinance clients spread the message among the community and help to mobilise customers. VisionSpring provides the technical support, deploying an optometrist and other support staff.

Optometrists at the camps refer those needing clinical care, such as cataracts, to eye specialists. VisionSpring subsidises the cost of the eyeglasses, so customers pay only ₹50; those who require bi-focal lens, however, pay ₹250.

## The Target Beneficiaries

Under this partnership, the project will screen 50,000 persons across 76 Equitas SFB branches in 12 districts of Maharashtra State. As of March, 2018, the project has covered 28,920 people (table A.1).

**Table A.1. Improved vision under Equitas-VisionSpring partnership (as of 31 March, 2018)**

Data point	Total	Share
No. of customers	28,920	100%
Men	12,618	44%
Women	16,302	56%
Persons diagnosed with cataracts	3,201	11%
Persons identified to have other eye problems	888	3%
No. of spectacles dispensed	12,839	44%

### Eye Screening Camp in Pune City

**Shivaji Nagar** slum in Pune city was buzzing with activity at 9 o'clock in the morning, on 7 April, 2018 — a hot and humid day. CSR staff of Equitas Trust were busy setting up the eye screening camp in the narrow lane, which was blocked for traffic to facilitate smooth functioning of the camp.

About 80 women and men, mostly middle aged, were standing in a queue awaiting their turn to register for the camp. About 60 per cent of customers attending the camp on that day belonged to families of Equitas SFB clients. On one side in the lane, VisionSpring staff had a stand displaying glasses of power ranging from +1 to +3, which are sold for ₹50 upon presentation of a prescription written by the on-site optometrist.



Image 20. Optometrist testing the sight of a customer. (Credit: Equitas SFB)

## Impact

VisionSpring is committed to evaluate the impact of its Ujjwal Drishti Abhiyan project being implemented in Maharashtra and Delhi. The evaluation envisages to measure and assess the impact of eyeglasses on the lives of customers over a period of one year through baseline, midline and end line studies. The evaluation aims to assess the ability to address customers' vision disorders; the change in customers' productivity, income earning potential and quality of life; and to understand the relevance and effectiveness of program design and implementation.

## Methodology

Researchers adopted a mixed methodology of quantitative and qualitative research approach to obtain relevant data from multiple stakeholders. The sample size for baseline, midline and end line assessment is 600, 300 and 300, respectively. As of August, 2018, the baseline has been completed with 572 respondents (of which 296 are in Pune city).

## Results of Baseline Survey

Of the 572 respondents, 51 per cent were women, 71 per cent of respondents were 40 to 60 years old, 18.5 per cent of respondents were illiterate and 61.4 per cent were employed. The baseline survey found that 46 per cent of respondents received an eye exam for the first time through this program, suggesting a lack of affordable access to eye care in the areas. Among this sub-set of respondents, 56 per cent reported 'Can't see properly' as a reason for visiting the camp. The data shows that the work of 20.2 per cent of respondents was often affected by impaired eyesight. In addition, the data clearly showed that eye problems were more prominent in the age group of 40-60 years. In total, 89.3 per cent of survey respondents had their vision problems recognized and corrected.

## Productivity

The baseline results revealed that 41.4 per cent of the employed respondents reported that poor vision has reduced their income because of their inability to take additional shifts. An additional 10.6 per cent stated that their vision problems prevented them from picking up productive activities such as night shifts and new jobs.

## Quality of Life

Poor vision has affected the physical activity of 95 per cent of the respondents, and they report facing difficulties in their daily lives. The baseline also shows that 37 per cent, most of them employed, are worried that their poor eyesight might worsen, rendering them unemployed.

## Stories of Change

**Zakir Hussain Shaikh**, a 48-year old resident of Pune, does wall painting and earns approximately ₹400 per day. He has suffered from near-sighted vision for quite some time but did not go to an eye specialist because the costs exceed his means. Of late, his vision problems prevented him from producing quality wall painting, which in turn has affected his income.

Zakir heard about the eye camp from a neighbour's wife, who is a client of Equitas SFB. He was excited to know that it would cost only ₹50 for both the check-up and a pair of glasses. He gladly sacrificed his wages for the

day to attend the camp. The eye glasses have improved his vision and his confidence.



