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Health impacts of group-based microfinance

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Group-based microfinance for collective empowerment: systematic review of health impacts

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Abstract

Objective To assess the impact, on health-related outcomes, of group microfinance schemes based on collective empowerment.

Methods We searched the databases Social Sciences Citation Index, Embase, MEDLINE, MEDLINE In-Process, PsycINFO, Social Policy & Practice and Conference Proceedings Citation Index for articles published between 1 January 1980 and 29 February 2016. Articles reporting on health impacts associated with group-based microfinance were included in a narrative synthesis.

Findings We identified one cluster-randomized control trial and 22 quasi-experimental studies. All of the included interventions targeted poor women living in low- or middle-income countries. Some included a health-promotion component. The results of the higher quality studies indicated an association between membership of a microfinance scheme and improvements in the health of women and their children. The observed improvements included reduced maternal and infant mortality, better sexual health and, in some cases, lower levels of interpersonal violence. According to the results of the few studies in which changes in empowerment were measured, membership of the relatively large and well-established microfinance schemes generally led to increased empowerment but this did not necessarily translate into improved health outcomes. Qualitative evidence suggested that increased empowerment may have contributed to observed improvements in contraceptive use and mental well-being and reductions in the risk of violence from an intimate partner.

Conclusion Membership of the larger, well-established group-based microfinance schemes is associated with improvements in some health outcomes. Future studies need to be designed to cope better with bias and to assess negative as well as positive social and health impacts.

Introduction

Microfinance initiatives have become popular, particularly in low- and middle-income settings, as a means of promoting rural development,¹ increasing the bargaining power of women and improving household welfare.² Such has been the enthusiasm for these schemes that, in 2006, the Nobel Peace Prize was awarded jointly to Muhammed Yunus and Grameen Bank – a microfinance scheme in Bangladesh.

The potential of microfinance to improve health is now being recognized.^{3–5} The impacts of microfinance initiatives need to be considered in current theory debates about the role that control over destiny plays as a fundamental social determinant of health.⁶ Poor control over destiny, which is a characteristic of women in some societies, can be damaging to population health. In general, population and child health improve and the life expectancies of both men and women increase as the participation of women in decision-making increases.⁶

Group-based microfinance schemes attempt to harness the collective power of mutual support – with members pooling their savings and making small loans to each other so that they can set up small businesses. Most aim to improve the economic power of – and employment opportunities for – women in their immediate community, and many aim to confront engrained discriminatory attitudes to women.² Some aim to facilitate the attendance of girls at school and change attitudes to the paid employment of women outside their homes. The members – who are mostly women – form groups for saving and credit, and are offered literacy classes, legal, social and empowerment training and technical and marketing support (Box 1).

It has been argued that the enthusiasm for microfinance has outstripped the evidence of its effectiveness⁷ and that microfinance schemes have the potential to do harm. Schemes can suffer from so-called mission drift and end up favouring those who are more credit-worthy while excluding the ultra-poor.^{8–12} In some settings, the imposition of a business model on poor female members of a microfinance scheme may lead to increased debt, repayment stress and exploitation.^{13,14} The result may be an exacerbation of inequalities rather than a reduction.

We conducted a systematic review of group-based microfinance based on collective empowerment that covered all health conditions and all countries and assessed the impact on health. We addressed three questions: (i) what impact do group-based microfinance schemes

based on collective empowerment have on health; (ii) what role does empowerment play in the pathways from microfinance to health benefits; and (iii) do the impacts of the schemes differ based on the ethnicity, sex and/or socioeconomic status of the members?

Methods

We reviewed evaluations of group-based microfinance in any country, using published systematic review methods,¹⁵ and assessed the quality of each relevant study using procedures tailored to social interventions in community contexts.¹⁶

Search strategy

We searched the databases, Embase, MEDLINE, MEDLINE In-Process, PsycINFO, Social Policy & Practice (Box 2), Social Sciences Citation Index and Conference Proceedings Citation Index (Box 3) for articles published between 1 January 1980 and 29 February 2016. We checked the reference lists of relevant articles and contacted policy-makers and academics for publications in press and in the grey literature.

