Microfinance – A Gateway to Healthcare for Poor Rural Woman

Thengamara Mohila Sabuj Sangha, Bangladesh

Thengamara Mohila Sabuj Sangha (TMSS) is a well-known national level non-government women’s development organization working in the remote villages of Bangladesh. The organization works towards improving the poor socio-economic condition of women to a more prolific state. With the initiation of its microfinance program in 1986, TMSS has evolved through a continuing learning process from the participating communities. Health and education were the two basic services found to be crucial in sustaining the microfinance program. With this realization, TMSS integrated primary healthcare into the program in 2000 and has been growing ever since. The case study narrates the integrated approach of Health, Education and Microfinance of TMSS to increase access to healthcare in rural Bangladesh.

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# Table of Contents

Acknowledgements ............................................................................................................ 3
Disclaimer .......................................................................................................................... 3
Copyright .......................................................................................................................... 3
Executive Summary ............................................................................................................ 4
Introduction ....................................................................................................................... 6
Health; The Unmet Need for Women .................................................................................. 6
TMSS in Health for Rural Women ....................................................................................... 7
Organization of the Group ................................................................................................ 10
Utilization of Local Human Resources ............................................................................. 10
Network of Services from Primary to Tertiary care ......................................................... 11
Social Mobilization for Health ......................................................................................... 12
Performance ...................................................................................................................... 12
Community Perspective on TMSS Healthcare ................................................................. 13
Conclusion ......................................................................................................................... 14
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Disclaimer

The case study has been compiled after primary and secondary research on the organizations and published with their approval. The case has been compiled after field visits to the organization in April 2011. The author of the case or ACCESS Health International is not obliged or responsible for incorporating any changes that may have occurred thereafter. The case study has been developed with a specific focus to highlight some key practices/interventions of the organization and does not cover the organization in its entirety.

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Executive Summary

The technology based modern world is moving towards reaching the un-reached outer spaces of the universe with information and knowledge. On the other hand, many poor developing countries like Bangladesh are struggling to achieve Millennium Development Goals (MDGs) and access to basic healthcare services. In Bangladesh, reaching the un-reached rural communities and making quality healthcare accessible to them is a mammoth task for the public system alone. A low level of health awareness, lack of proper information and cost of healthcare make the rural people vulnerable to life-threatening diseases. Traditionally, receiving healthcare and nutritious food for women is the last priority of the society.

Conversely, the microfinance services rightly targeted the vulnerable section of the poor communities that mostly comprise women and the underprivileged. Microfinance is a proven financial service to poor rural women in Bangladesh who traditionally lack access to banking and other social services. This innovative financial service was started in the mid-seventies in Bangladesh with microfinance pioneer Dr. Mohammad Yunus, who started and shaped the industry of micro financing. The program was able to create an avenue for the poor women that gave them access to health information and primary health-care services in the course of its long journey of social development and poverty alleviation efforts.

TMSS (Thengamara Mohila Sabuj Sangha) is a well-known national level non-government women’s development organization working in the remote villages of Bangladesh. The organization works towards improving the poor socio-economic condition of women to a more prolific state. Currently these women have limited or no access to healthcare or other social services. With the initiation of its microfinance program in 1986, TMSS has evolved through a continuing learning process from the participating communities. Health and education were the two basic services found to be crucial in sustaining the microfinance program. With this realization, TMSS integrated primary healthcare into the program in 2000 and has been growing ever since. It emphasizes skill-based human resource development and proper healthcare. It works for community capacity enhancement on health knowledge and information as well.
This novel approach of integrating microfinance, health and education gives extra mileage not only to the program participants but also to the community as a whole. It also leads to sustainability since the community capacity is being enhanced through healthcare and education. The program is supported by government owned Microfinance Institute Palli Karma Sahayak Foundation (PKSF). It uses TMSS funds and its income-generating projects for its sustenance.

The study team explored the possibility of integrating healthcare services and community participation into the TMSS program. The microfinance initiative is believed to be a gateway to health for the poor and rural women through its different financial activities. The forum for microfinance transaction allows women to talk about health and education as well as the exchange information and knowledge. TMSS also conducts health education sessions to make them aware of major health issues. Pregnant women and mothers get prenatal and postnatal care, while children receive immunization. TMSS also boasts of a referral network that provides a link with better facilities for secondary and tertiary care.
Introduction

Globally, microfinance is the new generation of social entrepreneurship. This industry is one of national pride for Bangladesh as it helps women build capacity and connect them with social progression. Bangladesh successfully exported the microfinance model to the external world by enabling women to be the focus of development. This alternate financing system offers small scale loans to the poor (microcredit) and a range of financial services that include credit, savings, insurance and remittance management (microfinance) apart from formal banking and other financial services. Based on their experiences, microfinance organizations recognized a need for non-financial inputs like education, health, skill training and organizational to improve sustainability and productivity.

