

Consultation on Integrating Micro Finance, Health and Nutrition Chennai, December 9, 2005

Health, Nutrition and Human Development

Indian development continues to be characterised by widespread and extreme poverty, with almost a quarter of the population living in contexts of chronic deprivation. This deprivation is multidimensional in character, has both monetary and non-monetary aspects and is expressed in a persistently high incidence of mortality, disease, undernutrition, poor education and a range of economic, social and political vulnerabilities.¹ Contemporary approaches to development, moreover, have characterised poverty not only in terms of basic deprivation, but as a lack of real opportunity to choose between types of living.² Poor health reflects both these critical dimensions of poverty: it is both a result of living in conditions of deprivation and is a crucial factor mediating the ability to make and exercise livelihood-related choices and participate in social, economic and political processes. Poor health due to frequent infections and sub-optimal nutrition imposes direct costs to poor households through high health-related expenditure, but also extracts severe cumulative and often "hidden" costs by compromising human capacity, productivity and potential across the lifecycle.

Undernutrition in the medium and long term is found to adversely affect worker productivity, while bouts of illness impact the wage earned, especially for daily wage earners, in terms of both the probability of a job as well as the amount of work hours.³ Correcting anaemia alone is associated with a 5% productivity increase for all blue-collar work and a 17% increase for heavy manual work.⁴ Over and above this are the economic and welfare costs of illness. On an average, approximately 5.3% of annual household expenditure in India is on health care. This accounts for almost 13.7% of non-food expenditures.⁵ Expenditure on health is one of the major causes of indebtedness amongst the poor in India.⁶

Specifically, nutritional status in the early years (in-utero and the first three years) is found to have an impact greater than singular episodes of illness⁷. Poor health and undernutrition during the highly sensitive period of fetal growth and development is

¹ Partnership for Development, Country Plan in India 2004-2008, DFID, 2004

² Sen, A. & Dreze, J. (1995), *Economic Development and Social Opportunity*, New Delhi, Oxford University Press.

³ G. A. Cornia and F. Stewart (1995), Two Errors of Targeting, in F. Stewart, *Adjustment and Poverty: Options and Choices*, London, Routledge.

⁴ J. Ross and S. Horton (1998), *Economic Consequences of Iron Deficiency*, Micronutrient Initiatives, Ottawa.

⁵ World Bank (2000), *Raising the Sights: Better Health Systems for India's Poor*, New Delhi

⁶ Hospitalised Indians spend more than half (58%) of their annual expenditures on health care. More than 40 % of those hospitalised borrow money or sell assets to cover expenses. A conservative estimate suggests that one quarter of hospitalised Indians fall below the poverty line because of hospital expenses. World Bank (2000), *Raising the Sights: Better Health Systems for India's Poor*, New Delhi.

⁷ A longitudinal study of a sample of children in Chile found that reductions in malnutrition through supplementary nutrition can generate benefits six to eight times the cost of the intervention through additional productivity. A similar study in Cali, Colombia found that a health and nutrition programme increased the life time earnings of individuals from 2.5 to 8.9 times that of an illiterate worker. Gustav Ranis, Frances Stewart and Alejandro Ramirez (2000), *Economic Growth and Human Development*, World Development, Vol. 28, No. 2.

generally manifested in low weight at birth, or birth weight of less than 2500 grams. Nearly one third of all babies in India are born with low birth weight, of which a large majority experience intra-uterine growth retardation (IUGR) or undernutrition in the womb.⁸ These vulnerable babies carry relatively greater risks of perinatal and neonatal mortality and are more susceptible to developing infections. Moreover, they are more prone to impaired growth and subtle neurocognitive deficiencies, the effects of which tend to be irreversible and persist until adulthood, especially for those children who grow up in poverty. Thus, low birth weight baby girls are more likely to grow up to be underweight and stunted women, who in turn have a higher probability of delivering low birth weight babies themselves, thereby perpetuating an intergenerational cycle of undernutrition and sub-optimal development.⁹ In addition, recent research has provided highly suggestive evidence linking low birth weight to coronary heart disease and diabetes in adult years.¹⁰

The first three years of an individual's life constitute a critical period for lifelong development. Environmental conditions at this stage, such as nutrition, health and psychosocial stimulation influence a child's cognitive and behavioural development and are expressed in the long-term growth and development trajectory that subsequently unfolds. These are critical years for the development of important functions, including the immune system, binocular vision, habitual responses and emotional control, which combine to influence a child's growth outcomes. Nutritional deficiencies and infection at this early stage interact to impact the physical growth and behaviour of a child and influence his or her interactions with the environment, thereby compromising cognitive development.¹¹ In India, around 58 percent of children between 12-23 months old are stunted or have low height for age, indicating a very high prevalence of chronic undernutrition in children under the age of three.¹²

The nutritional status of very young children is intricately related to and essentially mirrors the nutritional and health status of women and young girls across their lifecycles.¹³ Addressing the multiple health needs of the poor, especially improving the health and nutritional status of women and young children, then, is essential to achieve India's human development goals and translate the country's immense potential.