Inclusion and exclusion criteria

A report was only included if it described an experimental or quasi-experimental evaluation of a group-based microfinance scheme that: (i) employed collective empowerment strategies; (ii) was targeted at a group with some form of disadvantage; and (iii) was delivered among a free-living population in a community setting. To be included, a report also had to disaggregate data by some measure of socioeconomic status and describe at least one health-related outcome. We also included qualitative reports that related to an included study. No country or language restrictions were applied.

We excluded reports of individual loan schemes that focused solely on poverty alleviation but did not promote group solidarity and empowerment, and reports on schemes that included restrictions on how loans could be used.

Screening and selection

Titles and abstracts were screened before potentially eligible reports were retrieved in full text and assessed, independently, by two reviewers. Reasons for exclusion were recorded. Disagreements were resolved by discussion or by recourse to a third reviewer.

Study data

A single reviewer extracted data from each included report and applied a modified version of the quality assessment tool developed by Lorenc et al.¹⁶ Qualitative studies were assessed using the criteria of Mays and Pope.¹⁷ A second reviewer checked extractions and appraisals for accuracy and completeness. A narrative synthesis was performed.^{18,19} Differential impacts were identified – particularly in relation to ethnicity, sex and socioeconomic status. Reporting was based on the PRISMA-Equity 2012 extension guidelines.²⁰

Results

From 4050 articles, only 31 reports – covering 23 studies (Table 1) – met our inclusion criteria (Fig. 1). The included studies comprised one cluster-randomized controlled trial and 22 quasi-experimental studies that took advantage of naturally occurring comparisons and pre-existing data – e.g. from demographic surveillance systems and health surveys. All of the interventions targeted poor women living in low- or middle-income countries. Most were based in Bangladesh and many focused on women in rural communities. Although we identified some studies of microfinance schemes in central and south America, all but one were excluded because they did not meet the inclusion criteria.

Assessment of the included studies revealed that even the higher quality studies were potentially at risk from several forms of selection bias.

Impacts

Mortality and morbidity

Two higher quality longitudinal studies revealed that membership of the BRAC initiative, in Bangladesh, was associated with relatively low infant and child mortality compared with non-membership.^{21,22} The decline observed in the risk of infant death over a period of 10 years was greatest (53%) for infants of mothers who joined the BRAC scheme, followed by the infants of rich non-members (41%) and then the infants of poor non-members (31%).²¹ The risk of death for the infants of poor BRAC members declined to the level recorded for the infants of rich non-members. There was no association between BRAC membership and survival of children aged 1–5 years. In a further study by the same authors, however, the survival of children aged 1–5 years from poor households was found to be significantly improved if their mothers were BRAC members.²²

Two lower quality studies found that BRAC membership was associated with lower child mortality²³ or lower maternal morbidity.²⁴ A third study, based in Peru, found no association between length of membership in a group-based microfinance scheme and maternal depression²⁵ or child illness.²⁶

Women's sexual health

Impacts on sexual health and violence against women were reported in five evaluations, in Bangladesh, Ethiopia, India and South Africa. Of these evaluations, a study of the highest quality assessed the impacts of scheme membership on women's sexual health and risk of interpersonal violence in South Africa.^{28–30} This was a prospective, matched, cluster-randomized controlled trial – with a strong qualitative component – of the South African Microfinance for AIDS and Gender Equity intervention. This intervention included a large human immunodeficiency virus (HIV) health-promotion element, a microfinance component based on the Grameen Bank model and a so-called Sisters-for-Life gender-focused training component. The microfinance intervention was not associated with any significant changes in rate of unprotected sexual intercourse with a non-spousal partner (relative risk, RR: 1.02; 95% confidence interval, CI: 0.85–1.23) or HIV incidence (RR: 1.06; 95% CI: 0.66–1.69).²⁸ Stratifying by age, there was evidence of several beneficial effects on younger participants after two years of involvement with the programme. For example, when compared with women of the same age and poverty from control villages, female participants aged 14–35 years exhibited higher levels of HIV-related communication (adjusted risk ratio, aRR: 1.46; 95% CI: 1.01–2.12), were more likely to have accessed voluntary counselling and testing (aRR: 1.64; 95% CI: 1.06–2.56) and were less likely to have had unprotected sex at last intercourse with a non-spousal partner (aRR: 0.76; 95% CI: 0.60–0.96).²⁹ Qualitative data indicated that the intervention had led to a greater acceptance of intra-household communication about HIV and sexuality and increased confidence and skills that, in turn, appeared to have supported the introduction of condoms in sexual relationships.²⁹

