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Original Article

Do Micro Finance Programs Improve Health Conditions of the Poor in Bangladesh?

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ABSTRACT

This paper is an attempt to focus on dilemma about whether micro finance program has any impact on poverty alleviation in Bangladesh. Exploring the linkage of being a recipient of micro finance with improving health conditions was the main purpose. Information was collected through individual interviews of micro finance recipients in a certain area of the Northern Bangladesh. It has been found that micro finance program has been able to improve recipients' hygienic knowledge. The number of people cleaning both hands before taking meals, using clean water during cooking and drinking arsenic free water found mainly rising. Accordingly as suggested, it may be possible to improve health conditions of the poor by increasing their accessibility to micro finance programs which have facilities for dispensing healthcare services.

Introduction

Bangladesh is one of the most populous and emerging middle Income countries in the world. It has a huge population of 160 million (CIA World Factbook, 2013) and achieved tremedous positive resilts in human development indicators over the last few decades (Ahmed and Khan, 2011; Anderson, 2012). It has been estimated that at least 31.5 percent of the total population lives below the poverty line of which 17.6 percent are hard-core poor people in 2010. The figures for poor and extreme poor in 2000 were 48.9% and 34.3% respectively (bdnews24.com June, 20, 2013). Bangladesh has been adopting many poverty alleviation programmes to reduce the numbers of the poor for many decades. Bangladesh has a long history of the expansion of the micro credit program. The Government of Pakistan introduced green revolution in agriculture and village cooperative system in rural areas with a view to increasing employment opportunities and credit flows that could reduce high poverty rate in the early 1960s. It found that all these programs had increased rather reduced social inequality one decade or more later; rich became richer and poor poorer. Economists, sociologists, and other development think-tanker thought over the problem and came in a consensus that separate organization—focusing on income and employment generating activities—needed to be introduced for the poor. NGOs (both international and national)

activities on poverty alleviation found in very limited form during the late 1970s. At the same time, locally developed many NGOs started to give collateral free micro credit to the poor. There has been an increase in the number of NGOs with poverty reduction programmes since the early 1980s (Abedin, 2005:118; Hadi, 2001). Like other developing countries, many NGOs here were emerged for providing education to and improving social conditions of the oppressed classes in the 1970s and 1980s through different activities. These activities include group meetings, skills training, basic literacy and primary healthcare services (family planning, water and sanitation, immunisation, nutrition education and basic curative services). However, most of the leaders of these NGOs came from middle class families who had socialist ideological backgrounds. After the collapse of the Soviet Union in 1990, the focus of the NGOs has shifted to profit making activities. The most leading persons of the newly emerged NGOs are professionally trained (Kamat, 2004: 167-68; Hadi, 2001; Zohir, n.d) This has caused increasing a huge number of NGOs with micro credit programs at the end of the twentieth century. It is important to mention here that most of the NGOs tend to address the needs of the poor who are the participants of their development interventions (Karim *et al*. 2006). This indicates that exclusionary process is active in NGOs programs. With increasing the number of NGOs, particularly micro-credit-based, recent debates have questioned their efficacy in terms of reducing poverty (Amin *et al*. 2001; Bajracharya and Amin, 2013; Karim *et al*. 2006; Mahmud *et al*. 2012; PATH, 2011). Development practitioners favouring NGO activities argue that NGOs help the poorest of the poor who are not reachable by the government agencies. They create employment opportunities for thousands of unemployed youths, bring resources from abroad and try to uplift socio-economic conditions of the poor (Abedin, 2005: 119). For instance, the Human Development Report (2005) shows that Bangladesh has achieved success in human development in compared with India. It identifies access to micro credit as one of four strategies directly contributed to Bangladesh's advances (UNFPA &MSC, 2006:3). In contrast, the critics of NGO activities say that NGOs do not have accountability, misuse the fund and make division among people (Abedin, 2005: 119; Kamat, 2004:156; World Bank, 2005). Considering the debate in favour and against of NGO activities, particularly micro credit programme, the main target of the paper is to find out the impact of micro credit programme on health-related knowledge of the credit recipients. The rest of the paper is organized in the following manner. The next section deals with methodology taken in the study which is followed by the presentation and discussion of the data. The penultimate section describes main findings and builds up arguments based on findings. The paper draws its conclusion and looks forward in the final section.