Integrated Approaches to Maximise Health and Development Impact in Communities

The extremely poor health and nutritional outcomes prevailing in India today evidenced by the data above are a result of a complex mix of determinants ranging from individual, household and community-based factors to a host of systemic problems in extending access to essential health services. At the same time, there is a large and growing evidence base of potentially effective interventions that have been developed to address

⁸ Reddy, V et al., (1999) as cited in Sachdev, HPS (2001) 'Low Birth Weight in South Asia', *International Journal of Diabetes in Developing Countries*, 21(1).

⁹ ACC/SCN (2002), *Low Birthweight: Report of a Meeting in Dhaka, Bangladesh on 14-17 June 1999*. Eds J. Podja and L. Kelley, Nutrition Policy Paper # 18, Geneva.

¹⁰ Barker, DJP (1998), *Mothers, Babies and Health in Later Life*, Edinburgh, Churchill Livingstone.

¹¹ World Bank (2004), *Reaching out to the Child: An Integrated Approach to Child Development*, Oxford University Press, New Delhi.

¹² National Family Health Survey II, 1998-99

¹³ ACC/SCN (2002), *Low Birthweight: Report of a Meeting in Dhaka, Bangladesh on 14-17 June 1999*. J. Podja and L. Kelley (Eds.), Nutrition Policy Paper # 18, Geneva.

both the proximate and distal determinants of ill health and undernutrition. Unfortunately, the translation of such knowledge into impact on the ground has often been impeded due to a fragmented sectoral approach and an over-investment in vertical interventions that fail to account for the existence and interaction of multiple health and nutritional deficiencies in the population and to the interrelated socio-economic and systemic contexts within which they live.

This has become increasingly apparent as the sector has realised the centrality of informed and involved communities in promoting and sustaining effective health and nutritional change. Introducing community-based health interventions require close interactions with local communities and creative, well-managed systems of delivery and are therefore challenging to implement and scale. Social and economic development efforts in India have, however, already invested considerably in creating community-based structures and institutions, such as self-help groups, co-operatives, and village governance committees that offer potentially vibrant spaces for the integration of health and nutrition interventions. Such initiatives also provide institutional aggregators and sustainable systems that have the dual advantage of having deep local knowledge and community contact, as well as belonging to larger sectoral networks of scale.

The rapidly growing micro finance sector in India provides one such potential community-development system for the integration of health and nutrition-related interventions. This is especially since Micro Finance Institutions (MFIs) work primarily with groups of poor women and have created streamlined systems for frequent interactions.

Driven by an analysis of the important role that access to finance and financial products plays in addressing the myriad economic vulnerabilities faced by the poor, MFIs have pioneered innovative approaches to delivering these essential services and have focused on developing tools and systems to extend access, while trying to account for the imperatives of efficiency and equity. The past decade has witnessed the emergence of many micro finance approaches to create links between local 'self-help groups' (SHGs) or 'joint liability groups' (JLGs) and mainstream commercial sources of finance. Today the SHG-Bank Linkage programme spearheaded by NABARD is estimated to cover approximately 1.5 million SHGs and around 12 million women and their households across India.¹⁴ The Financial Intermediation model in micro finance, where banks provide on-lending credit to intermediary institutions such as an MFI, is estimated to reach about 3 million women in SHGs or JLGs. Surveys indicate that about 77% of all MFI members are located in rural areas, and nearly 54% of SHG members are from the poorest groups - these include landless and marginal farmers.¹⁵

As MFI's both deepen and expand their reach, there seems to be emerging potential to develop lateral linkages to address a range of their clients' needs, of which health and health-related expenditure is an important concern.

¹⁴ <http://www.nabard.org/roles/microfinance/index.htm>.

¹⁵ <http://www.worldbank.org/wbi/reducingpoverty/docs/newpdfs/case-summ-India-ScalingUp-RuralPoor.pdf>

The Consultation

It is in the context of the possibilities of leveraging such convergence for increased impact that this Consultation is located. Designed to facilitate a dialogue between experts and practitioners in the field of micro finance, health and nutrition, the programme aims to explore the possibilities of integration of effective health and nutrition interventions into the contexts within which MFIs operate. The Consultation will draw on the existing evidence base to identify cost-effective and replicable interventions with a high potential for impact on health and nutrition and discuss critical issues in the operationalisation of strategies such as programme design, enabling implementation systems, financing options and roles that MFIs can play in undertaking or facilitating interventions within their structures.

