

## Microfinance Intervention and Health Outcomes of Marginalized People: A Systematic Literature Review

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**ABSTRACT**

**INTRODUCTION:** People from developing countries may have poor health due to economic constraints. Microfinance institutions provide collateral-free microcredit to the unbanked people for their livelihood improvement. This study aims to assess the impact of microfinance services on the health outcomes of marginalized people. **MATERIALS AND METHODS:** The research is based on a review of empirical studies, reports, and data. The PubMed search engine was used to locate research publications on microfinance and health. The PubMed Open Database was applied to find the publications using the keywords "microfinance" and "health." All papers that were published from January 1, 2010, to April 15, 2023, were checked for the study. 71 research papers were discovered during the initial inquiry; nine duplicate articles were eliminated, and 13 were irrelevant to the study. Finally, 50 research papers and reports were selected for evaluation. **RESULTS:** Health outcomes and microfinance intervention are related. Microfinance services are useful to improve access to healthcare, health initiatives/awareness, and funding for healthcare services. When financial services are integrated with health care services, the poor and marginalized people benefit from the microfinance intervention in the diverse areas of health care services such as communicable and non-communicable diseases, food security and nutrition, contraceptives, and mental health risks of intimate partner violence, as well as health awareness, quality of life, social integration, and economic wellbeing. **CONCLUSIONS:** Financial accessibility is important for promoting the health of the underprivileged. The poor and marginalized individuals gain from the microfinance intervention in the broad spectrum of health care services when financial services are linked with health care services.

**Keywords:** Health awareness, health promotion, microcredit, microfinance services



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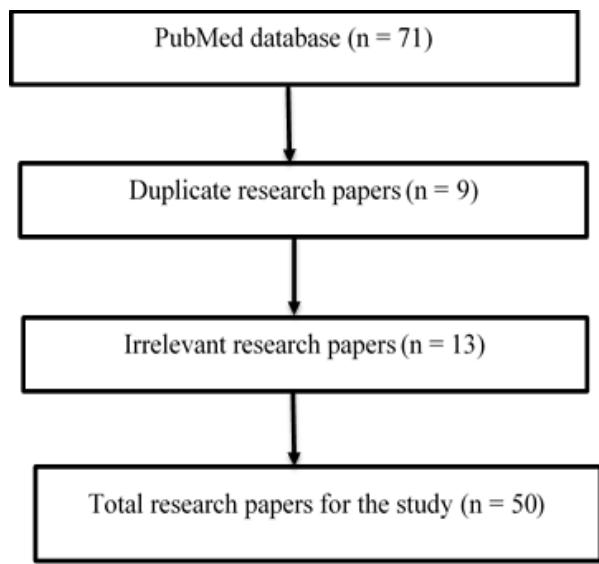
**BACKGROUND**

Microfinance (MF) is the delivery of financial services to underserved and financially excluded groups, frequently with the social aim of eradicating poverty and empowering women [1, 2, 3]. It has gained popularity, especially among low- and middle-income people, as a way to support rural development, provide women more negotiating power, and enhance household welfare [4, 5]. Microfinance institutions (MFIs) provide collateral-free microcredit to the poor and marginalized people for microbusiness and microenterprise creation [6, 7, 8]. Enforcing financial literacy, group accountability and repayment guidelines facilitate the sustainable operation of micro-business and micro-enterprises [9, 10]. People from developing countries may have poor health due to economic constraints. Through income generating [11, 12] and livelihood enhancement [13, 14, 15] programmes in developing nations like Nepal, microfinance has been proven to help enhance health outcomes.

A variety of channels are used to deliver microcredit, including cooperatives, village banks, self-help groups, and savings organizations. Microfinance and health promotion programmes were better together, although it was rarely possible to quantify changes in overall health outcomes [16]. This study contributes to the body of knowledge by concentrating on microfinance intervention and health outcomes of marginalized people who were active in MFIs. To explore the relationship between microfinance intervention and health outcomes, the following questions were designed for this paper: a) what is the status of financial institutions and health service-providing institutions in Nepal? b) what are the key factors that impact the integration of health and financial services? c) how does microfinance intervention improve the health outcomes of the people? d) what are the significant impacts of microfinance intervention on health outcomes?