**Mangal Kumbhar**, is a 45-year-old woman belonging to the Potter caste. She completed 7th grade in school, and her husband works in the nearby Government Ammunition factory. Mangal is a client of Equitas SFB with an outstanding loan.

Mangal works 7 to 8 hours every day making small toys of plaster of Paris. Of late, her eyesight has begun failing, and she could not touch up the toys properly. The eyes of the toys (mostly figures of goddesses) were not shaping well. As a result, her toys fetched a low price. Also fearing the huge cost, Mangal did not go for doctor consultation and glasses; an eye specialist and glasses purchased in the market would have cost about ₹1000 – 20 times greater than the Equitas-VisionSpring camp price of ₹50.

Mangal's eyesight has now improved drastically

and so also the quality of her toys, which again fetch a high price.



Photo credit: Equitas SFB

## Case Study F. Improving Health and Nutrition of Children

Project of Seva Mandir in Southern Rajasthan

### About Seva Mandir

Seva Mandir was initiated in 1968 with the mission to help the poorest communities improve their lives by addressing the problems that the community identifies as important. In the last five decades of its work in Southern Rajasthan, Seva Mandir has educated 35,000 out-of-school children in remote tribal areas and provided food security to 17,000 farmers by increasing land productivity and promoting local crops. To enhance the capacity of women to bring about financial independence and security, Seva Mandir also facilitates 670 savings and credit groups with membership of more than 11,000 poor women.

Seva Mandir promotes Village Committees (VCs), which are elected bodies with representation of at least 3 to 4 women. Seva Mandir also helps to create Village Development Funds (VDFs), managed by the VCs and audited by Seva Mandir, which collects financial contributions from the community for implementation of projects. By 31 March, 2018, Seva Mandir has formed 532 VCs and 618 VDFs to co-fund projects, manage them and also to act as pressure groups on the state government. Through VCs, Seva Mandir aims to build community ownership of the development process and to ensure long-term sustainability of their work.

### The Nutrition Programme

In 2017, Seva Mandir partnered with Plan International, piloting the integration of various interventions critical for mitigating malnutrition. The interventions included WASH, education on IYCF (infant and young child feeding practices) to caregivers and village level health workers, strengthening village-level institutions such *Balwadis* and Anganwadis, promoting vegetable gardens and strengthening government malnutrition centers.

With successful implementation of the pilot and evidence that the strategy addresses the malnutrition problem, Seva Mandir plans to scale up their efforts for prevention and treatment of malnutrition amongst children. The two main streams of the project strategy are as follows:

- 1. Home-based care:** The project uses the 1,000-days approach, which includes work with pregnant women, lactating mothers and newborns to 2 year-olds on nutrition and

health, immunization and WASH practices to improve the children's nutritional status. This strategy will be carried out through *Bal Sakhis*, a local cadre of women trained as 'friends of children' to provide neonatal and infant care in their community.

- 2. Institution-based care:** Seva Mandir works to strengthen government-run Anganwadis and runs Balwadis, day-care centres run by a *Sanchalika* (a woman trained on early child care and education) and providing full day pre-school education, nutrition and safe environment to the children of age 0–5 years. Seva Mandir establishes Balwadis in areas far from government-provided services such as Anganwadis. Seva Mandir's work with Anganwadis includes monitoring of centres to improve their functioning; work on ensuring better nutrition and community awareness; improving capacities of Anganwadi workers; and improving infrastructure. Additionally, Seva Mandir ensures immunization of children through government immunization camps, and severely acute malnourished children are treated at the Malnutrition Treatment Centre (MTC) run by Seva Mandir in Udaipur district.

## Project Implementation Model

### *The Health Problem*

Malnutrition is a vexing problem in India, contributing to 45 per cent of deaths of under-5 children (IFPRI, 2015), and in Rajasthan state, 48.8 per cent of under-5 children are stunted, 23.4 per cent wasted and 38.4 per cent are underweight (IIPS, 2017c). The problem is even more acute in Seva Mandir's operational areas of Udaipur and Rajasmand districts, which are predominantly rural and tribal. Improper feeding practices, lack of health and hygiene, poor maternal health and lack of nutrition are contributing to malnutrition in these areas.