Session II: Integrating Effective Intervention Strategies

There is an increasing body of evidence about intervention strategies that are effective in improving health and nutrition outcomes, with a focus on women and children. These range from enhancing local knowledge and improving practices, direct interventions aimed at correcting and preventing micronutrient deficiencies to improving the reach and use of healthcare services and facilitating financial protection against illnesses. This session will present and discuss a range of specific initiatives that have potential for integration within MFI structures and processes.

Increasing Access to Information, Enhancing Knowledge and Impacting Behaviour

One of the most effective strategies in improving maternal and child health and nutrition indicators is Behaviour Change Communication (BCC), which is a process of understanding people's socio-economic, political and cultural situations and influences, developing messages that respond to the concerns within those situations, and using communication processes to increase knowledge levels with a view to promoting enabling attitudes and optimum behaviours and practices.

Women's health and nutritional status across their lifespan and the nutritional status of young children (0-3 years) are determined by multiple factors, including prevailing knowledge, beliefs and practices at the level of the individual, household and community, as well as the access that women and children have to health and nutrition services. For instance, pregnant women in both urban and rural areas commonly follow the practice of 'eating down' i.e. eating less food, with the understanding that smaller babies are easier to deliver. This practice is likely to impact gestational weight gain for the mother. Similarly low awareness about optimum infant caring practices, such as the importance of colostrum feeding and exclusive breastfeeding, places the child at an increased risk to morbidity, malnutrition and stunting.

Therefore BCC strategies with women in the reproductive age group, especially pregnant and nursing mothers, promote practices related to nutritious dietary intake, care during pregnancy regarding adequate rest and distribution of workload, hygiene practices, early initiation of and exclusive breast-feeding, complementary feeding and weaning, psychosocial care etc. BCC as a strategy can thus impact change at a significant level even in a relatively resource-constrained environment simply by assisting communities

in overcoming critical knowledge gaps and promoting optimal practices. The session will seek to address the following issues in developing these strategies:

- Importance of contextualisation in behaviour change communication strategies
- Existing household and community-level dynamics related to micro finance activities
- Effective facilitation of group-based processes

Sustaining Nutrition Security

While BCC-related interventions are most effective in facilitating the uptake of optimum practices that are viable within the resource constraints that families face, in certain geographic and socio-economic contexts it becomes important to address the access, availability and affordability of nutritious foods. Maternal micronutrient deficiencies during pregnancy have serious implications for the mother as well as the developing foetus. For example, iron deficiency anaemia during pregnancy is thought to increase the risk of maternal mortality, or cause pre-term delivery and adversely affect the birth weight of the child, and both iron deficiency anaemia and vitamin A deficiency during pregnancy may significantly increase the infant's risk to morbidity and mortality, cognitive development as well as eyesight. In India, about 87% of all pregnant women suffer from iron deficiency anaemia, of which about 10% are severely anaemic.¹⁶

Multiple micronutrient deficiencies tend to co-exist and addressing a single micronutrient deficiency may not achieve a significant impact on the nutritional status of the infant. It is possible to consider strategies aimed at correcting multiple micronutrient deficiencies, such as increasing consumption of micronutrient rich food, food fortification, and supplementation. On the specific issue of improving nutrition security in the community, the session will focus on:

- Direct nutrition interventions that may be developed to overcome micronutrient deficiencies in a community
- Explore the role of MFIs supporting such interventions, including the promotion of local production of vegetables and fruits through approaches such as kitchen gardens and linking with food fortification and supplementation interventions

Improving Access to Health Services

Optimum nutritional status is not only function of adequate dietary quality and intake, but is crucially determined by exposure and frequency of infection. In addition, there are a set of essential health services, such as antenatal care, safe delivery services, postnatal and neonatal care, and immunisation that are required by women and their children. It is therefore important to improve access and quality of these services to poor communities by linking and strengthening existing systems of delivery. This session will consider the ways in which MFIs through network and wide presence in various geographies may be positioned to enable improved access to health and nutrition services, and specifically discuss the following aspects:

- Developing linkages with the public health system and the ICDS programme;

¹⁶ ICMR Bulletin, Vol. 30, No. 2, February 2000

- Networking with healthcare service providers – private as well as health programmes led by other NGOs
- Mobilising women for collective action to make the public systems more responsive to community needs
- Develop monitoring and accountability mechanisms

Micro Financial Products for Health

A number of strategies for improved practices in the community will require financial support in order for their effective adoption, and MFIs can play a central role in facilitating community health financing mechanisms. These include interventions aimed at improving nutrition security, such as consumption of better foods, promotion of local kitchen gardens and improved food storage facilities, and strategies such as setting up a crèche for the children of working mothers; these may be financed by providing credit to women on flexible terms such as priority sanction, extended loan term, etc.