Findings on the impacts on women's sexual health assessed in two other higher quality studies were equivocal. In Bangladesh, women in villages participating in the Grameen Bank scheme were more empowered ($P < 0.01$) and more likely to use contraceptives than women in villages without the microfinance scheme (59% versus 43%; $P < 0.01$).³¹ In contrast, no significant association was found between BRAC membership and contraceptive use. Ethnographic data indicated that the Grameen Bank scheme may have increased contraceptive use partly by strengthening women's economic roles and

empowerment and partly by directly promoting family planning and influencing community norms.³² Members of microfinance schemes showed relatively high scores for economic security, contribution to family support, freedom and mobility and freedom from domination.³² A further longitudinal controlled study in India, evaluated the three-year impact of Pragati – a multicomponent microfinance and health-promotion intervention for female sex workers. In this study, the incidence of sexually transmitted infections decreased and the frequency of condom use at last paid sex increased as microfinance exposure increased over time.³³

Three lower quality studies also assessed women's sexual health. One showed associations between microfinance membership in Bangladesh and higher contraceptive use.^{34,35} The other two, in Ethiopia and Peru, found no association between membership and women's health.^{25,36}

Violence against women

Impacts on interpersonal violence against Bangladeshi or South African women were reported in seven evaluations. The highest quality study found that, after two years, levels of such violence decreased in all four study villages covered by the South African Microfinance for AIDS and Gender Equity intervention but stayed the same or increased in the four control villages.³⁰ Women's membership in the intervention was associated with a reduced risk of exposure to interpersonal violence (aRR: 0.45; 95% CI: 0.23–0.91).³⁰ Improvements in all nine of the investigated indicators of women's empowerment were observed.³⁰ Women members had a greater say over household decision-making and felt more able to challenge the acceptability of violence, to expect and receive better treatment from their partners, to leave abusive relationships and to raise public awareness of interpersonal violence in their village.³⁰

Another study, also assessed as higher quality, measured violence within spousal relationships in Bangladesh. In this study, women who participated in the BRAC or Grameen Bank schemes – and women who were non-members but lived in Grameen Bank villages – were found to be less likely to be beaten by their husbands than women in control villages.³⁷ In this study, the role of empowerment was not clear and the effect of women's contribution to family support on violence was not significant.³⁷ Ethnographic data indicated that, in relatively rich households, women's membership of a microfinance scheme may have led to an initial increase in violence as the women's roles and status were redefined and they had

increased involvement in the cash economy – leading to a struggle for control over household finances. However, this effect dissipated over time.³⁷

Five lower quality studies, all in Bangladesh, gave mixed results. One study found that microfinance participation was associated with a reduction in the likelihood of interpersonal violence against women of 6.8%.³⁸ In contrast, after controlling for confounders, two studies found no statistically significant association between microcredit participation and current experience of such violence.^{24,39} A further lower quality study in Bangladesh found that the better educated women experienced increased exposure to interpersonal violence following membership of a microfinance scheme. This study was poorly adjusted for bias, however.⁴⁰ Another study in Bangladesh, that used propensity score matching to construct an appropriate comparison group of non-members, revealed that levels of interpersonal violence did not differ significantly between members and non-members.⁴²

Nutrition

Impacts on nutrition were reported in seven evaluations, in Bangladesh, Ethiopia, Ghana, India and Peru. The findings were inconclusive. Some studies showed that scheme membership brought nutritional benefits – mainly for the infants and children of members – and others revealed no significant effects.

