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REGIONAL OFFICE FOR Africa

INTERSECTORAL CASE STUDY

MICROFINANCE AS A VEHICLE FOR PROMOTING HEALTH AND INTERSECTORAL ACTION ON HEALTH: A CASE FROM GHANA

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CONTENTS

SUMMARY

This case study focuses on the role of two MicroFinance institutions (MFIs) in Ghana, the Freedom from Hunger MFI initiated in 2006 and Grameen Ghana MFI initiated in 2003. Both integrate health programmes within MFIs to improve social, economic and health outcomes in low income women, integrating inputs from finance, health, agriculture and other economic sectors. Grameen Ghana has added use of mobile phones for community health within a rights based framework, to provide information to women and track delivery of services. The scale of MFIs globally and in Ghana and the debate on their health benefit motivates the case study.

Both schemes in Ghana were initiated by international NGOs working with national partners and implemented through highly decentralized local self-governing credit associations with support from local field agents. While attribution of cause is difficult, an evaluation of one of the MFIs found improved incomes and health behaviours compared with control groups. The MFIs were found to strengthen women's self-esteem and confidence and to support health care uptake. Positive features were found to be the field agents and community health workers that connect women to local systems; links made to health services; participatory health literacy processes amongst MFI members; and clear agreements on roles and accountability in partnerships. Shortfalls were identified. MFIs need to integrate explicit measures that generate social advocacy on gender norms, target structural determinants of women's health and build accountability of service delivery. Business expansion meant longer working hours and limited time for the family and the pressure not to default on loans led to stress, asset depletion and wider debt in some MFIs. It is proposed that greater attention be given to real-time monitoring of MFIs that integrate health goals and processes and that the women involved in their design have a stronger voice.

1. Introduction

This case study focuses on the role of MicroFinance institutions (MFIs) in Ghana in improving health through improving women's social and economic positions, health literacy and service uptake. It describes a context of economic growth and inequalities in wealth across gender, social group and area. It covers two recent MFI schemes from the last decade, over a period of six to 10 years. The first, Freedom from Hunger (FFH) and Lower Pra Bank Scheme was initiated in 2006, while the second, Grameen Ghana was initiated in 2003. Both link credit processes with interventions on health, targeted at low income women, described in more detail in the next section. This is thus a case study of health goals and activities within an economic sector. Both schemes integrate health education and identification by women of actions to improve their health and that of their households and communities, or to strengthen service access. Grameen Ghana has added a further tool, the Mobile Technology for Community Health (MOTECH), as a means to enhance communication between health services and the women. The case study presents the methods used, the context for the work on MFIs and health in Ghana, and outlines the evidence on the inception, process and features of the two examples of health programmes integrated within MFIs. The case study explores the achievements, impacts, facilitators and barriers to the work and the learning from the experience of processes that embed health goals and processes within a sector outside health. The case study also reported on debate in the literature on the role and impact of MFIs versus approaches that more directly challenge gender norms and address economic and health service barriers to women's health.

2. Methodology

The case study is based on a review of documented literature. The case study work was initiated by a review of the background documents for the work, i.e. the World Health Organization (WHO) analytic framework on Health in All Policies and the Scoping review on status of implementation of intersectoral action (ISA) in the African Region. From these documents, the case study database made available by WHO and the guidance for the case studies, three papers on specific case study areas were selected. The three cases were selected to reflect work in different regions of the continent (west, east and southern) and work that met one or more of the inclusion criteria of collaboration (work) between more than one government sector; improvements to equity as a target outcome of intersectoral action, either implicitly or explicitly; or intervention to prevent inequities in health. A source paper from the WHO database provided was used to identify the case (Mayou 1998 and in this case on MFIs and women's health). Published and grey literature on the case were then sourced through an internet search of internet libraries and Google using as key words the country and theme of the case study, in this case 'Ghana', 'microfinance', 'women's health', with (using 'and' and 'or') intersectoral, and health equity. Further information was sourced by following up on references cited in the publications sourced. The case study work was contracted and drafted in May 2013. Key informant interviews were not included in the Terms of References (TORs) due to short time frames. The case studies face the limitation of and information gaps from using publicly available documentation. This case study includes literature on microfinance in Ghana and from systematic reviews of microfinance as an intersectoral intervention for health that include Ghana. Given the debates in the literature on the positive and negative impacts of microfinance, the case study describes how the microfinance schemes provided a vehicle for health promotion and intersectoral action, but also searched for documented impact on other determinants of health, including income security, debt, social and psychological costs and benefits and women's empowerment. This raises a more general methodological issue (not specific to Ghana) discussed in the conclusions on the determination of whether a practice is 'good', noting that internally 'successful' models need to be evaluated in relation to their impact at deeper levels of determinants, and in relation to the opportunity costs of alternatives.