Methodology

Primary data was collected by using questionnaire interviews. A research team consisting of one Principal Investigator (PI) and four Research Assistants (RAs) was formed. I was the PI and four male students from the Department of Sociology, University of Rajshahi, were recruited as RAs. Initially a draft questionnaire was developed on issues, such as socio-economic background of the respondents and the knowledge on different public health issues gained from

being members of different NGOs. The questionnaire used in the study had three parts. The first part asked some general questions like age, occupation, household size and income and marital status. The following part put some questions on NGO-related issues, such as how many NGOs the respondents have memberships, for how long they have involvements and so on. In the last part, few questions on the idea of different public health issues like have you gained new knowledge on public health after being members of NGOs?; What steps did you take to apply the knowledge you gained from different activities of NGOs? were asked. Several discussions were held among the researchers who found certain anomalies regarding ordering the questions and then felt the necessity of adding few more questions with changes and adjustments in the questionnaire. With some addition and correction, the questionnaire was finalized for pre-testing. Both open and close-ended questions were incorporated in the questionnaire.

The pre-test was conducted among four respondents in order to test the effectiveness of suitability of the research instrument and to discover possible weaknesses, inadequacies, ambiguities and problems so that they could be corrected before actual data collection took place. It was also done in order to test the need of adding new questions so that clear information on certain issues could be addressed in the questionnaire. After the pre-testing, necessary correction and modifications were made in the questionnaire. It was then ready for conducting interviews among micro credit recipients.

Once the questionnaire was finalized after the pre-testing, RAs prepared themselves for conducting interviews. It should be mentioned here that proper orientation and training was given to the RAs who conducted the interviews. This was important in the sense that the issue dealt in the study is different in terms of nature from usual research subjects dealt in social sciences. RAs were then briefed and advised to adopt necessary strategies and techniques depending on varying situations for interviewing NGO members.

Field investigation began in early December and ended in late December 2007. Using purposive sampling technique, 100 members of different NGOs were interviewed in different villages of different thanas in Kustia district under Rajshahi division. The underlying reason for doing this is to find out the variation among NGO members with diverse socio-economic backgrounds in terms of their perception about the effect of micro credit programme on public health. Table 1 (in appendix) indicates the areas where interviews were done.

After completing the field investigation, all the questionnaires were edited and some errors were detected and corrected accordingly. Frequency distribution tables with percentage and figure are provided to describe responses. All kinds of data processing activities were done manually.

Data Presentation and Analyses

Data on socio-economic characteristics of the respondents illustrated in table 2 (in appendix) reveals that about 83 percent were females. As found, 69 percent were aged between 25 and more than 40 years. Of these, a large number (33 percent) belonged to the 25-30 year age group. The sample was not homogeneous in terms of level of education and monthly family income. Conversely, the sample was homogeneous in regards to occupational status. Only 27 percent had no education whereas 47 percent of the respondents were educated up to primary level of education. The majority of the

respondents (82%) were housewives. Only 45 percent of the respondents had monthly income below 3000 Taka which is followed by 40 percent having income between 3000 and 5000 Taka.