Of the three higher quality studies, all from Bangladesh, one found that women from villages with any microfinance scheme showed similar increases in their body mass index to women from neighbouring villages without microfinance.⁴³ In another study, the prevalence of stunting was found to be higher (84.6%) among children of poor non-members than among the children of BRAC members (67.3%) or rich non-members (69.4%).⁴⁴ Weight-for-height *z*-scores of children aged 24–35 months from BRAC households were significantly higher ($P < 0.05$) than those of their counterparts from control households.⁴⁴ The final higher quality study found no significant differences between BRAC households and non-member households in terms of three other indicators of nutritional status in children and women.⁴⁵

We included four lower quality studies relating to nutrition in our systematic review: one each from Ethiopia, Ghana, India and Peru. Various outcomes were measured, including: women's and children's body mass indexes, anthropometry, food security, food consumption and haemoglobin. Findings were mixed, with some schemes showing benefits for microfinance members and others showing no effects.^{26,27,46–48} Two studies – one with

unadjusted selection bias – found that improvements in several empowerment variables were associated with microfinance membership.^{46,48}

Well-being and health-care use

One higher quality study evaluated the Indian Self Help Groups scheme and found that membership was associated with significant reductions in emotional stress and significant increases in the use of health care.⁴⁹ A beneficial spillover effect was also noted for non-participants who lived in a household with a member. No associations were found between participation and self-assessed health or exposure to health risks. This study excluded a socially marginalized group of women – i.e. Paniya women – because they were considered “prone to underestimate their health”. Women members used loans to help cover their health expenditures.⁵⁰

Two lower quality studies in Bangladesh revealed associations between microfinance membership and increases in emotional stress – but only for non-members in households that received loans⁵¹ – and use of maternal delivery care.⁴¹ A final study from Peru found that length of participation in a microfinance scheme had no association with women’s access to cancer screening or their number of sick days.²⁵

Discussion

Although we searched for evaluations of group-based microfinance schemes that covered any disadvantaged group in any country, all identified studies that met our inclusion criteria were concerned with the empowerment of poor women in low- or middle-income countries, mainly in Asia.

There is clear evidence of improvements in some important maternal and child health outcomes associated with membership of the long-established BRAC and Grameen Bank microfinance schemes in Bangladesh, including better child survival.^{21,22} and use of contraceptives.³¹ Results from studies, in a range of countries, on nutritional status and the general health of women who were members of schemes were equivocal. Membership of a microfinance scheme specifically for female sex workers in India was associated with decreases in sexually transmitted infections and increases in condom use during paid sex.³³ A complex picture emerges for the impact of microfinance on interpersonal violence. The evidence indicates that, while microfinance may eventually lead to a reduction in such violence, an initial increase may occur as gender norms are challenged. The most robust

study, a cluster-randomized controlled trial, showed that microfinance schemes can reduce the risk of physical or sexual violence by an intimate partner.³⁰

The few included studies that measured aspects of empowerment generally found improvements in empowerment associated with membership of the major schemes^{30–32,46,48} – though these did not necessarily translate into improved health outcomes.³² Others have warned that the provision of credit to women does not guarantee their control over the credit's use and may lead to excess anxiety over the pressure to pay back loans – diminishing, rather than increasing, any sense of empowerment.³⁰ The studies with a strong qualitative component provided some of the most convincing evidence of the role of empowerment in the creation of the beneficial effects of microfinance schemes. In the study of the South African Microfinance for AIDS and Gender Equity intervention, participants revealed how reductions in violence resulted from a range of responses – some linked to increasing confidence and empowerment of the women in handling potential flash points.³⁰ In Bangladesh, microfinance schemes can empower women by strengthening their economic roles, increasing their say over household decision-making and changing community norms.³²

We found no relevant studies that assessed the impact of microfinance schemes on ethnic inequalities in health. Some evidence did emerge on how microfinance schemes might help tackle socioeconomic and gender inequalities in health. Most notably, evaluations in Bangladesh indicated that the BRAC microfinance scheme may help to narrow the inequalities in health between boys and girls and the rich and poor.^{35,44} Such schemes may work not only through improvements in the economic status of the mothers who become members but also through cultural changes in the way girls are valued and nurtured, leading to additional gains for poor girls in relation to poor boys.

The potential for a microfinance scheme to have adverse health impacts was largely unexplored in the evaluations included in our review. Although there have been indications of increased violence between intimate partners as the result of the female empowerment promoted by microfinance, the most robust relevant studies have shown overall reductions in such violence, at least in the long term.^{30,37} The potential negative health impacts of microfinance schemes as a result of the debt stress associated with the repayment of loans have yet to be investigated in detail.^{11–14,52}

Research into the positive and negative impacts of microfinance schemes may be particularly challenging, not least because of the potential for selection bias of various forms.