3. Context

Ghana is located on West Africa's Gulf of Guinea, a multiparty democracy with a total land area of 238 533sq km and a total population of 23.5 million in 2009, 49% of whom are urban. The country is the world's second largest cocoa producer and Africa's second biggest gold producer and has recently started producing oil. It has one of the continent's fastest growing economies. Its economic status was revised upwards in 2011 to a lower-middle income country. Economic growth has been associated with poverty reduction, with people below the national poverty line falling from 52% in 1991 to 28% in 2005 *(3)*. Nevertheless, this positive trend masks geographical, occupational and social differentials in wealth and poverty. Rural poverty is estimated to contribute approximately 90% to national poverty. Poverty declines were concentrated in urban Accra and the rural forest regions, while the rural savannah areas in the northern part of the country experienced an increase in poverty, and food farmers experienced the lowest decline in poverty *(2)*. The Ghana Poverty Reduction Strategy (GPRS I and II) has identified human development; good governance and civic responsibility; private sector competitiveness for growth and a focus on modernizing agriculture as priorities *(6)*.

In a 2012 review of health equity in Ghana it was reported that there has been steady progress in achieving Millennium Development Goals (MDGs) by 2015 in areas like universal primary education and poverty reduction, but that challenges still exist in the areas of child health and mortality, maternal mortality and gender equality and while communicable disease burdens remain high, there is a rapid rise in non-communicable diseases. The average life expectancy at birth is estimated as 60 years, higher in females than in males. Nevertheless in many other areas Ghanaian women are more at risk of and more vulnerable to ill health, particularly in poor households. The maternal mortality ratio at 560 per 100 000 live births and infant mortality rate at 76 per 1000 live births is high *(2)*. Inequalities in wealth are associated with inequalities in health and its determinants. The adult literacy rate is 63%, although much lower for women (57%) than for men (71%). While the net primary school enrolment ratio is almost at gender parity, girls are more likely to drop out of school. The poorest 20% of the population are 22 times more likely to have bush sanitation than the wealthiest 20% of the population *(2)*.

Ghana has a commitment to constitutionalism and to universal coverage of key social services. The Health Sector Medium Term Development Plan (HSMTDP) 2010-2013 set objectives to bridge the equity gaps in access to health care and nutrition services and to ensure sustainable financing arrangements that protect the poor, to improve access to quality maternal, neonatal, child and adolescent health services and to intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles, amongst others *(4)*. There appears to be a favourable policy environment for a Health in All Policies approach in Ghana. The 2007 Ghana Health Policy recognizes the limitations of a curative approach to health care and states *"The policy views health in its broadest sense as a multisectoral programme focusing on the physical, social, economic, and spiritual dimensions which can bring total health to individuals, their families and communities. There is therefore a paradigm shift from curative action to health promotion and the prevention of ill-health" (5)*.

Hence, for example, the 2011 Annual Report of the Ghana Health Service reports progress on activities and measures that engage across sectors, such as Health impact assessment (HIA) in the oil and gas sector, a range of health promotion activities and a climate change and health project *(4)*.

One of the measures to address gender inequalities in access to services is through improved economic opportunities for women. Microfinance, or the provision of financial credit has been identified as one input for improving production or employment in women *(7)*. At the same time low income households experiencing higher levels of illness can face costs of illness that lead to difficulties with loan repayment and savings deposits, so that loans and assets are used to pay for healthcare expenses. This linked concern for improving economic opportunity and for improving health has led to microfinance service

providers playing a cross-sectoral role in improving access to health services, and for health services to use the organizational vehicles of microfinance to support service uptake *(8)*. Globally, over 3500 microfinance institutions (MFIs) provide microcredit and financial services to more than 155 million households, of which about a fifth are estimated to be living below the poverty line. A review of literature found a growing number of studies assessing links between MFIs and health, with some arguing that MFIs have contributed to health benefit in diverse areas such as maternal and child health, malaria and other infectious disease and reduced domestic violence in their role in supporting health literacy, enhancing access to health services and addressing financial, geographic and other barriers *(10)*.

Women are often targeted by MFIs given their more limited access to conventional forms of financial services, although often because women are more reliable for repayment of loans, as microfinance schemes have not been found to challenge socially embedded structures that perpetuate gender inequity *(9,10)*.

MFIs are widespread in Ghana. Ghana has a regulatory framework under the Banking Law (1989) and the Non-Bank Financial Institutions (NBFI) Law (1993) that accommodates a tiered structure of licensed financial intermediaries, including MFIs *(9)*. These take a number of forms. Rural and community banks (RCBs) were established in 1976 to mobilize savings in rural areas, owned by members of the community through purchase of shares. They run MFIs. In 2007, there were 129 RCBs in Ghana with 1.2 million depositors and about 150 000 borrowers. While their focus has largely been rural, the three northern savannah regions, which are considered the poorest regions, are the least served. Savings and loans companies (S&L) were also set up as MFIs under the Non-Bank Financial Institutions Law 1993, with 15 licensed in 2008 and more than 160 000 depositors. Non-government organizations (NGOs) accept deposits and give credit to their members and have played a role in extending MFIs into more impoverished northern regions *(9)*. This case study explores MFI practice that explicitly addresses health and access to health services, especially for women and particularly in poorest areas. Given its focus on the poorest regions the schemes covered are those set up by NGOs, generally seek zero collateral, finance economic activities and include health related activities.