Table 1. Names of areas where interviews were done

Name of villages	Union	Thana	District	No of respondents
B. Mirzapur	Khokna	Khokna	Kustia	21
Mahadipur	Amla	Mirpur	Kustia	13
Swastipur	Alampur	Kustia Proper	Kustia	5
Boro Ailchara	Ailchara	Kustia Proper	Kustia	34
Rajinathpur	Khokna	Khokna	Kustia	5
Alampur	Alampur	Kustia Proper	Kustia	22
Total				100

(Source: Field work)

Table 2. Socio-economic Characteristics of the Respondents

Socio-economic Characteristics	n	%
Sex		
Male	**17**	**17**
Female	**83**	**83**
Age (in year)		
<25	**31**	**31**
25-30	**33**	**33**
30-35	**18**	**18**
35-40	**12**	**12**
>40	**6**	**6**
Total	**100**	**100**
Level of Education		
No education	**27**	**27**
Primary	**47**	**47**
Secondary	**25**	**25**
Higher Secondary	**1**	**1**
Total	**100**	**100**
Occupation		
Housewife	**82**	**82**
Agriculture	**7**	**7**
Small traders	**3**	**3**
Rickshaw/Van puller/driver	**2**	**2**
Waver	**3**	**3**
Working women	**2**	**2**
Others	**1**	**1**
Total	**100**	**100**
Monthly Family Income (in Taka)		
<3000	**45**	**45**
3000-4000	**20**	**20**
4000-5000	**20**	**20**
5000-6000	**9**	**9**
6000+	**6**	**6**
Total	**100**	**100**

(Source: Field work)

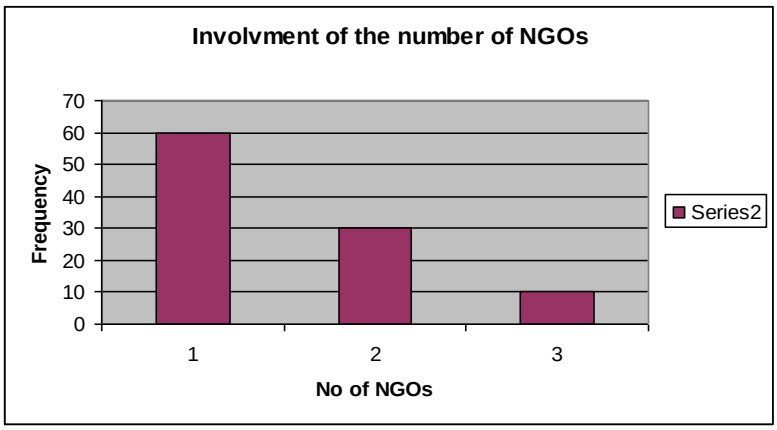

Figure 1. Respondents' involvement in the number of NGOs

Figure 1 indicates the numbers of NGOs the respondents had memberships and involvements. Sixty percent of the respondents were the members of a single NGO whereas 30 and 10 percent had involvement with two and three NGOs respectively. Figure 2 describes how long (in terms of year) the respondents have been with NGOs. As revealed that 32 percent of the respondents had connection with NGOs for more than six years while 15 and 14 percent had 3 and 2 years involvement respectively. That means, the notion of NGO is not new to them.

Pie-chart in figure 3 shows whether NGOs members have public health knowledge. Fifty four percent did not have any knowledge on public health. In contrast, 46 percent gained certain knowledge on public health from different NGOs. This indicates that NGOs are yet to play vital role in the improvement of people's knowledge about public health. As mentioned by the respondents in table 3, 35 percent gained knowledge about using tube well water, followed by using sanitary toilets (34%) and using family planning method (24%). As illustrated in table 4, 41 percent of the respondents had no definite idea how much they spent monthly for medical purpose while 15 and 13 percent monthly spent Taka 200-300 and 400-500 correspondingly.