### *Their Solution*

**Knowledge and Behaviour Change:** Seva Mandir educates caregivers on proper childcare and nutrition. They conduct intensive training on IYCF and WASH for pregnant and lactating women and mothers of children under two years. Appropriate WASH practices can contribute immensely to healthier children and communities.

To enhance nutrition security at the household level, Seva Mandir promotes kitchen gardens to expose the households to better nutritional practices and does recipe trials with mothers and community members on preparing nutritious meals with locally available resources. Seva Mandir also promotes kitchen gardens in Balwadis and Anganwadis, encouraging the staff to include garden vegetables in the *khichdi* and *dalia* prepared for the children.

**Health System Strengthening:** In a project in Udaipur district, Seva Mandir works to strengthen 1,335 Anganwadis, which they leverage to enhance its outreach and work to combat malnutrition. Seva Mandir also provides day care, pre-school education and health and nutrition support to children unreached by Anganwadis through Balwadis. In Balwadis, children receive three meals a day: one hot meal of khichdi or dalia (alternating days) and two snacks of ready-to-eat fortified sweet and salty nutria soya pops (morning and evening). The nutrition is supplemented with Vitamin A and deworming medicine, besides Manol, an ayurvedic supplement for iron.

**Providing Healthcare:** Seva Mandir trains village health workers, or Bal Sakhis, to identify and treat malnourished children. Bal Sakhis do a primary screening of children to identify the 'moderately', 'severely' and 'severely acute malnourished' (SAM) children and take those identified as SAM to the MTC. Further, the children's nutrition is tracked and their progress monitored, and Bal Sakhis counsel mothers and other family members to continue with the treatment. Community-based Management of Acute Malnutrition camps are organized by trained nurses to treat SAM children locally, and if complications occur, children are taken to the MTC immediately.



## Impact

Seva Mandir participated in a three-year action research study on 'The influence of affordable day-care centres on women's empowerment in India' in collaboration with Centre for Microfinance, Institute for Financial Management and Research and McGill University. This research was carried out in 160 locations and involved opening Balwadis in 80 locations using a randomized controlled trial methodology.

The research sought to look at the impact of Seva Mandir Balwadis on women's empowerment, which was captured through various dimensions such as women's freedom of movement, involvement in household decision making, views and attitudes towards gender issues and experience of domestic violence. The research project ended in January, 2018. A baseline survey of 3,177 mothers was conducted, along with qualitative interviews with parents. Anthropometric data on 5,000 children from one to five years was also collected. The baseline, midline and end line were conducted in study hamlets. The key findings of the study are as follows:

- Access to Balwadis reduced the proportion of acutely malnourished children by 22 per cent.
- Of those mothers offered day-care, 43 per cent used the facility.
- The Balwadi program decreased the time spent by mothers on childcare and enabled them to work round the year and work at places farther away from home, thus enhancing their income.
- Mothers reported that the intervention decreased their stress and anxiety and enhanced their happiness.

### Stories of Change

**Pushpa Devi** is the Sanchalika (Seva Mandir grass-root field worker) of Som Balwadi in Som village of Jhadolblock. On average, 20 children attend the Balwadi six days a week.

Kanu is a baby girl of one and half years, and her parents, very poor daily wage earners, often would leave Kanu unattended, playing in the dirt all day long. Moreover, Kanu's parents could not afford to provide her a nutritious diet. As a result, Kanu used to fall sick very frequently, which made her very weak and pale. Her parents could not provide her with adequate care and treatment due to their

poverty and lack of awareness. Noticing Kanu's plight, Pushpa Devi persuaded Kanu's parents to put her in the Balwadi.

Kanu joined the Balwadi in early 2018, and since then, her physical condition has drastically improved. At the Balwadi, Kanu has learned to wash her hands, enjoys eating the food and plays with the other kids. Kanu does not fall ill anymore, and she looks much happier. Seeing their daughter's progress, her parents are thrilled and ever grateful to Pushpa Devi and the Balwadi run by Seva Mandir.