4. Initiation of the programme in Ghana

As noted above, MFIs in Ghana have grown over a period of thirty years, with a legal framework that establishes and regulates their role. There is documentation of schemes dating back to the early 1990s. For example, the Sinapi Aba Trust scheme was initiated by Opportunity International, an international NGO headquartered in the US involved in MFIs in over 40 countries in the south, Eastern Europe, and Russia. The scheme mixed credit, health and spiritual services *(11)*. The Nsoatreman Women Empowerment Programme is a Credit with Education (CwE) scheme that was introduced in 1996 by a Ghana bank in partnership with Freedom from Hunger (FFH) that provided both credit and education on health, nutrition, family planning and business practices. The scheme set up solidarity groups of five to six rural women engaged in a business activity other than farming, who were then organized into a Credit and Savings Association (CSA) *(9)*. These schemes both suggest a similarity of inception, with US based NGOs with health and social objectives partnering with local implementing partners with MFI capacity, and offering a mix of credit and social programmes in the design.

This case study covers two more recent schemes from the last decade, which cover a period of six to 10 years. The first, Freedom from Hunger (FFH) and Lower Pra Bank Scheme was initiated in 2006, while the second, Grameen Ghana was initiated in 2003. Both link credit processes with interventions for health, described in more detail in the next section. This is thus a case study of embedding health in a wider economic policy and economic activity. As for the experiences in the 1990s, they both have international initiators and leads, from the US for FFH and Bangladesh for Grameen Ghana. FFH worked

with a local Ghanaian finance institution, while Grameen Ghana incorporated itself locally. In both cases they targeted the lowest income regions of the country and low income women within those regions. For both, embedding health within microfinance for women was implemented as a means to empower low income women:

- financially, in terms of increased incomes and control over incomes, although without explicit strategies for redistributing resources or for challenging gender subordination;
- in terms of health literacy and the autonomy and means to act on their health and use health services; and
- as an entry point for social mobilization of women, although with limited explicit integration in the inception portfolio's documentation of other activities beyond health and credit needed for transforming gender and class relations.

Both thus sought to address gender inequalities in economic, social well-being and health (12;20;Grameen Ghana 2013).

There is evidence of political support in Ghana for such schemes. In September 2006, for example, then President Kufuor inaugurated a new US$ 50 million Micro-Credit and Small Loans Scheme to make loans of between US$ 100 and US$ 2000 with zero collateral requirements. The scheme was a partnership between two organizations, Freedom from Hunger, a US based NGO that provided technical assistance and helped to secure subsidized finance from external funders, and the Lower Pra Rural Bank that staffed and implemented the scheme. It was a two-pronged intervention, targeted exclusively at women but with no other means testing or minimum requirements, and providing loans of up to $300 for income-generating activities. The scheme also provided weekly information and education of health and nutrition, business skills, and management of the Credit Association (CA) during CA meetings. Freedom from Hungers' Credit with Education programme was triggered to address both chronic hunger and poverty, on the basis of evidence that access to financial services (loans and savings) for poor households can improve incomes, that income increases that will have the most direct, positive impact on food security and nutrition are those earned by the poorest households, controlled by women and earned in steady and regular amounts; and that income in itself is unlikely to have a substantial impact on malnutrition of women and young children unless key practices affecting maternal and child health and nutrition are also adopted *(20)*.

Grameen Ghana also provides a MFI in Ghana that includes women. It is based on the experience of Grameen Bangladesh and linked to the latter. In June 2003, Grameen Ghana gave its first loans to women groups in the Zabzugu/Tatale district of the Northern Region of Ghana under a UNICEF funded Integrated Community Based Development Programme (ICBDP). Principally, the ICBDP sought to link various social development activities, such as nutrition, health and education, with micro credit delivery to improve the quality of life of children and the status of women in target communities. From this beginning Grameen Ghana had by 2012 established its presence in five more districts including Tamale, Nanumba North, Nanumba South, Central Gonja and Karaga districts all in the Northern Region, the lowest income region of the country. It was reported to have 11 806 active clients out of which 441 are directly involved in agriculture production, with a portfolio of about $500 000, of which about a third went to agricultural lending (Grameen Ghana 2013). Grameen Ghana reported also opening a branch in the Upper East region and plans to set up new schemes in parts of the Northern Volta region by the end of 2016, reflecting its aims to work in poverty endemic regions and to avoid concentrating in one region.

5. Embedding health in microfinance: the two schemes in Ghana

This section describes the two schemes, their objectives, target population and design for embedding health within an economic institution targeted at a vulnerable community. The next section provides further information on their implementation.

