

# Leveraging the Power of Women's Groups and Financial Services to Improve Knowledge and Behaviors for Improved Child and Maternal Nutrition

## BACKGROUND

Microfinance institutions (MFIs), self-help promoting institutions (SHPIs), and their self-help groups (SHGs) reach about 90 million poor women in India, bringing them together regularly to participate in financial activities that support their livelihoods. Through SHGs, women have access to financial services, such as loans, savings, and insurance. SHGs also provide a strong platform for women to participate in health and nutrition services, such as health and nutrition education, information on government health and nutrition programs, linkages to health providers and community health volunteers, health fairs, and access to savings and loans designed specifically to help households cover direct and indirect health expenses. SHGs are also a way for women to educate their peers, influence behaviors, and more systematically and cost-effectively benefit from streamlined, integrated financial and health and nutritional services.

Since 2007, Freedom from Hunger and the Microcredit Summit Campaign, in partnership through the Health and Microfinance Alliance (HMA), have worked with 38 MFIs and SHPIs across nine states in India that collectively reach more than 7.3 million women with financial services. Recognizing that poor health and nutrition are barriers for their clients to fully benefit from financial services, achieve food security, and lift themselves from poverty, Freedom from Hunger and the Microcredit Summit Campaign work independently and collaboratively with interested

MFIs and SHPIs to integrate health and nutritional services. The technical assistance from HMA includes health financing product design; health and nutrition education curriculum design; training systems design; facilitation of relationships with local health and nutritional services (e.g., primary care center health workers and hospitals); and government programs. The HMA has also actively engaged Indian MFIs, SHPIs, public and private health providers, government, private enterprises, and researchers and academics in a community of practice to encourage more local engagement. Two HMA "State of the Field" reports have been written to examine these integrated programs from both the health and the financial sector perspectives, and to identify challenges to and opportunities for further collaboration (Metcalf et al. 2012; Saha and Rao 2014).

## APPROACHES AND METHODS FOR COLLABORATION

All of the MFI and SHPI programs rest on a strong foundation of community-based health and nutrition education dialogues developed by Freedom from Hunger and facilitated by trained MFI and SHPI staff. Some MFIs and SHPIs also deploy their own community health volunteers (CHVs) to carry out home visits among their clients and members of the surrounding communities, to support behavioral change and facilitate access to relevant health and nutritional practices, including women's health, pre- and post-natal care, early

and exclusive breastfeeding, complementary infant feeding, prevention and management of diarrhea, water and sanitation, childhood illnesses, and reducing the nutritional risks of diabetes and other chronic diseases.

These CHVs, who are primarily volunteers, are recruited by the MFI or SHPI from among the existing SHG members, and are often recognized by their peers for their leadership skills, acceptance in the community, and experience in healthcare. The MFIs and SHPIs train the CHVs in local health and nutrition issues, and then the CHVs are deployed to work in their respective villages. In addition to sharing health information, the CHVs provide families with health products, such as oral rehydration solution, deworming medication, iron and folic acid, and home water filters.

The MFIs and SHPIs, through the efforts of the CHVs, work collaboratively with local public health providers, including accredited social health activists and anganwadi workers, to encourage access to and use of locally available health services and health products. They also collaborate with health organizations, such as the Indian Institute of Public Health, Gandhinagar, the West Bengal Voluntary Health Association, the Global Alliance for Improved Nutrition, the Center for Health Market Innovations, Apollo Hospital, and Susrut Eye Hospital to

- ▶ Develop **telemedicine programs** that provide a videoconference arrangement through which a patient in a remote area can directly interact with a doctor based in an urban hospital. Some basic medical tests, such as blood pressure and electrocardiogram tests, are conducted by local health workers, and the results are transmitted to the doctor. The doctor in turn can assess the patient's needs and send prescriptions electronically, if needed.
- ▶ Organize **health camps** to test and treat vision and dental problems.
- ▶ Set up **medicine points** that make a range of generic medicines and health supplies available in remote areas.
- ▶ Provide **general health checkups**, pediatric and gynecological care, and cancer screenings.
- ▶ Address **other pertinent health and nutrition concerns** of their clients and the communities they serve.