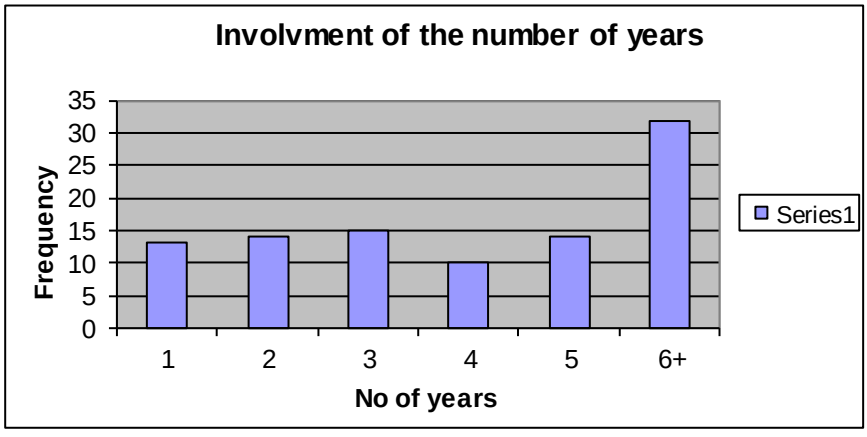

Figure 2. The number of years respondents involved with NGOs **(**Source: Field work)

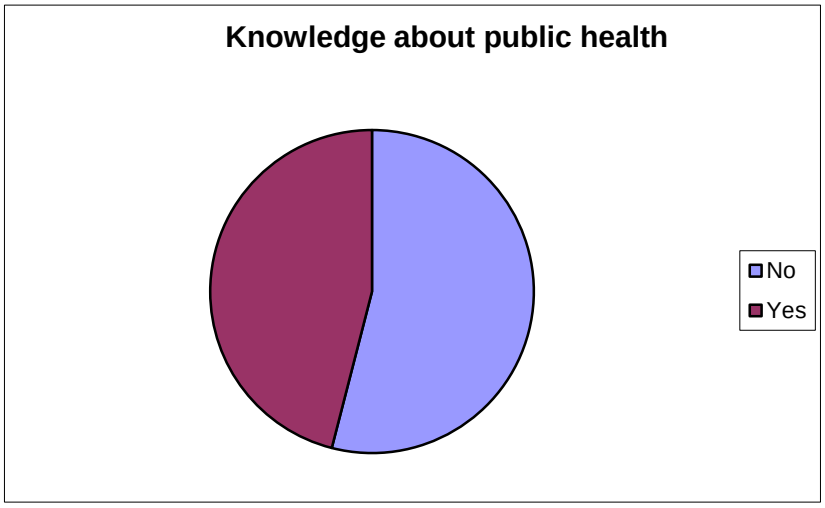

Figure 3. Respondents' knowledge about public health given by NGOs (Source: Field work)

Table 3. Types of Knowledge NGOs provided*

Types of knowledge	n
Use tube well water	35
Use boiling water	5
Use Sanitary Toilets	34
Covering foods	6
Use family planning method	24
Information on hygienic	8
Work hard	1
Cultivate vegetables in homestead	1

(Source: Field work) *=Multiple responses

Table 4. Amount of money spent monthly for medical purposes

Amount (in Taka)	n	%
100-200	12	12
200-300	15	15
300-400	10	10
400-500	13	13
500+	9	9
Not Definite	41	41
Total	**100**	**100**

(Source: field work)

Pyramid (in figure 4) shows whether the respondents or their family members faced any physical troubles in the last year or not. Eighty-five percent of the respondents reported that they, including their family members, had physical troubles in the last year. As reported in table 5 (in appendix), more than half of the respondents (64%) had fever which is followed by coughing (31%) and cold-related problems (23%).

Cone in figure 5 reveals types of treatment the respondents used for curing diseases they faced in the last year. Seventy-nine respondents out of eighty five mentioned that they sought allopathic treatments