Very few of the relevant studies we identified employed the most robust designs. There is a need for more high quality studies that employ appropriate designs that can cope with all of the complexity and potential confounding to be found in the settings in which microfinance schemes must operate. Few, if any, of the evaluations included in our review could disentangle the effects of the main microfinance scheme from those of additional health-promotion and/or health-care components. Even within the microfinance component, it is hard to disentangle the role of the empowerment strategy from that of the poverty-reduction component. Measurement of differential impacts by socioeconomic status is also rare but studies in Bangladesh have shown how this could be done and revealed its potential value.

In conclusion, group-based microfinance schemes represent perhaps the largest experiment in collective empowerment in the world to date. These schemes – and their potential impacts on both health and poverty – deserve close scrutiny. In terms of improvements in selected health outcomes, the evidence coming from the larger, long-established schemes is encouraging. Many questions remain, however, including the scale of the potential for microfinance schemes to do harm. These questions need to be addressed by appropriately designed evaluations that incorporate community-wide assessments of all potential impacts.

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Competing interests:

None declared.

References

1. Sengupta R, Aubuchon C. The microfinance revolution: an overview. *Federal Bank of St Louie Review*. 2008;90(1):9–30.
2. Ngo TMP, Whahhaj Z. Microfinance and gender empowerment. *J Dev Econ*. 2012;99(1):1–12. <http://dx.doi.org/10.1016/j.jdeveco.2011.09.003>
3. Leatherman S, Metcalfe M, Geissler K, Dunford C. Integrating microfinance and health strategies: examining the evidence to inform policy and practice. *Health Policy Plan*. 2012 Mar;27(2):85–101. <http://dx.doi.org/10.1093/heapol/czr014> PMID:21343235
4. Dworkin SL, Blankenship K. Microfinance and HIV/AIDS prevention: assessing its promise and limitations. *AIDS Behav*. 2009 Jun;13(3):462–9. <http://dx.doi.org/10.1007/s10461-009-9532-3> PMID:19294500
5. Caldas A, Arteaga F, Muñoz M, Zeladita J, Albuja M, Bayona J, et al. Microfinance: a general overview and implications for impoverished individuals living with HIV/AIDS. *J Health Care Poor Underserved*. 2010 Aug;21(3):986–1005. <http://dx.doi.org/10.1353/hpu.0.0326> PMID:20693740
6. Whitehead M, Pennington A, Orton L, Nayak S, Petticrew M, Sowden A, et al. How could differences in ‘control over destiny’ lead to socio-economic inequalities in health? A synthesis of theories and pathways in the living environment. *Health Place*. 2016 Mar 14;39:51–61. <http://dx.doi.org/10.1016/j.healthplace.2016.02.002> PMID:26986982
7. Adams J, Raymond F. Did Yunus deserve the Nobel Prize: microfinance or microfarce? *J Econ Issues*. 2008;42(2):435–43. <http://dx.doi.org/10.1080/00213624.2008.11507152>
8. Serrano-Cinca C, Gutierrez-Nieto B. Microfinance, the long tail and mission drift. *Int Bus Rev*. 2014;23(1):181–94. <http://dx.doi.org/10.1016/j.ibusrev.2013.03.006>
9. Nawaz S. Microfinance and poverty reduction: evidence from a village study in Bangladesh. *J Asian Afr Stud*. 2010;45(6):670–83. <http://dx.doi.org/10.1177/0021909610383812> PMID:21174878
10. Mersland R, Strom R. Microfinance mission drift? *World Dev*. 2009;38(1):28–36. <http://dx.doi.org/10.1016/j.worlddev.2009.05.006>
11. Hishigsuren G. Evaluating mission drift in microfinance: lessons for programs with social mission. *Eval Rev*. 2007 Jun;31(3):203–60. <http://dx.doi.org/10.1177/0193841X06297886> PMID:17478628
12. Ghalib A. How effective is microfinance in reaching the poorest? Empirical evidence in programme outreach in rural Pakistan. *J Bus Econ Manag*. 2013;14(3):467–80. <http://dx.doi.org/10.3846/16111699.2011.639796>
13. Bateman M. The role of microfinance in contemporary rural development finance policy and practice: imposing neoliberalism as “best practice”. *J Agrar Change*. 2012;12(4):587–600. <http://dx.doi.org/10.1111/j.1471-0366.2012.00376.x>