The development of these integrated services starts with systematic planning that involves a landscape analysis to help MFIs and SHPIs understand the existing health system service provision for the communities they currently serve. Freedom from Hunger provides technical support and oversight to MFIs and SHPIs to help them create and maintain linkages with health practitioners and services. Depending on the competencies, capacities, and comparative advantages of financial and health service practitioners operating in any given area, three basic types of integration can occur—unified, parallel, and linked. In some cases, a hybrid approach is adopted for some organizations, depending on the services being provided.

Table 1 (pages 4-5 ) summarizes some concrete details of how MFIs and SHPIs provide these services. Cross-sectoral efforts often fall in the “linked” category of integration, where health and financial service actors come together with a common goal and purpose.

These health and nutrition services are currently reaching more than 700,000 MFI and SHPI clients and benefiting their 3.5 million household members. But there is great potential, even among the existing 38 partners, to reach all of their 7.3 million clients with health and nutrition services. The current level of coverage is limited because many of these programs are in the pilot stage, or they are limited by demand for the services from the community and have limited access to existing community health services, or there are funding constraints for the MFIs and SHPIs for initial investments or ongoing support for scale-up.

## KEY FINDINGS

Evidence continues to mount regarding the health services provided by MFIs and SHPIs. These studies have shown that as a result of SHG membership, women and their families experience enhanced health and nutrition knowledge; improved social and economic capital; increased rates of institutional births, family planning services, antenatal care, and immunizations; and reduced neonatal mortality and malnutrition (Freedom from Hunger 2014; Saha and Rao 2014). One recent evaluation (Johnson et al. 2014) conducted with the MFI Bandhan, located in West Bengal, has been important for understanding and promoting the



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potential of these integrated approaches for poor households. Bandhan and Freedom from Hunger identified pressing health needs and concerns of Bandhan clients, and designed a responsive and cohesive health package of health loans and health education forums for clients and community members that deliver behavior change communication on breastfeeding; pre-, post-, and neonatal care; infant and child feeding; and diarrhea. Further, health product distributors, known as Swastha Sahayikas, reinforce health messages during home visits, sell health products, and support referrals to local healthcare services.

The evaluation suggests that over a five-year assessment period, there were significantly higher rates of immediate breastfeeding, proper introduction of complementary foods, and use of oral rehydration solution to manage diarrhea among Bandhan's clients. Women also reported improved health knowledge and capacity to make health and nutrition decisions; greater trust of information and services provided; and increased confidence in advising others with respect to prenatal care, infant feeding, and diarrhea prevention and management (Table 2, page 6).

Because all of the health and nutrition programs—including health and nutrition education, health products, health financing, and linkages to health providers and local health services—are added to existing MFI and SHPI structures and processes, the cost of program development is low and likely to be sustained after initial investment in capacity building is completed. MFIs and SHPIs that have scaled up these nutrition programs have found them to be low cost, particularly when utilizing the unified model of integration referenced above, with costs of about US\$1 per family per year (Reinsch, Dunford, and Metcalfe 2011). These integrated programs are most likely to be successful among MFIs and SHPIs that have strong financial and operating processes, strong leadership support from the MFIs and SHPIs for improved health and nutrition of clients, willingness to invest in MFI and SHPI program staff for start-up and operations, and initial financial support for the program launch.