## References

- Baum, A., Elize, W., & Jean-Lou, F. (2017, November). Microfinance Institutions' Successful Delivery Of Micronutrient Powders: A Randomized Trial In Rural Haiti. *Health Affairs*, 36(11). Retrieved August 14, 2018, from <https://www.healthaffairs.org/author/Baum%2C+Aaron>
- Black, RE et al. (2013, June 6). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 382(9890), 427-451. Retrieved August 30, 2018, from [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60937-X/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60937-X/abstract)
- Bloom, D. (2011). 7 Billion and Counting. *Science*, 333(6042), 562-569. Retrieved August 11, 2018, from <http://environment.harvard.edu/sites/default/files/Bloom.7BillionandCounting.Science.29%20July%202011.pdf>
- Daley-Harris, S. (2005). State of the Microcredit Summit Campaign Report 2005. Washington, DC: Microcredit Summit Campaign. Retrieved August 11, 2018, from <http://www.microcreditsummit.org/resource/51/state-of-the-microcredit-summit.html>
- Dunford, C. (2001). Building Better Lives: Sustainable Integration of Microfinance with Education in Health, Family Planning and HIV/AIDS Prevention for the poorest Entrepreneurs. *Journal of Microfinance/ESR Review*, 3(2), pp. 1-25. Retrieved August 14, 2018, from <https://scholarsarchive.byu.edu/esr/vol3/iss2/2/>
- Gray, B et al. (2012). Evaluating the Integration of Microfinance and Health Education in India with SKDRDP and ESAF. Washington DC and Davis CA: Microcredit Summit Campaign & Freedom from Hunger. Retrieved August 29, 2018, from [https://www.freedomfromhunger.org/sites/default/files/ffh\\_indiareport\\_web.pdf](https://www.freedomfromhunger.org/sites/default/files/ffh_indiareport_web.pdf)
- Gupta, I., & Bhatia, M. (2017, May). The Indian Health Care System. New York: The Commonwealth Fund. Retrieved August 5, 2018, from The Commonwealth Fund: <https://international.commonwealthfund.org/countries/india/>
- Gupta, R. K., & Kumari, R. (2017, July-Sept). National Health Policy 2017: An Overview. *JK Science*, Vol. 19(No.3), 135-136. Retrieved July 31, 2018, from [https://www.researchgate.net/publication/323629227\\_National\\_Health\\_Policy\\_2017\\_An\\_Overview](https://www.researchgate.net/publication/323629227_National_Health_Policy_2017_An_Overview)
- IFPRI. (2015). Global Nutrition Report 2015: Actions and accountability to advance nutrition and sustainable development. Washington, DC: International Food Policy Research Institute (IFPRI). Retrieved August 29, 2018, from <http://dx.doi.org/10.2499/9780896298835>
- Institute of Medicine (US). (2012). Drug-Resistant TB in India. In *Facing the Reality of Drug-Resistant Tuberculosis in India: Challenges and Potential Solutions: Summary of a Joint Workshop by the Institute of Medicine, the Indian National Science Academy, and the Indian Council of Medical Research* (pp. 17-35). Washington DC: National Academies Press (US). Retrieved August 29, 2018, from <https://www.ncbi.nlm.nih.gov/books/NBK100386/>
- International Institute for Population Sciences (IIPS). (2017). National Family Health Survey (NFHS-4), 2015-16: India Fact Sheet. Mumbai: Ministry of Health and Family Welfare. Retrieved August 5, 2018, from [http://rchiips.org/nfhs/factsheet\\_NFHS-4.shtml](http://rchiips.org/nfhs/factsheet_NFHS-4.shtml)
- IIPS. (2017). National Family Health Survey - 4 (2015-16). State Fact Sheet: Bihar. Mumbai: Ministry of Health and Family Welfare. Retrieved August 29, 2018, from [http://rchiips.org/NFHS/pdf/NFHS4/BR\\_FactSheet.pdf](http://rchiips.org/NFHS/pdf/NFHS4/BR_FactSheet.pdf)
- IIPS. (2017). National Family Health Survey - 4 (2015-16). State Fact Sheet: Rajasthan. Mumbai: Ministry of Health and Family Welfare. Retrieved August 29, 2018, from [http://rchiips.org/NFHS/pdf/NFHS4/RJ\\_FactSheet.pdf](http://rchiips.org/NFHS/pdf/NFHS4/RJ_FactSheet.pdf)
- IIPS. (2017). National Family Health Survey - 4 (2015-16). State Fact Sheet: Uttar Pradesh. Mumbai: Ministry of Health and Family Welfare. Retrieved August 29, 2018, from International Institute for Population Sciences: [http://rchiips.org/NFHS/pdf/NFHS4/UP\\_FactSheet.pdf](http://rchiips.org/NFHS/pdf/NFHS4/UP_FactSheet.pdf)
- Jack, SJ et al. (2012). Effect of Micronutrient Sprinkles on Reducing Anemia: A Cluster-Randomized Effectiveness Trial. *Arch Pediatr Adolesc Med*, 166(9), 842-850. doi:10.1001/archpediatrics.2012.1003