5.1 Freedom from Hunger Credit with Education

The evidence on the Freedom from Hunger (FFH) Credit with Education (CwE) case study comes largely from Freedom from Hunger *(20)*. The programme focuses on women to explicitly address gender inequalities in access to credit. Women are identified as the group that has the greatest ability to impact household nutrition and family well-being, given their role in domestic food, environmental, child care activities and service uptake, and their limited access to formal credit, savings and life skills information. The CwE credit mechanism is based on the village bank methodology pioneered by the Foundation for International Community Assistance. It organizes and trains women, in this case from low income households in the poorer Northern Regions of Ghana, where formal credit has a low presence. It provides loans to their credit associations that are then on lend as individual loans for about four to six months. Interest is based on the scheme viability and is lower than other sources of credit used, such as money lenders (levels unspecified in the literature). The women are supported to form the Credit Associations, with groups of 20 to 30 women made up of four to seven solidarity groups, each solidarity group having four to seven members. Access to credit intends to enable women to expand and diversify their enterprises in areas such as food processing, small livestock rearing, retail or small scale manufacture and to replace more costly sources of working capital or inputs. After group formation, Credit Associations participate in training when members deposit savings, with skills support on MFI aspects, such as managing the group, keeping financial registers and understanding payment and deposit procedures. The interest income finances the credit and savings services, as well as the embedded MFI education services, and the CwE element is designed to become self-financing within 18 months to three years after start up.

The CwE element is organized to take place within village bank meetings and the choice of topics depends on local needs and demand, organizational objectives, and aims to support uptake of local services (e.g., immunization; primary health clinics). Typically, during a loan period of four to six months, one or two topics are explored in depth in a series of learning sessions, each session building on the previous session *(20)*. The schemes thus aim to support women to value their individual and collective strengths (their social autonomy), to strengthen their resource base for their own economic activities (their economic autonomy) and to provide information for local health promoting activities within the group (at individual and social level) and discuss and overcome barriers to uptake of available health services. Notably the design of the schemes does not explicitly include transforming services, or demanding or organizing new services or any wider engagement on local decision-making structures, such as local councils that affect the delivery of economic or social services. However the objective of building collective interaction and self-esteem is noted to be a lever for women's confidence to take a more active role within their household and community *(20)*. As discussed in the next section, the model relies on the joint role of information and social organization in the MFI and the possibility of improved incomes to generate a change in women's power to lever wider changes that affect their health.

5.2 Grameen Ghana MFI and Mobile Technology for Community Health

Grameen Ghana follows a similar approach, target group and assumptions, but has a wider funding portfolio and a rights based approach to its health interventions. It has added a further tool, the Mobile Technology for Community Health (MOTECH), as a means to bring the health sector itself into more direct relationship with the women, and to give women a means to communicate with their services to improve health outcomes for mothers and their newborns. The information for the case comes from Grameen Foundation 2013 and Grameen Foundation, MOTECH 2011*(13)*.

Grameen Ghana provides a mix of grants, concessionary loans and commercial loans using initial support from charitable donations to meet a share of operational costs. Its major MFI products for low income groups, with a particular focus on women, are Credit with Education, Agriculture Loans and Energy Loans. The organization uses a rights based approach for embedded programmes in the MFIs that promote people's rights to access quality education, food, and health and sanitation facilities. The approach is reported to use a transfer of knowledge and skills in collective MFI processes to empower members to advocate and demand for transparency and accountability in the planning and implementation of development policies and programmes. The approach involves changing the "can't do" attitude that suppresses poor people from challenging policies, procedures and practices that perpetuate poverty. In this respect, the Grameen Ghana MFI processes go a step further than those in the FFH CwE activities in addressing the social determinants of health, by not only advancing social and behavioural change within the group on health using own resources, but in explicitly using the rights based approach to build collective power to make demands for participation in decisions on local services.

The Mobile Technology for Community Health (MOTECH) initiative in Ghana is an innovation that follows from this approach that was launched in 2010 as a partnership between Ghana Health Service, Grameen Foundation and Columbia University's Mailman School of Public Health. The MOTECH system was launched in July 2010 in the Upper East Region and then in Awutu Senya district in the Central Region and is intended for national application in Ghana. Funded by a grant from the Bill & Melinda Gates Foundation, the project as reported, is a pilot and provides a community level complement to Grameen Ghana's work within the MFIs (the common region reported in the literature is Upper East). It uses mobile phones to increase the quantity and quality of prenatal and neonatal care in rural Ghana, with a goal of improving health outcomes for mothers and their newborns. It introduces mobile phone technology into Grameen Ghana's a rights based framework, providing opportunities for both receiving information and for ensuring and tracking delivery of services. The software system used in Ghana is available via OpenSource license. It currently provides two interrelated mobile health services. The first is a "Mobile Midwife" application that enables pregnant women and their families to receive SMS or voice messages that provide time-specific information about their pregnancy each week in their own language, including reminders on services and advice on accessing resources such as birthing kits, or reducing costs of transport to services. The second application helps community health workers to record and track the care delivered to women and newborns in their area, ensure that mothers in their area use available services and that the services and resources are available for that care. The reports are compiled and available for local review and fed to district and regional management offices. (There is an assumption that women empowered through the rights based approach in the MFI schemes will be involved in local review of such information on services, but this is not explicitly stated) *(13)*.