Thengamara Mohila Sabuj Sangha (TMSS) is a national level non-government women’s organization that works toward alleviation of poverty, socioeconomic development and empowerment of women. It began in 1980 with a few poor women of Thengamara village of Bogra district who started saving a portion of their rice to help each other. A new leadership in 1986 helped in bringing about result-based communal activities. It took the microfinance model from Dr. Mohammad Yunus and added other social activities with the objective of women empowerment. Since then TMSS has been growing with various initiatives including capacity enhancement, education and health service delivery. In the year 2000 it incorporated healthcare into its Microfinance Program. It took steps in building-up of knowledge, behavior change and primary healthcare. Field workers conduct regular door-to-door visits to provide health information and organize health education sessions. Satellite and static primary healthcare clinics are in operation.

Health- the Unmet Need for Women

In Bangladesh it is a well-known fact that healthcare for women is traditionally very low. Due to the high gender inequality that exists in the country, women do not participate in decision-making in every sphere of life including healthcare. Bangladesh Demographic and Health Survey (BDHS) 2007 showed that rural women of Bangladesh received minimal healthcare. With little geographical variation the report says, 43.8 percent of rural women did not receive antenatal care during pregnancy. This figure is worse for the lowest wealth quintal which showed that 58.3 percent women did not receive any
prenatal care during pregnancy. Analysis for this near absence of healthcare for pregnant women showed a lack of awareness on antenatal care, nutrition and other health related issues. The pregnant woman and her family members did not have awareness on the importance of antenatal care. Further, more than 70 percent of women assumed that antenatal care was not especially required for pregnant women. Consequently, home delivery without skilled care prevails in rural areas with 89 percent deliveries taking place at home. According to this report only 54 percent of married couples used contraceptives resulting in an unmet need in family planning services of almost 18 percent.\(^1\). The nutritional status of rural women is reported to be poor too. The study village of Tenhgamara is no exception to this national data. The curative treatment for secondary or other diseases in women is mostly neglected. As a result they suffer from different chronic reproductive health problems.

### TMSS in Health for Rural Women

TMSS has come forward in this situation. It uses the same forum of microfinance participants to deliver primary care with emphasis on maternal and child health. TMSS has introduced HEM (Health, Education and Micro Finance), to ensure sustainable development at different project locations. HEM aims to achieve national and international health goals like Millennium Development Goals. During a discussion between the Managing Committee and the Medical Director of TMSS, the committee reiterated the importance of poverty alleviation. The Medical Director said, “There is ambiguity on the direct relation between economic empowerment and health for poor people. However, the microcredit program is not enough for sustaining social changes; it needs to be incorporated into other basic components. Health and education are two crucial components for any sustainable and result based progression”. The integrated approach of HEM was felt to be necessary and timely.

\(^1\) Bangladesh: DHS, 2007 - Final Report (English); http://www.measuredhs.com/pubs

“Our experience says that microfinance and other social development support like health and education work better to attack poverty most efficiently. This organization believes that without ensuring basic education and sound health microcredit is not successful for reducing poverty”.

Medical Director TMSS
During the field visit to TMSS, it was found that this microfinance plus model with its integrated approach to poverty management, gave positive results for the betterment of the community. During the weekly meeting for financial transactions (borrowing money, repaying loan, deposit money or use of deposit scheme) TMSS also organizes health and education sessions among the participants. The non-participants of the scheme can also avail of the health services. The field workers conduct door-to-door visits to inform the women of the coming weekly health session. The assigned field workers for a particular group in a village ensure participation of group members and other women in the health session. Prior to the financial transaction, the health worker and paramedic/medical assistant jointly conduct the health session. The session comprises of a lesson on antenatal care, postnatal care, immunization, nutrition, hygiene, safe drinking water, child health and home management of child care, awareness on HIV/AIDS and tuberculosis and malaria control issues. Different visual aids like flip charts and models are used during the discussion session, which is found to be interactive. The presenter encourages questions and gives sufficient time for the participants to talk freely. Usually, the duration of a session is one hour. On wrapping-up the discussion in the rural sub-centre or in the satellite session the paramedic/medical assistant consults with patients. At the same time, the microfinance transactions go on. Pregnant women usually come for the postnatal check-up; children come for the treatment of common cold and other minor ailments. The paramedic provides postnatal care and other healthcare services. Drugs are also available here at a special price which is lower than the market price.