- Jeemon, P., & Stephen, M. (2009, Nov). Health outcomes in Indians in comparison with other countries: India specific summary findings based on World Health Statistics (2008). *Indian Journal of Medical Research*, 130(5), 570-572. Retrieved August 11, 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/20090108>
- Johnson, A et al. (2014). Longitudinal Study of the Impact of the Integration of Microfinance and Health Services on Bandhan Clients in India. Davis, CA: Freedom from Hunger. Retrieved August 29, 2018, from <https://www.freedomfromhunger.org/longitudinal-study-impact-integration-microfinance-and-health-services-bandhan-clients-india>
- Lorenzetti, LMJ, Leatherman, S, & Flax VL. (2017, June). Evaluating the effect of integrated microfinance and health interventions: an updated review of the evidence. *Health Policy Plan*, 32(5), 732-756. <https://doi.org/10.1093/heapol/czw170>
- Lucky Iron Fish. (2018, May 31). Research update - Lucky Iron Fish significantly increases hemoglobin levels and reduces anemia in rural Guatemalan community. Retrieved August 28, 2018, from Lucky Iron Fish: <https://luckyironfish.com/blogs/news/research-update-lucky-iron-fish-significantly-increases-hemoglobin-levels-and-reduces-anemia-in-rural-guatemalan-community>
- Metcalfe, M. et al. (2012). 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. Davis, CA, and Washington, DC: Freedom from Hunger and the Microcredit Summit Campaign. Retrieved August 29, 2018, from <http://microcreditsummit.org/resource/41/state-of-the-field-of.html>
- Metcalfe, M., Hollingworth, S., Stack, K., & Sinclair, M. (2014). Leveraging the Strengths of Two Sectors to Achieve Widespread Change in Health and Poverty: A Business Case for Integrated Microfinance and Health Programs. Davis, CA: Freedom from Hunger. Retrieved August 29, 2018, from <https://www.freedomfromhunger.org/leveraging-strengths-two-sectors-achieve-widespread-change-health-and-poverty-business-case>
- Ministry of Finance. (2018, February 01). Ayushman Bharat for a new India -2022, announced. Retrieved from Press Information Bureau, Government of India: <http://www.pib.gov.in/PressReleaselframePage.aspx?PRID=1518544>
- Ministry of Health and Family Welfare. (2017). National Health Policy, 2017. New Delhi: Ministry of Health and Family Welfare, Government of India. Retrieved July 31, 2018, from <https://mohfw.gov.in/documents/policy>
- NABARD. (2017). Status of Microfinance in India, 2016-17. Mumbai: National Bank for Agriculture and Rural Development (NABARD). Retrieved August 11, 2018, from <https://www.nabard.org/auth/writereaddata/tender/1307174808Status%20of%20Microfinance%20in%20India%202016-17.pdf>
- NABARD. (2018a). EShakti: Digitisation of Self Help Groups. Retrieved August 11, 2018, from EShakti: A Project of NABARD on Digitisation of Self Help Groups: <https://eshakti.nabard.org/Downloads/EShakti%20brochure%202018.pdf>
- NABARD. (2018b). Status of Microfinance in India 2017-18. New Delhi: National Bank for Agriculture and Rural Development (NABARD). Retrieved August 30, 2018, from <https://www.nabard.org/auth/writereaddata/tender/1907183104SMFI%202017-18.pdf>
- Pahwa, D., Dhar, V., & Godinho, N. (2017, Dec 10). Financing UHC in India. Retrieved July 31, 2018, from UHC Coalition: <https://medium.com/health-for-all/financing-uhc-in-india-5345e9cfc5eb>
- Prost, A et al. (2013, May 18). Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *The Lancet*, 381(9879), 1736-1746. Retrieved August 14, 2018, from [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60685-6/abstract](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60685-6/abstract)
- Ravi, S., & Kapoor, M. (2017). Brookings India Health Monitor. Brookings India. Retrieved August 29, 2018, from <https://www.brookings.edu/research/brookings-india-health-monitor/>
- Raza, WA et al. (2016, January 4). Healthcare seeking behaviour among self-help group households in Rural Bihar and Uttar Pradesh, India. *BMC Health Services Research*, 16(1). doi:<http://doi.org/10.1186/s12913-015-1254-9>
- Registrar General of India. (2011). Provisional Population Totals : India : Census 2011. New Delhi: Office of the Registrar General Census Commissioner, India. Retrieved August 30, 2018, from <http://censusindia.gov.in/2011-prov-results/indiaatglance.html>