The access to and quality of healthcare that is available to the poor during catastrophic episodes is also determined to a large extent by the ability of the household to meet expenses. This relates to the need for medicines, emergencies during pregnancy or delivery, care for severely malnourished children or for children suffering from severe diarrhoea, etc., where in addition to the direct costs of treatment at a government or private provider, there are a number of indirect costs which relate to cost of transport, food for members of the household accompanying the patient and bribes paid to doctors and other staff to ensure timely attention and care. About 25% of families in India where an individual is hospitalised, are pushed into poverty due to the high healthcare expenses that are incurred.¹⁷ It is therefore imperative to consider interventions that are designed to facilitate financial protection against the cost of illness and improve access to healthcare for poor populations. Risk-pooling arrangements such as insurance and mobilising a community-based fund for meeting healthcare expenses through pre-payment of premiums or installments over a period of time, may be effective in securing financial protection against the cost of illnesses. This session seeks to discuss the various micro finance related products that may be effective instruments in sustaining health and nutrition intervention strategies.

Session III: Financial and Technical Resources for Health Interventions

It is possible to envisage three potential models for integrating health interventions with micro financial services:

- While micro financial services remain the focus of MFIs, health and nutrition interventions with the same groups and communities are undertaken by another organisation which has experience and expertise in health;
- Multiple programmes which include micro finance and health, are offered by the same organisation but are resourced by different units or staff;
- Both micro finance and health are offered by the same staff of the MFI

The critical issues that need to be taken into account in a discussion on the relative opportunities and challenges of these models are the MFI's organisational capacity and

¹⁷ Peters D., A. Yazbeck, GNV Ramana & R. Sharma (2001): *India: Raising the Sights: Better Health Systems for India's Poor*, World Bank, Washington D.C.

structures and financial costs of the programme, without compromising on the quality and effectiveness of either micro financial services or health and nutrition interventions.

The intervention design, implementation structures and the roles that MFIs can play in undertaking health and nutrition interventions have implications for the nature of the technical resources that will be required for the programme. With limited MFI capacity in developing health and nutrition intervention strategies, effective partnerships with health and nutrition experts and resource organisations, can bring technical capacity to areas such as conceptualisation and design, needs assessment, implementation and evaluation. This session seeks to explore possible partnership models with a focus on the following issues:

- What is the technical capacity that will be required for implementation of health and nutrition interventions?
- What are potential partnership models between MFIs and health and nutrition experts and resource organisations?
- What additional human resources or team(s) will be required at the MFI?

In addition, a critical area of discussion is the issue of financial resources that will be required for undertaking health and nutrition interventions – both programme and administrative costs. Do MFIs have the potential to support health and nutrition intervention from the utilisation of the surplus generated from micro finance? Other models include seeking and receiving grant funding from donor agencies, and in partnering with government schemes and programmes.

- A potential financing option may be for MFIs to allocate a certain proportion of their surplus to supporting a health intervention programme. Is this feasible?
- What are the possibilities for forming linkages with government programmes on health and nutrition interventions?

Session IV: Research and Evaluation

Research is a critical area in undertaking work on integrating micro finance, health and nutrition in order to develop an evidence-base for models of demonstrated effective intervention strategies which may be considered for scaling through other institutions, particularly other MFIs. At the outset, it is important to conduct strong formative research and have baseline data on existing knowledge, attitudes and practices and health seeking behaviour as well as on access to services with respect to maternal and early child health and nutrition. This can help formulate strategies based on an in-depth understanding of the socio-cultural, economic and political context of the communities with which interventions are planned. Further, it is vital to develop process monitoring indicators for continuing learning during the course of the programme, and finally to undertake impact evaluation of the programme on the health and nutritional status of the communities as well as the financial performance of groups. Several other dimensions of the programme would be interesting for nesting sub-studies; these include issues such as the impact on intra-household allocation of finances (savings and expenditure patterns), levels of expenditure on seeking healthcare, effectiveness of community health insurance models, the impact of behaviour change communication programmes on group and community-level dynamics, diffusion effects of group-based interventions on other women, community support for other development initiatives, etc.