A number of measures have been built in to explicitly support equity of access to MOTECH in low income groups. Mobile phone ownership is not ubiquitous in rural Ghana and it is common for a phone to be shared in the family (and controlled by the male in the household) or for there to be a single phone used by many members of the community. A women registering for MOTECH can note whether the phone is personal, household or public and can access messages from health services (and re-listen to them as many times as they like) by calling a toll-free "short code" number from any mobile phone using any telecommunications provider. The Mobile Midwife service is also offered free of charge to users. As the universal short code number was not toll-free at the time of launch, which it is now, the system was designed to respond to a "flash" from a client (ie deliberately giving someone a missed call (by calling for a few seconds and then hanging up) so the other party returns (and pays for) the call, which the MOTECH system then does *(13)*. The health worker information system improves communication between health services and communities and between local services and district systems to obtain support. As further discussed in the next section, this supports the rights framework when the communication of messages and gathering of information is combined with more active social

processes, including community health volunteers (CHVs) liaising in a two way flow of information as ambassadors for MOTECH between health facilities and community members.

(Note: No online information could be found on the specific tools cited.)

6. Implementing health promoting activities in the two MFIs

This section describes the processes, sectors, actors and role of the health sector in the implementation of the two schemes and particularly their health related elements.

As noted earlier, both processes were initiated and organized by international organizations (Freedom from Hunger and Grameen Ghana) with national partners who co-led the progress. As an MFI, their financial arrangements have been discussed in the earlier section. These are both institutions outside the health sector that embedded health within their goals and activities. The schemes thus involved the finance sectors (Lower Pra Rural Bank and Grameen Ghana), their regulators, and the health and education sectors, as well as sectors involved in rural production and markets, such as ministries of agriculture. The work was led by the MFIs (and thus framed as a finance sector activity) while the NGOs initiated and capacitated the process with local actors leading in the implementation. Grameen Ghana, as an MFI, also built a more direct co-operation with the health sector and local telecommunication services in the MOTECH. The programmes, while initiated from national level actors, were highly decentralized. They were implemented at local level, through self-governing credit associations with support from local field agents. The MFI NGOs (Grameen Ghana and Freedom from Hunger) appeared to play a major role in making the connections between local and national processes and capacities and international resources for grant support, and in providing a framework for activities that would facilitate horizontal links with different actors in the community and vertical links across levels. The monitoring and evaluation methods used are discussed in the next section.

6.1 Freedom from Hunger Credit with Education

In the Freedom from Hunger CwE the solidarity groups and credit associations are run by the women members themselves, who elect three members to be the president, treasurer and secretary of the group, decide the rules for the association, implement their own loan analysis and manage the schemes. The FFH CwE has a field agent who provides capacity support to the group before the loan to the credit association, and gives ongoing support as needed during the life of the scheme. The field agents are usually young men and women from the local area with secondary school education. They are responsible for recruiting new village banks, training the members to manage their own affairs as a non-formal co-operative, and attending the regular meetings to oversee and assist the financial transactions of the group and to facilitate the learning sessions on business, health and education. They usually work in distant rural areas with poor infrastructure, travelling as much as three to four hours each day to provide services to clients in credit associations, covering as many as 15–20 credit associations each week. They link with local health services for information for the health sessions. These focus on areas such as diarrhoea management and prevention, breastfeeding, infant and child feeding, family planning, immunization, HIV/AIDS prevention and care, women's health, integrated management of childhood illnesses (IMCI), and malaria prevention and treatment. The areas covered are selected by the women and the field agent as issues that have high levels of impact on family well-being or where the women's own actions can have an impact, either directly or in terms of improving service uptake. The field agent is not a teacher but a facilitator, whose role is to draw knowledge and ideas from the group, and to engage participants into learning from each other as much as from the field agent. The MFIs co-ordinate with the health sector on services provided, so that information sessions directly tally with services" *(20)*. The module on self-esteem led by the field agent is identified as particularly important as it builds social confidence in the women to engage on their issues within their household

and community. In all areas participatory learning methods are used to generate collective discussion and critical reflection on current practices, areas for change, actions to be taken and to build solidarity between the women.

6.2 Grameen Ghana MFI and Mobile Technology for Community Health

Grameen Ghana similarly uses local field personnel and women's local associations and networks, and applies participatory approaches to strengthen collective discussion and reflection on the component on health. The institution has built closer and more active links with the health sector, particularly the Ministry of Health at national level and community health workers, midwives and district managers at local and district level, as reflected in the MOTECH scheme. Information Officers on the District Health Management Team (DHMT) are involved in analysis of the MOTECH reports on health service delivery. The Grameen field team also engages all the people in the community who have an impact on others' health decisions, local health providers; other NGOs working in the same geographical area; and community leaders, such as village chiefs.

These processes are noted to bring very different institutional cultures together. The MOTECH programme, for example, was made up of an equal partnership between Columbia University, Ghana Health Service and Grameen Foundation. Clear lines of accountability across the project team or clear agreements of commitments from each partner were not established and communicated at the outset of the project and Grameen Ghana note that this made it difficult to enforce agreements made later at the field-team level and led to misunderstandings that can disrupt trust. They also note that the pace and style with which the different organizations operate was also very different. Grameen Foundation is built on a culture of social entrepreneurship and rapid innovation, and programmes like MOTECH are by their nature rapidly innovating and entrepreneurial. This is quite different from the "gradual consensus building" model typically employed in health systems. Adjustment was required by Grameen Foundation both in the pace of development and the amount of communication required with partners to make the collaboration successful *(13)*.