- Registrar General of India. (2014). Sample Registration System Statistical Report 2013. New Delhi: Office of the Registrar General & Census Commissioner. Retrieved August 30, 2018, from [http://www.censusindia.gov.in/vital\\_statistics/SRS\\_Reports\\_2013.html](http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2013.html)
- Sa-Dhan. (2017). The Bharat Microfinance Report 2017. New Delhi: Sa-Dhan. Retrieved August 29, 2018, from <http://www.sa-dhan.net/index.php/bharat-microfinance-report/>
- Sa-Dhan. (2018). Quarterly Financial Report January 2017 – March 2018. New Delhi: Sa-Dhan, The Association of Community Development Finance Institutions. Retrieved August 11, 2018, from <http://www.sa-dhan.net/index.php/q-mf-report/>
- Sa-Dhan. (in press). Microfinance Directory, 3rd Edition. New Delhi: Sa-Dhan, The Association of Community Development Finance Institutions.
- Sa-Dhan. (various years). Bharat Microfinance Report. New Delhi: Sa-Dhan, The Association of Community Development Finance Institutions. Retrieved August 11, 2018, from <http://www.sa-dhan.net/index.php/bharat-microfinance-report/>
- Saha, S., & Rao, DSK. (2014). Integrated Health and Microfinance in India, Volume II: The Way Forward. Washington, DC, and Davis, CA: Microcredit Summit Campaign and Freedom from Hunger. Retrieved August 29, 2018, from <http://www.microcreditsummit.org/resource/183/integrated-health-and-microfinance-in.html>
- Sankar, MJ et al. (2016, December 07). State of newborn health in India. *Journal of Perinatology*, 36, pp. S3-S8. Retrieved August 12, 2018, from <https://www.nature.com/articles/jp2016183>
- Scroll Staff. (2018, February 20). India 12th worst among 52 lower middle-income nations for newborns, says Unicef report. Scroll. Retrieved August 29, 2018, from <https://scroll.in/latest/869315/india-12th-worst-among-52-lower-middle-income-nations-for-newborns-says-unicef-report>
- The Times of India. (2018, August 15). PM Narendra Modi's Independence Day speech: Highlights. Retrieved from The Times of India: <https://timesofindia.indiatimes.com/india/pm-narendra-modis-independence-day-speech-highlights/articleshow/65408666.cms>
- The Wire Staff. (2018, February 20). India 12th Worst for Newborns Among 52 Low-Income Countries: UNICEF Report. The Wire. Retrieved August 30, 2018, from <https://thewire.in/health/india-12th-worst-newborns-among-52-low-income-countries-unicef-report>
- WHO. (2012). Global data on visual impairment 2010. Geneva: World Health Organization (WHO). Retrieved August 29, 2018, from <http://www.who.int/blindness/publications/globaldata/en/>
- WHO. (2017). Global tuberculosis report 2017. Geneva: World Health Organization (WHO). Retrieved July 31, 2018, from [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/)
- Yasmeen, A. (2018). Only one doctor in most primary health centres. *The Hindu*. April 1, 2018. Retrieved August 31, 2018, from <https://www.thehindu.com/news/national/only-one-doctor-in-most-primary-health-centres/article23408696.ece>



## NOTES

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