## MATERIALS AND METHODS

This study aims to assess the impact of microfinance services on the health outcomes of marginalized people. The research is based on a review of empirical studies, reports, and data. The PubMed search engine was used to locate research publications on microfinance and health. The PubMed Open Database was applied to find the publications using the keywords "microfinance" and "health." All papers that were published from January 1, 2010, to April 15, 2023, were checked for the study. 71 research papers were discovered during the initial inquiry; nine duplicate articles were eliminated, and 13 were irrelevant to the study. Finally, 50 research papers and reports were selected for evaluation with the study titled "Microfinance intervention and health outcomes of marginalized people: A systematic literature review." The inclusion and exclusion criteria for this research are mentioned in Figure-1.



## RESULTS AND DISCUSSION

### Status of Financial Institutions in Nepal

Financial institutions consist of commercial banks (A class), development banks (B class), finance companies (C class) and microfinance institutions (D class) as per the classification of Nepal Rastra Bank (NRB). The status of financial institutions including microfinance has been presented as per the province in Table 1. As per the above table, the total number of BFIs in Nepal is 119 including the Infrastructure Development Bank. The status of financial institutions is poor in Karnali province and higher in Bagmati province. Microfinance institutions are higher in Lumbini and Madhesh provinces and lower in Karnali and Sudur Paschim provinces. Since financial inclusion and inclusive growth are closely related, Nepal must increase its level of financial inclusion [18].

### Status of Health Service-Providing Institutions in Nepal

Everyone has a fundamental right to health, according to the Nepalese constitution. There are numerous challenges facing Nepal's health system, including unequal access to medical care, poor infrastructure, a lack of essential pharmaceuticals, poorly regulated private providers, inadequate funding for health, and a lack of human resource retention in rural areas. However, through sub-health posts (SHP), health posts (HP), and primary health centres (PHC) in rural regions, the government of Nepal has made significant efforts to improve access to essential health services for every individual. Table 2 shows the status of health service institutions in Nepal. As per Table 2, the status of health services providing institutions and facilities is not sound. The promotion of the health sector has been hampered by the budget constraints of Nepal. A successful approach for ensuring equitable access to healthcare services is social health insurance. In Nepal, there is a poor uptake of social health insurance. Social health insurance is a powerful tool for enhancing the health system in underdeveloped countries like Nepal [20].

### Factors Impacting the Integration of Health and Financial Services

The role of a microfinance organization is crucial in promoting health benefits, such as: (i) improving the socio-economic situation of the members (ii) offering non-financial benefits, such as improved health, hygiene, and sanitation, and the longer the duration of association, the better the health outcome; (iii) financing healthcare costs through microinsurance and health loans has been linked to increased use of healthcare services and better financial protection against the costs of care; (iv) expanding health awareness to improve access to antenatal care, safe delivery and immunization, and reductions in infant mortality and birth rate; and (v) increasing knowledge and intensifying acceptance of affordable healthcare products and services, such as non-clinical family planning methods and point-of-use water treatment items, offered through self-help groups (SHGs) [21]. Three key factors—the health determinants, the design and administration of microfinance programmes, and the type of health programme—have been recognized as having a significant impact on the integration of health and financial services. Regulation and policy environments are a fourth overarching dimension. The factors that affect people's knowledge, attitudes, and beliefs about health and health services are influenced by a variety of social, geographic, economic, and individual factors. These social factors are linked to poverty, social norms, and support. Access to health services is also influenced by availability,

**Table 1 | The Status of Financial Institutions in Nepal**

Province	A	B	C	D	Total
Koshi	758	194	36	870	1,858
Madhesh	577	84	51	1,061	1,773
Bagmati	1,807	332	108	776	3,023
Gandaki	599	190	37	579	1,405
Lumbini	746	257	46	1,168	2,217
Karnali	201	21	3	237	462
Sudur Paschim	327	52	6	460	845
Total number of branches	<b>5,015</b>	<b>1,130</b>	<b>287</b>	<b>5,151</b>	<b>11,583</b>
Total number of BFIs <sup>^</sup>	<b>21</b>	<b>17</b>	<b>17</b>	<b>63</b>	<b>119*</b>

Source: Monthly statistics of NRB, Mid-June 2023 [17].