Services at the satellite clinic or rural sub center are offered free for the microfinance participants. However, the paramedic refers patients to TMSS static facility if needed. TMSS offers primary
**Healthcare** from a small sub-centre. Secondary care is available at the medical center while the TMSS 500 bed medical college hospital offers tertiary care. TMSS health sector activities are closely linked with the government plan of achieving health MDGs. It ensures full immunization coverage for all children at either its static centre or government centers or follow-up for preventing drop-out from subsequent immunization dose, antenatal and post natal care for all pregnant women in its working areas. Patients diagnosed with tuberculosis and malaria is referred to appropriate facilities. The organization provides information on HIV/AIDS prevention to its beneficiaries and refers to the appropriate facility if further intervention is required.

Following are the service components of a sub-center at the village level from a sub-center under HEM model:

- Health awareness for women
- Primary healthcare services by medical assistant or paramedics:
  - Antenatal Care
  - Postnatal Care
  - Immunization
  - Child healthcare e.g. diarrhea, common cold, first dose of antibiotic for pneumonia and further reference for better care
  - Health check-up e.g. blood pressure, fever, headache, muscle pain, abdominal pain, menstrual pain etc.
  - Pregnancy test (using paper strip)
  - Blood sugar test (using paper strip)
  - Family planning (oral pill, condom)
- Drug dispensing for common ailments
- Referral system for secondary and tertiary care
- Priority for the disabled, poor women and children
- Nutritional counseling to pregnant women and young mothers
- Prevention of HIV/AIDS campaign
- Anti drug and anti smoking campaign
- Support for installation of latrines and provision of safe drinking water
TMSS has established 483 branches all over the country at the village level. A branch office is considered as the ‘Center of Activities’ from where all the efforts are made to provide care for the targeted people. The health program has been organized under the supervision of a branch management. At present, TMSS emphasizes the use of credit, health and education that can support the same people.

**Organization of the Group**

Microfinance is the most important and significant program of the organization. The organization follows methodical steps to reach the unreached:

- Area selection & feasibility study
- Identification of target people
- Staff orientation and training
- Group formation
- Door-to-door delivery of information
- Service delivery at the center

TMSS healthcare program proposed to achieve national goals and MDGs with emphasis on the following objectives:

- To reduce child mortality rate\(^2\)
- To reduce maternal mortality ratio.\(^3\)
- To provide healthcare services at a subsidized rate, especially to poor people.
- To bring about awareness on health services among the people.
- To build community capacity on health
- To extend medical education
- To develop human resources for health

**Utilization of Local Human Resources**

\(^2\) Child mortality, also known as under-5 mortality, refers to the death of infants and children under the age of five. The child mortality rate or under-5 mortality rate is the number of children who die by the age of five, per thousand live births per year.

\(^3\) The number of maternal deaths per 100,000 live births. A *maternal death* (as cited in International Classification of Disease or ICD-10, [WHO, 1992]) is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, and can stem from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. [https://www.cpc.unc.edu/measure/.../maternal-mortality-ratio-mmr](https://www.cpc.unc.edu/measure/.../maternal-mortality-ratio-mmr)
Since its inception, TMSS has always honored the local capacity and existing resources. The capacity enhancement of local health resource therefore is a core activity of TMSS. It has identified the local Traditional Birth Attendant (TBA) in its working areas. The training and assessment of the TBAs has been conducted using scientific methods by professionals. The community has approved the TBAs as a first-hand local health resource for maternal care. Training includes identifying danger signs for a pregnant mother during antenatal, delivery and post natal periods. They have also been taught about the referral mechanism and the required support system of reference. TMSS made the referral system very effective with the help of these trained TBAs. They are now able to understand the high risk pregnancy and danger signs during pregnancy and risk for neonates. Therefore, these trained TBAs refer the patients to appropriate centers when required.

Today it is a fact that home delivery is still common in rural areas. With proper training and the logistical support a TBA can help in safe delivery. The capacity building program is an on-going event of TMSS. It organizes refresher training at regular intervals. The TBAs participate in different knowledge management forums, workshops and seminars. The TBA also accompanies the patient to the hospital or any other health facility when needed. The patient and her family also feel reassured by her presence.