whereas only one in ten sought homeopathic treatment. As found in table 6, those (79) who used allopathic treatment for being cured mentioned that they used this sort of treatment for being cured swiftly (61), available in hospital (8), and easily adjust with body (5). In contrast, those (10), used homeopathic, reported that they used for being cured swiftly (4) and less expensive (3). More than half of the respondents had knowledge about sanitary toilet, drinking water, adulterated food, diarrhoea, and smoking each before they were members of NGOs. More than three-fourth of the respondents had knowledge on family planning and used to take decisions for going to doctors before being members of any NGOs. However, positive impact of being members of NGOs found. An increase in the number of respondents with knowledge of different public health issues due to their involvements in different NGO activities found. For instance, the number of the respondents having knowledge on bad effects of smoking increased from 63 to 87, followed by using sanitary toilet from 59 to 80, family planning from 81 to 99, drinking water from 67 to 78, avoiding adulterated food from 68 to 79, taking decision on going to doctors for treatment from 88 to 98, and diarrhoea from 59 to 63 percent. Most of the respondents with NGO memberships took steps for introducing sanitary toilet, making safe drinking water available and avoiding adulterated foods. Conversely, fewer respondents found taking steps in protecting diarrhoea, avoiding smoking, using family planning methods and taking decision to go to doctors for treatment though most of them had knowledge on these issues for being members of NGOs.

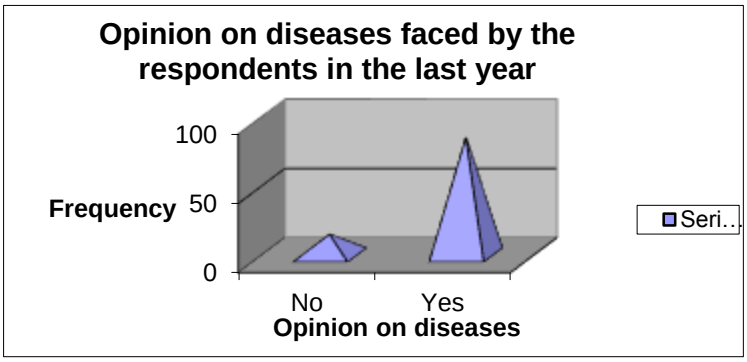

Figure 4. Opinion on diseases the respondents faced in the last year (Source: Field work)

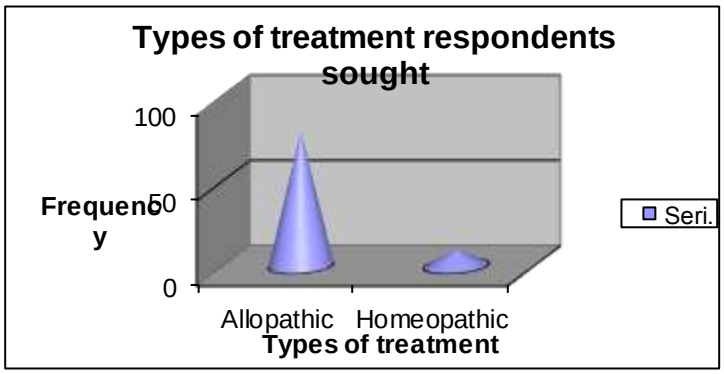

Figure 5. Types of treatment the respondents sought during their troubles (Source: Field work)

Table 5. Types of diseases the respondents faced last year*

Types of diseases	n
Vomiting	4
Fever	64
Coughing	31
Cold related troubles	23
Gastric	4
Appendicitis	5
Jaundice	4
Diarrhoea	8
Pneumonia	9
Allergy	2
Ear problem	2
Cardiac	4
Kidney	1
Chest-pain	3
Female disease	3

(Source: Field work);*=Multiple responses

Table 6. Reasons for taking either allopathic or homeopathic Treatment*

Types of reasons Allopathic	Homeopathic
Cure fast/ to be cured (61)	To be cured (4)
Adjust with body (5)	Less expensive (3)
Available in hospital (8)	Less dangerous (2)
Available in pharmacy (2)	Near to home (1)
No belief in others (2)	
Easily available (3)	

(Source: Field work); Here () = Frequency; *=Multiple responses

Table 7. Impacts of NGOs members on knowledge about different issues

Types of Issues	Before NGOs		After NGOs		Steps	
	Yes	No	Yes	No	Taken	Not taken
Sanitary toilet	59	41	80	20	80	20
Drinking water	67	33	78	22	78	22
Adulterated food	68	32	79	21	75	25
Diarrhoea	59	41	63	37	51	49
Smoking	63	37	87	13	53	47
Family planning	81	19	99	1	83	17
Decision on going to doctors	88	12	98	2	51	49