MFIs and SHPIs aiming to improve the food security and nutritional outcomes of their clients are challenged by their ability to adapt their programs to meet the specific health context needs of their clients. Local health practitioners do and can continue to play a larger role in ensuring that

## EXHIBIT 1 Forms and Brief Examples of Integration

	Unified
<b>Services Provided to Clients</b>	<ul style="list-style-type: none"> <li>• A credit officer or SHPI animator facilitates financial services, such as savings, loans, and insurance, and also provides health and nutrition education to SHG group members during regular meetings or at specified times.</li> </ul>
<b>Role of MFI/SHPI</b>	<ul style="list-style-type: none"> <li>• MFI cross-subsidizes the cost of added health and nutrition education to its credit groups.</li> <li>• SHPIs use donor funding to cover the cost of financial and education services.</li> <li>• Credit officers or SHPI animators are trained on the education sessions internally and deliver the education during regular meetings.</li> </ul>
<b>Role of Health Providers</b>	<ul style="list-style-type: none"> <li>• Local or international health practitioners may be consulted in the design of the education sessions.</li> </ul>
<b>Advantages and Disadvantages of the Approach</b>	<ul style="list-style-type: none"> <li>• Unified integrated services are usually the most cost-effective approach, as addition of health education and services are marginal costs to total service delivery for the MFI or SHPI.</li> <li>• Credit officers are not health professionals, so they are limited to a certain degree in relation to what they can provide.</li> </ul>

Parallel	Linked
<ul style="list-style-type: none"> <li>• A credit officer or SHPI animator facilitates financial services, such as savings, loans, and insurance.</li> <li>• CHVs or designated health staff recruited and trained by the MFI or SHPI provide health and nutrition education, make home visits, refer clients and household members to local services, and sell health products. The trainings may happen during regular financial meetings or at other specified times.</li> </ul>	<ul style="list-style-type: none"> <li>• A credit officer or SHPI animator facilitates financial services, such as savings, loans, and insurance.</li> <li>• Local CHVs, accredited social health activists, anganwadi workers, and private and public medical practitioners are invited to provide education and/or health services to SHGs. Services include health camps, discounted health services, health insurance products, and health and nutrition education, etc.</li> </ul>
<ul style="list-style-type: none"> <li>• MFI cross-subsidizes the cost of added health education and health services to its credit groups.</li> <li>• CHVs may primarily be volunteers trained by the MFI/SHPI to provide health and nutrition education or make home visits, but the MFI/SHPI will develop business and procurement models for the CHVs' provision of health products.</li> <li>• CHVs can also be permanent staff of the MFI/SHPI.</li> <li>• SHPIs use donor funding to cover the cost of financial and health services. SHG members typically do not pay for health education or linkages to providers, but will pay for health products, and some health services, such as medical treatment.</li> <li>• MFIs cover all costs up to the completion of the referral to the local health provider.</li> <li>• MFI clients pay for the services out of pocket or through specific health-financing products designed by the MFI.</li> </ul>	<ul style="list-style-type: none"> <li>• MFIs and SHPIs might design specific financial services meant to improve access to certain health services available in the community, such as health savings or loans.</li> <li>• SHPI and MFI staff will collaborate with local health providers to make referrals to their services when need is identified through home visits and other monitoring methods, or will negotiate discounted rates or packages of services for their clients.</li> <li>• MFIs might cover the cost of (or cost-share with health providers for) transporting health providers to specified locations for health fairs and other health services.</li> <li>• MFI clients pay for the services out of pocket or through specific health-financing products designed by the MFI or SHPI.</li> </ul>
<ul style="list-style-type: none"> <li>• CHVs who are also members of SHGs or MFI groups may become the volunteers for the MFI or SHPI.</li> <li>• Local health providers are notified by MFI and SHPI staff of the linkages they would like to make for their clients.</li> <li>• Health providers might provide discounted rates for MFI and SHPI clients and their family members.</li> <li>• Health providers cover their typical costs for provision of services.</li> </ul>	<ul style="list-style-type: none"> <li>• Health providers might provide discounted rates for MFI and SHPI clients and their family members.</li> <li>• Health providers provide periodic "health camps" specifically for the MFI/SHPI clients at market or discounted rates.</li> <li>• Health providers cover their typical costs for provision of services.</li> <li>• Health providers benefit from having organized groups of women that meet regularly and who receive marketing of their health services.</li> </ul>
<ul style="list-style-type: none"> <li>• Parallel services are generally the most expensive, because parallel staff members are employed to provide separate services within the same organization.</li> <li>• Credit officers are able to focus on financial service provision, which is important for financial sustainability of the MFI or SHPI.</li> <li>• Health service staff is able to provide more comprehensive health services.</li> </ul>	<ul style="list-style-type: none"> <li>• Linked services can be cost-effective so long as both organizations are able to cover their respective costs.</li> <li>• Credit officers are able to focus on financial service provision, which is important for financial sustainability of the MFI or SHPI.</li> <li>• Health service staff is able to provide more comprehensive health services.</li> <li>• Requires more time to build partnerships, develop common goals, and create a shared vocabulary.</li> </ul>