14. Taylor M. The antinomies of “financial inclusion”: debt, distress and the workings of Indian microfinance. *J Agrar Change*. 2012;12(4):596–605.
<http://dx.doi.org/10.1111/j.1471-0366.2012.00377.x>
15. Centre for Reviews and Dissemination. *Systematic reviews: CRD’s guidance for undertaking reviews in health care*. York: University of York; 2009.
16. Lorenc T, Petticrew M, Whitehead M, Neary D, Clayton S, Wright K, et al. Environmental interventions to reduce fear of crime: systematic review of effectiveness. *Syst Rev*. 2013;2(1):30. <http://dx.doi.org/10.1186/2046-4053-2-30> PMID:23663285
17. Mays N, Pope C. Qualitative research in health care. Assessing quality in qualitative research. *BMJ*. 2000 Jan 1;320(7226):50–2.
<http://dx.doi.org/10.1136/bmj.320.7226.50> PMID:10617534
18. Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *J Health Serv Res Policy*. 2005 Jul;10 Suppl 1:6–20.
<http://dx.doi.org/10.1258/1355819054308576> PMID:16053580
19. Popay J, Baldwin S, Arai L, Britten N, Petticrew M, Rogers M. *Narrative synthesis in systematic reviews*. Lancaster: Lancaster University; 2006.
20. Welch V, Petticrew M, Tugwell P, Moher D, O’Neill J, Waters E, et al.; PRISMA-Equity Bellagio group. PRISMA-Equity 2012 extension: reporting guidelines for systematic reviews with a focus on health equity. *PLoS Med*. 2012;9(10):e1001333. <http://dx.doi.org/10.1371/journal.pmed.1001333> PMID:23222917
21. Bhuiya A, Chowdhury M. Beneficial effects of a woman-focused development programme on child survival: evidence from rural Bangladesh. *Soc Sci Med*. 2002 Nov;55(9):1553–60. [http://dx.doi.org/10.1016/S0277-9536\(01\)00287-8](http://dx.doi.org/10.1016/S0277-9536(01)00287-8) PMID:12297241
22. Bhuiya A, Chowdhury M, Ahmed AU. Bangladesh: an intervention study of factors underlying increasing equity in child survival. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging inequities in health: from ethics to action*. Oxford: Oxford Scholarship Online; 2001.
23. E-Nasreen H, Bhuiya A, Ahmed AU, Chowdhury M. Women focused development intervention reduces neonatal mortality in rural Bangladesh: a study of the pathways of influence. College Park: Center for International Policy Exchanges; 2006. Available from:
http://www.umdcipe.org/conferences/policy_exchanges/conf_papers/Papers/2411.pdf [cited 2016 May 23].
24. Ahmed SM, Adams AM, Chowdhury M, Bhuiya A. Gender, socioeconomic development and health-seeking behaviour in Bangladesh. *Soc Sci Med*. 2000 Aug;51(3):361–71. [http://dx.doi.org/10.1016/S0277-9536\(99\)00461-X](http://dx.doi.org/10.1016/S0277-9536(99)00461-X) PMID:10855923
25. Hamad R, Fernald LC. Microcredit participation and women’s health: results from a cross-sectional study in Peru. *Int J Equity Health*. 2015;14(14):62.
<http://dx.doi.org/10.1186/s12939-015-0194-7> PMID:26242582