7. Impact and lessons learnt

7.1 Achievement of objectives and impacts

Neither the Freedom from Hunger CwE nor the Grameen Ghana MFIs had formally evaluated their MFI impacts on health, but the data cited earlier on numbers reached, and other outputs suggest that the schemes expanded MFI activities, and delivered on the weekly information activities. A systematic report of outputs against objectives of the MOTECH programme was not available in the literature. The participatory approach of the Freedom from Hunger CwE is identified to have built greater capacity for use of information and for problem solving in the women's groups. *"Information about new practices reaches women who are ready to consider it and who have the self-confidence and mutual support to try new ways to enhance their families' well-being" (20)*. Grameen Ghana report a significant increase in networking within the district generated by the MFI, such as in the collaboration between the Ministry of Farming and Agriculture and the District Farmers' Network with consultation between them daily on improving service delivery and productivity.

"I commend Grameen Ghana for this feat because the farmers now are more confident and win a lot of awards".
Yakubu Alhassan, AEA, Nakpa Zone.

Further there is some report of improvements in adult and health literacy amongst participants (Grameen Ghana 2013).

"After successfully completing the reflect cycle, I can now read and write both in English and Likpalkpa. Also anytime I prepare to go to the clinic, I pick the right documents needed. Before then, I could not even identify my name on any document but now, every time my girl returns from school, I practice my English language with her and she is very happy for me".
Bolni Biibi, Adult Education Participant. (Grameen Ghana 2013).

The Grameen Ghana intervention using mobile phones reported that as women received information about when they were due for care, they began to show up at their local health clinic and ask for prenatal care and immunizations. It also identified service gaps. By having a parallel system of mobile phones present in each of the clinics and mobile forms that aggregate data quickly, gaps in the clinical system were more visible and easy to report. For example, immediately upon the introduction of MOTECH, various barriers were immediately identified, including fuel for nurses to visit mothers for post natal care; absence of refrigerators to hold vaccinations; and in lack of training of nurses to carry out child welfare checks. The field presence, monitoring structures, and real-time data visibility that MOTECH enabled meant that such deficiencies in the health delivery system were very quickly identified and escalated within Ghana Health Service for resolution *(13).*

There was no reporting of the extent to which Grameen Ghana's rights based framework generated advocacy or social demand on health services. There was also no report of whether the assumption of self-reliance in the MFIs within three years was being achieved.

Freedom from Hunger had implemented a more structured evaluation in its CwE in the 1993-6 period (described earlier). Eleven programme villages were randomly selected stratified by size and distance from main road, covering 23% of women in these villages. Six control villages were included. The likelihood of a selection bias in the MFI sites of women with higher education and background income was noted *(14).* The CwE clients were found in the evaluation to have a significantly greater increase in monthly non-farm earnings—almost double—as compared to non-participants in the same communities or residents living in control communities. Clients most commonly attributed their increased incomes to business expansion, reduced input costs as a result of buying in bulk or with cash rather than on credit, and new activities or products made possible by access to loans. There was also a significant increase among participants in giving their newborns the first antibody-rich milk, colostrum, rather than discarding it, relative to the two non-participant groups. Mothers in the programme exclusively breastfed their babies for longer, with periods closer to the desired six months. Participants rated themselves significantly more confident that they would earn more in the future and that they could prevent their children from getting diarrhoea and other illnesses, and were taking on more active roles in community activities. Measurements showed the nutritional status of one-year-old children in participant households to have significantly improved relative to the children of residents in control communities. The percentage of participants' children categorized as malnourished, based on height-for-age, decreased by eight percentage points between the baseline and follow-up periods, while the percentage of malnourished increased in control communities *(14,16).* The improvements in Ghana were reported to be greater than those in a similar scheme in Bolivia, attributed largely to the quality of the participatory education received by participants *(18).*

DelaCruz et al *(19)* evaluated Freedom from Hungers' CwE in the 2000s using a community randomized pre-test/post-test design to compare the knowledge and behaviours of MFI clients receiving malaria education (n=213) to those receiving diarrhoea education (n=223) and to non-client controls (n=268). Between baseline and follow-up, MFI clients receiving malaria education were most likely to have had improved knowledge of malaria complications during pregnancy; to own at least one bed net; and to report at least one child or woman of reproductive age sleeping under a bed net. There were several limitations noted in the analysis, in terms of reliability of self-reported data, variation in educational session attendance and conducting the baseline and follow-up interviews in different malarial season environments, although the latter was noted to cause the results to be understated *(10).*

Evaluating the link between MFIs and health or even socio-economic outcomes is however complex. MFIs normally take place alongside other social and economic activities that make it difficult to separate out the specific impact of the credit activities and a review of studies that evaluated MFIs found that inadequate evidence on the characteristics of service users, contexts, and implementation processes gave the impression of microfinance institutions and service users as being homogenous, and that impact assessments examined outcomes, but were not always clear about the causal pathways *(7,9)*. The monitoring tools for the schemes were not available in the literature.