## EXHIBIT 2 Selected Bandhan Impact Assessment Results

Characteristic	Pre-Test %	N=	Post-Test 1* %	N=	Post-Test 2** %	N=
<b>Breastfeeding and Addressing Malnutrition</b>						
<b>Knowledge</b>						
Percentage of women clients who knew how soon after birth a child should be breastfed (answered "immediately" or "within 1 hour")	71	240	97+++	180	92^^^,◇	181
Percentage of women clients who knew a child should be exclusively breastfed for 6 months	75	240	92+++	180	97^^^, ◇	181
Percentage of women clients who knew one should add oil, protein, or vegetables to first foods for a baby to make them more nutritious	93	240	96	180	98^^	181
<b>Behavior</b>						
Among women clients who have or care for a child 12 months of age or younger, percentage whose child or child in their care was breastfed immediately or within 1 hour of birth	61	98	93+++	74	75	20
Percentage of women clients who reported introducing complementary foods to a child's diet at age 6 months or older	60	67	88++	48	100^	8
<b>Diarrhea, Sanitation, and Safe Water</b>						
<b>Behavior</b>						
Percentage of women clients with a child in their household or care who had diarrhea in the last 3 months and who treated that child with oral rehydration solution	60	10	88+	42	100^	10
Percentage of women clients who treated a child in their household or care with special liquids at home (such as coconut water, lentil water, or rice water)	30	10	69+	42	80^	10
Percentage of women clients who gave their child with diarrhea more than usual to drink	0	10	17	42	50	10

Source: Johnson et al. 2014.

\*Significant difference between pre-test and post-test 1: + p < 0.05, ++ p < 0.01, +++ p < 0.001

\*\*Significant difference between pre-test and post-test 2: ^ p < 0.05, ^^ p < 0.01, ^^^ p < 0.001; and significant difference between post-test 1 and post-test 2: ◇ p < 0.05, ◇◇ p < 0.01, ◇◇◇ p < 0.001

these programs meet targeted health needs, instead of remaining generic in their focus. MFI and SHPI leaders also have voiced that poor health infrastructure and the lack of support from public health systems challenge their ability to make their programs either sustainable or comprehensive.

## LESSONS LEARNED AND CONCLUSION

The microfinance and health and nutrition programs that have been developed by MFIs and SHPIs in India represent important examples of the underdeveloped opportunities for cross-sectoral approaches and partnerships to improve the nutrition and health of women and children in India. Public health practitioners and actors interested in these approaches are equally encouraged to identify interested MFIs and SHPIs currently operating in their area for further and deeper collaboration. Exposure visits to integrated programs and small pilot programs are important first steps before risking the necessary investment costs needed to scale up these types of programs. This also allows time for assessing outcomes and costs of the program, which are important factors for developing scalable and sustainable integrated financial and health programs.

Public health practitioners, in their endeavor to expand universal health care in India, are positioned to benefit from the sustainable and effective group-based platforms of MFIs and SHPIs that currently serve millions of women and their families. Well-run MFIs and SHPIs that have strong social missions and have established service channels into hard-to-reach areas and communities can play an effective role in behavioral change communication and forging linkages with local health and nutrition services to support improved nutrition for women and children. This in turn promotes greater health awareness and increased demand for health services.