(Source: Field work)

Main findings

Poor spent much for illness and resultantly fail to repay loans

As most of the respondents were poor and micro-credit recipients, they were asked how much money they spent for illness of their family members monthly. It has been found that 41 percent of the respondents had no definite idea how much they spent monthly for medical purpose while 15 and 13 percent spent

monthly Taka 200-300 and 400-500 correspondingly. This cost must be for normal physical problems. It might be the case that they spend money only for medicine which is also subsidised because normal treatment in most of the cases is free. Moreover, it is worthwhile to mention here that 45 and 40 percent of the respondents with monthly income below 3000 Taka and between 3000 and 5000 Taka found. It is thus clear that the respondents spent not less than 10 percent of their monthly income for illness of their family members.

Similarly, another study conducted in Kenya found that households in the bottom 20 percent of the socioeconomic scale spent more than 10 percent of their total expenditures on acute illnesses and that about 30 percent households faced 'potentially catastrophic cost burdens' as a result of illness. Likewise, Freedom from Hunger—conducted a research in Bénin and Burkina Faso in 2006—found that poor microfinance clients spent an average of 30 percent of their annual income to combat malaria alone (Dunford *et al.* 2007:2). This exorbitant costs has caused micro credit recipients fail to repay their loans. For instance, Grammen Bank reports that, among its clients, illness and related expenditures are the leading cause of failure in micro-credit-business and loan default (Ohri, 2004:6).

Micro-credit programme helps build up awareness of the poor about public health

The number of NGOs in Bangladesh dealing with micro-credit programme has been increasing for many decades. Their main activities are to provide loans and health education which helps their clients to be more aware about public health issues. The scenario depicted in the study is not exceptional. All of the respondents in the study are the members of the NGOs who receive not only micro-credit from different organisations but also some sort of health education. Knowledge about public health is disseminated and shared in the weekly or forth-nightly meetings which are normally arranged for credit disbursements and repayments. Resultantly, awareness of credit recipients about public health issues has been developed though they all are not able to take necessary steps for various reasons like lack of money and foods, gender barrier in different contexts and so on. However there has been an increase in the number of respondents with knowledge of different public health issues. For instance, there is an increase of 24 percent (knowledge on bad effects of smoking), 21 (using sanitary toilet), 18 (family planning), 11 (drinking safe water and avoiding adulterated food each), 10 (making decisions to go to doctors for treatment) and four (knowledge on diarrhoea) between before and after being members of different NGOs. Almost all of the respondents found taking endeavours for setting sanitary toilet, tube wells for safe drinking water, and avoiding adulterated foods. Conversely, fewer respondents found reluctant to take necessary steps though they all have knowledge on different health-related issues. One of the main reasons for this difference is that micro-credit participants might probably have better opportunities to learn about healthcare in group meetings compared to the non-participants (Hadi, 2001). However, like the study, an evaluation study in Ghana found that program participants had better health knowledge and practices in breastfeeding, diarrhoea treatment and immunization because the microfinance program provided education on these issues (MkNelly and Dunford 1998 and 1999 in

UNFPA & MSC, 2006: 9). Similarly, Barnes (2001 in UNFPA & MSC, 2006: 9) unearthed that participants' children had better nutritional status than non-participants' children in Ghana. He also found that clients of FOCCAS with health education in Uganda had better health care practices than non-clients and 32 percent of clients had tried at least one HIV/AIDS prevention practice compared to 18 percent of non-clients. Two studies on Bangladesh corroborate the same results. For example, Khandker (1998 in UNFPA &MSC, 2006:14) revealed that members of the BRAC—offering a variety of social and financial services to clients who had participated for more than four years—had higher rates of contraceptive use. Another study done by (Steele *et al*. 1998 in UNFPA &MSC, 2006:14) documented that the participants of a new microfinance program were 1.8 times more likely to use contraceptives than the control group one or more year later. Moreover, rigorous studies held in Ghana and Bolivia revealed a significant improvement in health and nutrition practices of mothers who attended regular meetings where microfinance transactions and health education were provided by the same field agent (Dunford *et al*. 2007:3). Besides these, the other study found that maternal knowledge was much greater among credit forum participants than non-participants (Hadi, 2001).