There is debate in the literature on whether MFIs have positive effects on women's health. A MFI programme in South Africa achieved significant reductions in interpersonal violence against women by linking microcredit and health education that included collaboration of individuals with both expertise in microfinance and violence prevention, and efforts to address the broader social environment that shaped women's vulnerability to violence *(7)*. Since the Ghana evaluations reported above, further work on MFIs has raised more negative findings, however, that were not adequately captured in these earlier evaluations. Some have reported that the loans have not been translated into structural higher incomes, more productive businesses or other classic economic improvement indicators and that they have been used to meet other pressing needs with repayment has been accomplished by taking out other loans. MFIs have been found to be associated with stress, social pressure and increased debt, outcomes which have not been reflected in any success indicators *(17)*. A study in Ghana found that rather than facilitating women's empowerment, MFIs reinforced gender inequalities. Women were taking an increasing share of household expenses once they begun earning incomes while their husbands reduced their contribution towards the upkeep of the household. These women became progressively more overburdened, dampening rather than supporting their empowerment *(9)*. These more negative findings suggest a need to further disaggregate the positive opportunities and negative dimensions of women's participation in MFIs for well-being outcomes, further discussed in the next sections.

7.2 Opportunities and facilitating factors

As noted in the introduction MFIs were identified as a potential vehicle for improved health in women for their contribution to the capital needed for improving incomes and meeting catastrophic health costs, because they act as a vehicle for health information, social networking and strengthening of social confidence that support health care uptake and health promoting behaviour, and can be a social vehicle for introducing health innovations, such as mobile phones to support service uptake and accountability *(8)*.

In terms of direct contribution of improved income as a factor in improved health, an assessment of MFIs operating in Ghana in the 1990s found that the injection of capital into the enterprises supported had positive impacts on business turnover, on procurement of inputs/raw materials and machinery, creation of additional jobs, acquisition of business skills, marketing outlets and acquisition of domestic assets. These economic benefits were identified to be associated with a range of social benefits, including access to quality food and nutrition intake, water and sanitation facilities, and health services, enhanced public respect and acceptance, self-esteem, participation in community activities, monetary contributions to social projects and empowerment of women *(11)*. In a second assessment of MFI in Ghana, poorer service users were reported to be more likely to experience positive household and business outcomes and to have significantly increased contribution to the education of their children. The intervention enabled members to improve incomes not by increasing revenue but by reducing costs through buying in bulk at a discount, at cheaper prices and not having to buy on credit *(9)*.

It is argued, however, that MFIs are unlikely to achieve health benefit unless explicit measures are integrated that directly address health, including the intersectoral engagement, health literacy and communication tools described in the case studies. The addition of health training is argued to strengthen solidarity and group dynamics in participating loan centres, something that microfinance

alone is less likely to do *(15)*. Additionally, the impressive scale and financial sustainability achieved by Grameen Bank and other MFIs are argued to provide models for delivering cost-effective health interventions at scale, particularly to low income communities *(7)*.

The two MFIs described in this case study had features raised earlier that were identified as positive features for equity and intersectoral action, or for positive outcomes:

i. Use of grant funds and structuring of different credit options to take the financial circumstances of different women into account;
ii. Use of a rights based approach to integration of health and other social interventions to build action not only on health behaviours, but also advocacy for participation in governance and accountability of service delivery;
iii. Involvement of local field agents able to facilitate participatory processes and links across sectors, to provide information and constant encouragement and guidance, and to make vertical links between local and national levels;
iv. Linkages built with health, education, agriculture and other production sectors and with local NGOs, by field agents for the MFI with a knowledge of the local systems and their processes;
v. Obtaining visible policy support of health and other authorities. For example the MOTECH was implemented through an agency in MFIs, but had clear involvement and support of the Ghana Health Service and its personnel.
vi. Implementing health literacy using participatory processes that strengthen collective processes for exchange, reflection and identification of actions and that encourage uptake of health services;
vii. Involvement and support of community health workers in communication between women and health services and of district management, such as in the MOTECH programme;
viii. Identifying clear leadership, shared vision and ownership and developing and documenting clear agreements and lines of accountability for partnerships, with consistent weekly team meetings, using agreed tools for documenting and talking through the various development and implementation issues;
ix. Making clear in the community processes and implementing partners meetings what the success outcomes will be and tracking progress on these outcomes; and
x. Using accessible information technology like mobile phones to support service uptake and track service delivery and ensuring that use of the technology is not at a cost to low income women *(10, 13, 15, 20)*.

7.3 Challenges and barriers

Some studies have generated evidence that questions how far microfinance services in fact benefit women, and report a range of challenges and barriers to health benefits. In Ghana, business expansion resulting from access to credit meant longer working hours and limited time for the family. Members of credit associations faced pressure not to default on loans *(11)*. Weekly or fortnightly meetings afforded service users a forum to build social networks, but detracted from their time required for other business or household activities *(9)*.

There is also a report that MFI programmes divert the attention of women from other more effective strategies for empowerment and resources from more effective means of alleviating poverty *(12)*. An assessment of the Nsoatreman Women Empowerment Programme and Sinapi Aba Trust, in Nsoatre, two rural MFIs in Ghana, found that the MFIs contributed to household consumption more than to household asset accumulation, and that improved incomes in women led to a reduced contribution from men, progressively overburdening the women involved (9). Service users were not involved in the design and implementation of the schemes and other services and lacked knowledge on many of the components of the intervention *(9)*.