**Network of Services from Primary to Tertiary care**

TMSS is always providing proper healthcare that includes not only primary care but also secondary and tertiary level of care. It has established a network of services for this purpose. The primary care starts at the village satellite clinic at microfinance group members’ neighborhood. The satellite clinic usually organizes a weekly group meeting with its microfinance participants. Paramedical staff or medical assistants provide the service here. The 2<sup>nd</sup> tier of service is provided at the sub-center. There are 483 sub-centers at 45 districts of Bangladesh for all villagers irrespective of their microfinance participation and with a minimum fee for services (Tk-5.00/). The sub center is the first place for institutional development work. There is a duty roster to indicate the availability of the doctor who provides
healthcare to the villagers apart from paramedic/medical assistant. The sub centers operate on a daily basis. If necessary, the patients are referred by the village sub center to better facilities. TMSS has a good networking system and transportation facilities. Transportation is available to move patients from the sub center to other facilities at a nominal charge. Tertiary care is provided at Bogra district where TMSS has its own hospitals, diagnostic services and medical college. In addition most government facilities are linked with the TMSS network with the government service providers extending full support to TMSS.

Social Mobilization for Health

TMSS has a strategy of social mobilization for health that involves:

- The TMSS cultural team travels from village to village, urban and peri-urban areas and provide entertainment with educational and health messages. The team uses health-issues based folk songs and stage dramas as a means to mobilize health.
- Workshops with local school teachers and guardians that address issues regarding health and nutrition for adolescents. They also stress on the importance of prevention of early marriage.
- Training of the local government staff on health and relevant issues.
- Participation in different national/international days e.g. World Health Day, HIV/AIDS Day, and/or Safe Motherhood day with festivity.
- Meeting with religious leaders and husbands of women microfinance participants.
- The use of different promotional materials like leaflet, brochures, posters, sign boards and others for changing health seeking behaviors, improving health knowledge.
- Involve national experts and famous personality to spread the message to the masses.
- Continuous follow-up for improvement of situation.

Performance

The secondary data of the TMSS shows continuous improvement in the performance of not only its microfinance program but also other activities at the village level. The following table gives a record of healthcare performance for last five years which has shown significant improvement over the years.
## Community Perspective on TMSS Healthcare

On discussions held with the community women during a field visit at TMMS Gokul sub-center of Bogra district for this case study the women expressed their satisfaction on TMSS healthcare and other services. The following healthcare issues were discussed with the women.

- **Accessibility** - The women mentioned their satisfaction at the availability of the service in their neighborhood. It avoided travel cost and time for them.
• **Affordability** - Services offered at the satellite clinic were free of cost for the microfinance participants. At sub-center the cost was affordable for them. In addition they were happy that drugs were also available and at a discounted price than the market price.

• **Behavior of the field workers** – The village people expressed their happiness at the courteous behavior of the field workers who were from their own community. The paramedic or medical assistant who were mostly female were friendly towards them. The service provider understood their local dialect that helped them share their reproductive health issues without inhibition.

• **Quality of care** - The women were happy with the care they received. The service provider listened and the treatment given helped them. Basic parameters like blood pressure and weight were accurately measured and recorded.

• **Equity** - since they were all from a poor community, they never found any discrimination based on their social class.

• **Support and Referral Services** - TMSS offered them transportation service at a low cost. The referral centers provided good care if they had documents from TMSS. The entire microfinance program gave them the financial courage to opt for better treatment on reference from TMSS. Many women also expressed the approval of their husband and in laws’ for the care provided by TMSS. One ANC patient at a sub-center said, “my mother in-law is a member of the group, I do not face any opposition from her”.

**Conclusion**

Bangladesh has had tangible success and has proven its efficiency in operating its microfinance program. Globally, the model has been replicated in many developing countries including Africa. Integration of health and education added value to this program. The impact on women’s and children’s health is tremendous with the use of minimum resources. However, gender equity and equality is still an issue. On many occasions, the beneficiaries of microfinance program who are poor rural women experience non-cooperation from counterparts in terms receiving services. They are not fully empowered to use the money they borrow. Women are still vulnerable to the societal norm of male dominance. Gender -based domestic violence is an issue for the women and health care. Therefore male participation and integration into the program is important to improve the situation. Therefore a strategic work plan is needed to develop a participatory approach with both male and female participants for sustainable changes not only in health care but over all national development.