Integrated approach needs to be introduced by the NGOs

As mentioned in the first section, many NGOs in Bangladesh were developed to educate and improve social conditions of the oppressed classes in the 1970s and 1980s. With the collapse of the Soviet Union in 1990, the focus and leading members of the NGOs appear to have dramatically been changing. Now the main focus of different NGOs is to make profit and their leaders are well-trained highly educated. It is thus said that the number of NGOs with micro-credit programme has been rising from the end of the twentieth century. However, most of the micro-credit programmes here follow a 'minimalist' (providing financial services only) instead of an 'integrated' (financial and non-financial services are offered) approach. As a result, most of the NGOs generally face tremendous troubles when their clients fail to repay the borrowed money which is mainly used for treatment purposes. For example, the Grammen Bank report shows some adverse impacts of poor client health on micro finance institutions. These are: delayed loan repayment; inability to repay loans, resulting in default; poor attendance at MFI group meetings; decrease in client business performance, due to neglect and redirection of capital; and undermining MFI client group solidarity (Ohri, 2004:6). It is thus suggested that if the NGOs follow integrated approach, they can easily recover their money and help the poor improve their economic and social conditions (chan, 2008; Hamad, *et al*. 2011; Ohri, 2004: 9-10; PATH, 2011). Ohri (2004) and PATH (2011) have suggested three ways for all NGOs to easily provide integrated services to their clients. These are as follows:

1) Linked service delivery by two or more independent organizations operating in the same area- in this model, financial service is provided by one specialized microfinance institution and non-financial services, such as health, education and so on, are catalysed by one or more independent specialized or generalist organizations to the people in need at the same time. Self-Employed Women Association (SEWA) in India is the best example of this model. The SEWA has an exchange program with a medical college where students require rural internship training. Student interns provide curative care and preventative health education to SEWA clients.

2) Parallel service delivery by two or more programs of the same organization operating in the same area- in this form, the same organization can easily provide financial services by one staff and other services by other staff to the same people. The Grameen family in Bangladesh has two wings; Grameen Bank provides micro credit and Grammen Kalyan fulfils the health care needs of the rural people. And

3) Unified service delivery by one organization, one program, and one staff- in this channel, the same staff of the same organization can provide both financial and non-financial services to the clients. However, one condition should be followed that the staff have proper trainings in various issues. Such kind of model is applicable in the remotest areas where the existence of two separate service providers is meaningless.

Conclusion

Bangladesh is a developing country where many NGOs are working in micro credit arena. Most of the micro credit programmes have two main functions i.e., disbursing and recovering loans. Additionally, they provide certain health education in weekly or monthly meeting as basic health of their clients is well-connected with the survival of their activities. This health education has resulted in the improvement of the recipients' knowledge on public health issues. But it does not mean that health education is the only way to enhance awareness of the poor about public health. It is thus said that micro credit programme appears to work as a positive force which helps improve economic condition and general health condition of the poor. However, providing health education to the clients is an important to develop basic health knowledge but not enough to get rid of any serious physical complications. In order to avoid further attrition of the programmes due to serious illness of the clients, the study urges all the micro credit programmes to incorporate not only health education but also make the availability of and accessibility to healthcare services and products. For incorporating, three models, such as linked service delivery by two or more organizations, parallel service delivery by two or more programmes of the same organization, unified service delivery by one organization, one programme, one staff are suggested. All micro credit programme-oriented organizations should consider one of them by considering financial and non-financial viability of the model. For example, it has been observed that one NGO in the study area declares that they can bear half of the expenses if their clients fall in serious illnesses.

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