This finding from MFIs in Ghana is backed by wider literature that loans have not been translated into structural higher incomes, and have been used to meet other pressing needs, with repayment accomplished by taking out other loans. MFIs thus generate a risk of debt *(17)*.

As a vehicle for intersectoral programmes, they face the same challenges as other intersectoral activities. Different sectors may have different value bases, success criteria and management cultures. Individual policy networks tend to approach programmes from "different worlds", drawing from distinct vocabulary, ideology and modes of communicating new ideas. *(15)*. Multisectoral interventions in MFIs are reported to face challenges in the way different agencies are structured and function. Tensions may arise if roles are not clarified disrupting trust. The longer time frames required to see programme effects may create tensions and call for processes that manage diversities in institutional culture and sustain co-operation *(15,13)*.

8. Conclusions and recommendations

A context of improving economic performance with social and economic inequality in Ghana suggests that the opportunity exists for measures to widen the benefits from growth, including for health. Women, rural communities and the more remote Northern Region of Ghana are all identified as more disadvantaged. There is a policy support and a legal framework for measures to provide access to credit for economic activities, including for MFIs. While MFIs have expanded in Ghana, in the poorest Northern Region, access to credit for economic activities depends on schemes through NGOs. This is seen as an opportunity to link the provision of credit with programmes supporting health and education, creating engagement across finance, health, education, agriculture and other productive sectors. The MFIs that have been introduced and that integrate health appear to have largely been initiated by external NGOs working with local partners, bringing charity funding to support social programmes. They are however organized at local level, through a highly decentralized process, supported by local field agents. Linkages are built in the programmes between health, education, agriculture and other production sectors and with local NGOs, by field agents for the MFI with knowledge of the local systems and their processes. Community health workers appear to play a vital role in communication between women and health services and mobile phones offer opportunities for women's networks to further strengthen communication and track service quality, as in the MOTECH programme.

The case study described common organizational features of the two schemes. Both used improved incomes, health literacy, improved self-confidence and social networking in women as a lever for improved health. There is some evidence of improvements in these areas and of improved health and nutrition, although monitoring and evaluation of impact was not routinely integrated into the schemes or reported in the literature. While there is some evidence that the MFIs provided a vehicle for social networking amongst women, the relative contribution of incomes, information or skills and esteem building activities can't be differentiated in the positive health outcomes reported. It is likely that without the integration of health programmes within the MFIs, the health benefits would have been lower, as was found in the case control studies.

There is also a critique that low income women need more structural interventions on jobs, land, environments and markets to sustain supportive environments for their health, and action on social norms and factors that undermine gender equality. There is an enabling policy environment for this in the health system, with action on social determinants of health given high profile in Ghana's health policy. The Grameen Ghana MFI more explicitly used a rights based framework to engage on health and to generate advocacy on health environments and for accountability of health services. There was however no documentation on whether this led to greater participation in health planning, social demand on services or intervention on social determinants than in the Freedom from Hunger MFI. Common features of interaction with community health workers is important for strengthening uptake

of services, but there appears to also be scope for more direct interaction with health and other services than that described in the schemes to address barriers to access and uptake, and to widen the range of health interventions that could be integrated within MFIs *(10)*. The use of mobile phone technology in MOTECH is an innovation that has potential to further enhance communication between women and service providers, especially if it develops further to provide the necessary feedback loop from women to service providers.

The experience of MFIs suggests that while the schemes appear to provide elements of social networking and shared exchange useful for health promotion, they cannot automatically be assumed to be a 'promising practice' of action on gender inequalities in social determinants of health. The risks identified and lack of explicit challenge to gender norms suggests the need for further strategies and programme elements to address gender elements, and for further development of financial mechanisms that would strengthen income security, and avoid displacing time spent with family or spending on family needs. While all programmes are context-specific and need to be designed with participation of the affected women, proposals have been made for health goals and programmes in MFIs to include awareness training in gender issues for men and women to ensure that micro-finance leads to positive changes in women's positions; provision of services to decrease reproductive work to give women more time for income-earning and for wider social and political activities; and gender advocacy at local and national levels, such as to support women who have faced domestic violence and abandonment. While the social networks in MFIs offer the possibility of self-determined reflection and action within the credit associations, it would also be important to build women's participation, voice and agency in planning and decision-making on services that they use, and in the design of social programmes in MFIs *(12)*.

This case study identifies an area of integration of health goals and programmes in a financial sector institution and highlights both positive and negative features. In this respect two further points are raised: it is proposed that greater attention be given to real-time monitoring, rather than traditional baseline, midline, and end line surveys, to yield information on the benefits and risks of approaches used as they are implemented. For MFIs such monitoring should also gather and review evidence on women's time, household functioning and resources, income security and indebtedness. Secondly, further processes should be included to build women's capacity and confidence for and involvement in the design and review of schemes supporting their livelihoods and health programmes.

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