\*including Infrastructure Development Bank

<sup>^</sup>Banks and financial institutions**Table 2 | Status of Health Service-Providing Institutions in Nepal**

Particulars	July				
	2018	2019	2020	2021	2022
<b>Health Institutions</b>	<b>4,513</b>	<b>5,717</b>	<b>7,154</b>	<b>7,566</b>	<b>7,598</b>
Hospital	123	125	125	125	154
Primary Health Center	203	203	203	205	196
Health Post	3,803	3,805	3,805	3,870	3,853
Ayurvedic Hospital	384	384	395	395	424
Sub-health Post/Basic Health Service Center	0	1,200	2,626	2,971	2,971
<b>Hospital Bed</b>	<b>8,172</b>	<b>8,172</b>	<b>8,172</b>	<b>11,640</b>	<b>15,790</b>
<b>Health Manpower</b>	<b>90,803</b>	<b>90,946</b>	<b>90,946</b>	<b>90,369</b>	<b>97,449</b>
Doctor	2,640	2,640	2,640	2,640	4,660
Nurse/ANM	20,510	20,653	20,653	20,653	24,693
Kabiraj (Ayurvedic HA)	613	613	613	613	613
Vaidya (Ayurvedic)	693	693	693	693	693
Health Assistant (HA, AHW)	14,347	14,347	14,347	14,347	15,367
Women Health Volunteers	52,000	52,000	52,000	51,423	51,423

Source: Economic Survey of Nepal for the fiscal year 2022/23, pp. 164 [19].

affordability, acceptability, and accessibility [22]. When education activities are effectively combined with knowledge and skills, they need to operate in daily living activities, including entrepreneurship. The strategy has demonstrated that even the underprivileged may improve their situation [23]. There are five main areas where microfinance has been shown to improve access to healthcare: (i) the social and economic circumstances of the poor; (ii) community health; (iii) health initiatives to increase client awareness; (iv) funding health care; and (v) the availability of affordable health-care services [24].

#### Nexus between Microfinance Intervention and Health Outcomes

Health awareness and behaviours in Nepal were positively impacted by microfinance intervention [25]. Participation in microfinance demonstrated positive

impacts on empowerment and no negative health implications [26]. The extent of the MF program's influence on outcomes remained unchanged even after adjusting for other confounding factors, indicating that all women consistently receive the program's health message, regardless of their socio-economic status and health system features [27]. Health programmes performed by self-help groups (SHGs) model of microfinance are linked to better health behaviours. It offers a way to address the health requirements of low-income women due to wide coverage and social capital creation [28]. Initiatives for sustainable development driven by the community that build on assets from traditional livelihoods (such as agriculture and livestock husbandry) and have a long-lasting effect on a person's health, family, and community [29]. As tools for enhancing economic stability, health, and women's

empowerment, various economic empowerment programmes (such as microcredit, village-led savings and loans, cash transfers, and transfers of productive assets for the poor) have shown conflicting results [30]. Benefits from MFIs are not only financial but also social because they need loan repayment supported by a social network. The social network and extra care given to MFI recipients have the potential to support new healthcare initiatives. MFIs can offer financial assistance while facilitating patient access to care, educating patients, and enhancing community capacity for health services and infrastructure [31]. Medication accessibility, financial resources, peer support, and a decreased caregiver burden are all advantages of an integrated microfinance-group medical visit non-communicable disease (NCD) intervention strategy [32].

### **Impact of Microfinance Intervention on Health Status**

The health of women and their children tends to improve when they participate in microfinance programmes. Reduced mother and newborn mortality improved sexual health, and, in certain situations, lower levels of interpersonal violence were among the changes that were noted. Membership in relatively large and well-established microfinance schemes generally resulted in higher empowerment. High empowerment contributed to enhancements in the usage of contraceptives and mental health as well as decreases in the risk of intimate partner violence [33]. When women were borrowing in groups and attending regular meetings at microfinance banks, their chances of having better health outcomes increased [34]. The various child nutrition indicators were higher who received microfinance services compared to the control group [35]. In Kenya, systolic blood pressure (SBP) reductions related to cardiovascular benefits were achieved by a strategy combining group medical visits (GMV) and MF for people with diabetes or hypertension [36, 37]. In Kenya, participants who tested positive for hypertension and diabetes returned for follow-up treatment after the establishment of a complete microfinance-linked, community-based, group care model [38]. The main coping mechanisms to handle food insecurity during the acute phase of HIV infection included borrowing money, which was followed by spousal assistance, loans from banks, moneylenders, or microfinance organizations, food borrowing, or selling agricultural products in West Bengal, India [39]. Farming practices that are enhanced by agricultural and financial interventions may result in better health outcomes via increased food security, income, and a varied diet [40, 41, 42]. Increased utilization of maternity waiting homes (MWHs) and health facility delivery were both related to