26. Moseson H, Hamad R, Fernald L. Microcredit participation and child health: results from a cross-sectional study in Peru. *J Epidemiol Community Health*. 2014 Dec;68(12):1175–81. <http://dx.doi.org/10.1136/jech-2014-204071> PMID:25180005
27. Hamad R, Fernald LCH. Microcredit participation and nutrition outcomes among women in Peru. *J Epidemiol Community Health*. 2012 Jun;66(6):e1. <http://dx.doi.org/10.1136/jech.2010.108399> PMID:21051776
28. Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C, et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet*. 2006 Dec 2;368(9551):1973–83. [http://dx.doi.org/10.1016/S0140-6736\(06\)69744-4](http://dx.doi.org/10.1016/S0140-6736(06)69744-4) PMID:17141704
29. Pronyk PM, Kim JC, Abramsky T, Phetla G, Hargreaves JR, Morison LA, et al. A combined microfinance and training intervention can reduce HIV risk behaviour in young female participants. *AIDS*. 2008 Aug 20;22(13):1659–65. <http://dx.doi.org/10.1097/QAD.0b013e328307a040> PMID:18670227
30. Kim JC, Watts CH, Hargreaves JR, Ndhlovu LX, Phetla G, Morison LA, et al. Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. *Am J Public Health*. 2007 Oct;97(10):1794–802. <http://dx.doi.org/10.2105/AJPH.2006.095521> PMID:17761566
31. Schuler SR, Hashemi SM. Credit programs, women's empowerment, and contraceptive use in rural Bangladesh. *Stud Fam Plann*. 1994 Mar-Apr;25(2):65–76. <http://dx.doi.org/10.2307/2138085> PMID:8059447
32. Schuler SR, Hashemi SM, Riley AP. The influence of women's changing roles and status in Bangladesh's fertility transition: evidence from a study of credit programs and contraceptive use. *World Dev*. 1997;25(4):563–75. [http://dx.doi.org/10.1016/S0305-750X\(96\)00119-2](http://dx.doi.org/10.1016/S0305-750X(96)00119-2)
33. Souverein D, Euser SM, Ramaiah R, Narayana Gowda PR, Shekhar Gowda C, Grootendorst DC, et al. Reduction in STIs in an empowerment intervention programme for female sex workers in Bangalore, India: the Pragati programme. *Glob Health Action*. 2013;6(0):22943. <http://dx.doi.org/10.3402/gha.v6i0.22943> PMID:24378194
34. Amin R, Li Y, Ahmed AU. Women's credit programs and family planning in rural Bangladesh. *Int Fam Plan Perspect*. 1996;22(4):158–62. <http://dx.doi.org/10.2307/2950813>
35. Amin R, Li Y. NGO-promoted women's credit program, immunization coverage, and child mortality in rural Bangladesh. *Women Health*. 1997;25(1):71–87. http://dx.doi.org/10.1300/J013v25n01_05 PMID:9253139
36. Desai J, Tarozzi A. Microcredit, family planning programs, and contraceptive behavior: evidence from a field experiment in Ethiopia. *Demography*. 2011 May;48(2):749–82. <http://dx.doi.org/10.1007/s13524-011-0029-0> PMID:21506020
37. Schuler SR, Hashemi SM, Riley AP, Akhter S. Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Soc Sci Med*. 1996

Dec;43(12):1729–42. [http://dx.doi.org/10.1016/S0277-9536\(96\)00068-8](http://dx.doi.org/10.1016/S0277-9536(96)00068-8)
[PMID:8961417](http://pubmed.ncbi.nlm.nih.gov/8961417/)