Through the intentional linking of microfinance to local health practitioners and national programs, such as the National Rural Health Mission, women and their families stand to benefit and thrive with better access to healthcare, reduced poverty, and improved overall health.

For more information, please visit:

- ▶ **Health and Microfinance Alliance:** <http://www.microcreditsummit.org/the-health-and-microfinance-alliance.html>

- ▶ **Freedom from Hunger—Microfinance and Health Protection:** <https://www.freedomfromhunger.org/microfinance-and-health-protection-0>

- ▶ **Microcredit Summit—Finance Healthier**

**Lives:** <http://www.microcreditsummit.org/about-the-project2.html>

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## NOTE

1. Bihar, Chhattisgarh, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Tamil Nadu, Uttar Pradesh, and West Bengal.

## Led by IFPRI

### Partnership members:

Institute of Development Studies (IDS)

Public Health Foundation of India (PHFI)

One World South Asia

Vikas Samvad

Coalition for Sustainable Nutrition Security in India

Save the Children, India

Public Health Resource Network (PHRN)

Vatsalya

Centre for Equity Studies

## WRITTEN BY

**Saraswathi Rao**, Freedom from Hunger

**Bobbi Gray**, Freedom from Hunger

**Marcia Metcalfe**, Freedom from Hunger

**Soumitra Dutta**, Freedom from Hunger

## SUGGESTED CITATION

Rao, S., B. Gray, M. Metcalfe, and S. Dutta. 2014. *Leveraging the Power of Women's Groups and Financial Services to Improve Knowledge and Behaviors for Improved Child and Maternal Nutrition*. POSHAN Implementation Note 5. New Delhi: International Food Policy Research Institute.



This Implementation Note was prepared for the *Together for Nutrition 2014: Working Across Sectors to Improve Nutrition in India* conference, held October 29–30, 2014, in New Delhi. This conference was co-hosted by POSHAN and Transform Nutrition and served as an important platform for learning and facilitating discussion around the challenging task of bringing diverse sectors together to improve maternal and child nutrition in India. For more about the conference and other papers on the topic of multisectoral convergence, please visit <http://poshan.ifpri.info/>.

### About Transform Nutrition

Transform Nutrition is a consortium of five international research and development partners funded by the UK government. Over 5 years, from 2012-2017, Transform Nutrition aims to transform thinking and action on nutrition and strengthen nutrition-relevant evidence in order to accelerate undernutrition reduction in South Asia and sub-Saharan Africa. For more information, please visit [www.transformnutrition.org](http://www.transformnutrition.org).

## ABOUT POSHAN

Partnerships and Opportunities to Strengthen and Harmonize Actions for Nutrition in India (POSHAN) is a 4-year initiative that aims to build evidence on effective actions for nutrition and support the use of evidence in decisionmaking. It is supported by the Bill & Melinda Gates Foundation and led by IFPRI in India.

## ABOUT IMPLEMENTATION NOTES

Implementation Notes summarize experiences related to how specific interventions or programs are delivered. They are intended to share information on innovations in delivery and are not research products.

## CONTACT US

Email us at [IFPRI-POSHAN@cgiar.org](mailto:IFPRI-POSHAN@cgiar.org)

## IFPRI-NEW DELHI

### INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

NASC Complex, CG Block,  
Dev Prakash Shastri Road,  
Pusa, New Delhi 110012, India  
T+91.11.2584.6565 to 6567  
F+91.11.2584.8008

## IFPRI-HEADQUARTERS

### INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

2033 K Street, NW,  
Washington, DC 20006-1002 USA  
T. +1.202.862.5600  
F. +1.202.467.4439  
Skype: IFPRIhomeoffice  
[ifpri@cgiar.org](mailto:ifpri@cgiar.org)  
[www.ifpri.org](http://www.ifpri.org)

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