access to Savings and Internal Lending Communities (SILCs). In addition, regardless of the presence of MWH, access to SILCs was linked to an increase in competent provider delivery [43]. With the help of the Nova MF intervention, women can lower their risk of contracting HIV and have access to alternative economic opportunities should they decide to cut back or cease sex work [44]. For those with leprosy, disabilities, or who are socially and economically marginalized in low- and middle-income countries, the success of integrated self-help and self-care groups affects the quality of life, social integration, and economic well-being [45]. Among HIV-positive people in Kenya, the intervention included a microfinance loan, financial and agricultural training, and a human-powered water pump. Through a number of mechanisms, better health has been linked to increased clinic attendance, including (i) decreased food insecurity and extreme hunger (ii) increased financial stability; (iii) increased productivity which strengthened social support; (iv) improved control over work situations; and (v) renewed desire to prioritize their health [46]. Inconclusive evidence exists about how income generation strategies affect HIV-related behaviours and outcomes. A small number of studies identified substantial intervention effects on condom use, the number of partners in sex, or other HIV-related behavioural outcomes; the majority of research found no meaningful change [47, 48, 49]. Adolescents in Uganda who were orphaned by AIDS saw significant benefits from an economic intervention that included matched savings in terms of their most important developmental outcomes [50]. A strong HIVRR intervention may be sufficient to reduce sexual and drug risk behaviours among female sex workers (FSW) who use drugs, as opposed to a combination HIV risk reduction (HIVRR) + MF intervention [51, 52, 53].

The programmes included a variety of intervention activities, such as group-based education and skill development mixed with microfinance for screening and referral to community resources. The prevention of intimate partner violence (IPV) remains a top goal. When implementing IPV programmes in low-resource communities, it is crucial to take into account the geographic, social, cultural, and economic settings due to the numerous challenges to programme implementation [54, 55, 56]. Participation in micro-savings had little or no effect on the likelihood that women in Mongolia would experience intimate partner violence [57]. The number of women who took part in the MF intervention in Tanzania decreased when it came to either physical or sexual intimate relationship abuse, or both [58]. For rural

communities, it's crucial to collaborate with local organizations to comprehend, plan, and modify actions. Local communities place a strong emphasis on the value of utilizing local resources to offer mediation services for resolving family disputes. Some of the negative effects of trauma may be lessened with assistance to improve family mediation interventions or the adaption of effective group psychotherapy techniques to address family relationships [59]. Microfinance and conditional cash transfer programmes have aided in raising income as part of interventions to reduce poverty. Investments in reproductive, maternal, neonatal, and child health (RMNCH) initiatives should be given priority in nations with widespread malnutrition because of their positive effects on public health [60].

It has been demonstrated that taking part in Savings and Internal Lending Communities (SILC) increases household wealth and financial readiness for childbirth for both men and women. Increasing financial resources and assisting parents financially in planning for pregnancy, SILCs are a potential intervention that can benefit underprivileged and rural populations [43]. Improvements in children's nutrition who are HIV-affected could result from livelihood interventions [61]. Diet, health, childcare, and education indicators for child protection were negligible, showing that there was no long-term difference in the effects of microfinance on beneficiaries' children versus non-beneficiaries' children [62]. Women who have lived through conflict in the Congo may benefit from the microfinance intervention program Pigs for Peace (PFP) by improving their economic and health results [63, 64]. In Ethiopia, women who exclusively breastfed their children benefited from MF services.

#### ADDITIONAL INFORMATION AND DECLARATIONS

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The practice of exclusive breastfeeding would also be improved by increasing the use of prenatal care and institutional delivery. Furthermore, it's critical to involve mothers in economic activities [65]. It is viable and acceptable to use group text messaging to encourage breastfeeding among microcredit clients, and it can be a useful component of a behaviour change program in Nigeria [66, 67]. Women's nutritional intake and health services are found to be improved, early marriage and conception are avoided, secondary education and purchasing power increased, work drudgery is reduced, and domestic violence is eradicated [68].

#### CONCLUSIONS

Access to finance matters the health promotion of the poor and marginalized people. There is a nexus between microfinance intervention and health outcomes. Microfinance services are useful to improve access to healthcare, health initiatives/awareness and funding for healthcare services. When financial services are integrated with health care services, the poor and marginalized people benefit from the microfinance intervention in the diverse areas of health care services such as communicable and non-communicable diseases, food security and nutrition, contraceptives, and mental health risks of intimate partner violence, as well as health awareness, quality of life, social integration, and economic wellbeing. Microfinance is a tool for the livelihood and health improvement of marginalized people, so microfinance institutions, regulatory authorities and the government should expand microfinance services to the rural and under-served people that ultimately promote health outcomes of the marginalized people in developing countries like Nepal.

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