38. Chin YM. Credit program participation and decline in violence: does self-selection matter? *World Dev.* 2012;40(8):1690–9. <http://dx.doi.org/10.1016/j.worlddev.2012.04.003>
39. Ahmed SM. Intimate partner violence against women: experiences from a woman-focused development programme in Matlab, Bangladesh. *J Health Popul Nutr.* 2005 Mar;23(1):95–101. [PMID:15884757](http://pubmed.ncbi.nlm.nih.gov/15884757/)
40. Dalal K, Dahlström O, Timpka T. Interactions between microfinance programmes and non-economic empowerment of women associated with intimate partner violence in Bangladesh: a cross-sectional study. *BMJ Open.* 2013;3(12):e002941. <http://dx.doi.org/10.1136/bmjopen-2013-002941>
[PMID:24319278](http://pubmed.ncbi.nlm.nih.gov/24319278/)
41. Dalal K, Shabnam J, Andrews-Chavez J, Mårtensson LB, Timpka T. Economic empowerment of women and utilization of maternal delivery care in Bangladesh. *Int J Prev Med.* 2012 Sep;3(9):628–36. [PMID:23024852](http://pubmed.ncbi.nlm.nih.gov/23024852/)
42. Bajracharya A, Amin S. Microcredit and domestic violence in Bangladesh: an exploration of selection bias influences. *Demography.* 2013 Oct;50(5):1819–43. <http://dx.doi.org/10.1007/s13524-013-0226-0> [PMID:23839101](http://pubmed.ncbi.nlm.nih.gov/23839101/)
43. Imai KS, Azam MS. Does microfinance reduce poverty in Bangladesh? New evidence from household panel data. *J Dev Stud.* 2012;48(5):633–53. <http://dx.doi.org/10.1080/00220388.2012.661853>
44. Khatun M, Stenlund H, Hörnell A. BRAC initiative towards promoting gender and social equity in health: a longitudinal study of child growth in Matlab, Bangladesh. *Public Health Nutr.* 2004 Dec;7(8):1071–9. <http://dx.doi.org/10.1079/PHN2004652> [PMID:15548346](http://pubmed.ncbi.nlm.nih.gov/15548346/)
45. Jalal CSB, Frongillo EA. Effect of poverty reduction program on nutritional status of the extreme poor in Bangladesh. *Food Nutr Bull.* 2013 Dec;34(4):402–11. <http://dx.doi.org/10.1177/156482651303400405> [PMID:24605690](http://pubmed.ncbi.nlm.nih.gov/24605690/)
46. Deininger K, Liu YY. Economic and social impacts of an innovative self-help group model in India. *World Dev.* 2013;43:149–63. <http://dx.doi.org/10.1016/j.worlddev.2012.09.019>
47. Doocy S, Teferra S, Norell D, Burnham G. Credit program outcomes: coping capacity and nutritional status in the food insecure context of Ethiopia. *Soc Sci Med.* 2005 May;60(10):2371–82. <http://dx.doi.org/10.1016/j.socscimed.2004.10.025> [PMID:15748684](http://pubmed.ncbi.nlm.nih.gov/15748684/)
48. Mknelly B, Dunford C. Impact of credit with education on mothers and their young children's nutrition. *Davis: Freedom from Hunger;* 1998.
49. Mohindra K, Haddad S, Narayana D. Can microcredit help improve the health of poor women? Some findings from a cross-sectional study in Kerala, India. *Int J Equity Health.* 2008;7(1):2. <http://dx.doi.org/10.1186/1475-9276-7-2>
[PMID:18186918](http://pubmed.ncbi.nlm.nih.gov/18186918/)

50. Mohindra KS. On poverty and health: an interventionist perspective; a study of women microcredit groups in Kerala, India. Ann Arbor: ProQuest Information & Learning; 2008.
51. Ahmed SM, Chowdhury M, Bhuiya A. Micro-credit and emotional well-being: Experience of poor rural women from Matlab, Bangladesh. World Dev. 2001;29(11):1957–66. [http://dx.doi.org/10.1016/S0305-750X\(01\)00069-9](http://dx.doi.org/10.1016/S0305-750X(01)00069-9)
52. Van Rooyen C, Stewart R, de Wet T. The impact of microfinance in sub-Saharan Africa: a systematic review of the evidence. World Dev. 2012;40(11):2249–62. <http://dx.doi.org/10.1016/j.worlddev.2012.03.012>

Box 1. Microfinance schemes based on collective empowerment

Roughly 5 million poor rural women in Bangladesh are involved in microcredit programmes, most of them associated with the BRAC or Grameen Bank microfinance schemes.

The BRAC scheme is designed for women living in poor and landless households. It involves the formation of women's groups for saving and credit, training and skills development, functional literacy – including legal and social awareness – and technical and marketing support. Money saved by a group is used to make loans to group members to support income-generation activities such as cottage industries and goat rearing. Sometimes these elements are combined with so-called bolt-on public health components such as the promotion of maternal and child health or family planning.

The main aims of the scheme are to reduce women's economic dependence on men, strengthen their positions within their families, draw them into the public sphere and expose them to new ideas and education. The theory is that the scheme may influence health in many different ways – e.g. it may increase demand for family planning services and reduce the social costs of fertility regulation, leading to fewer, healthier children and better maternal health. It may also lead to improvements in the care and nutrition of children and so reduce child mortality in general and, particularly, the high rates recorded among girls.

Box 2. Embase, MEDLINE, MEDLINE In-Process, PsycINFO and Social Policy & Practice search strategy

Titles and abstracts of articles published between 1 January 1980 and 29 February 2016 were searched for the following terms: “micro-credit\$”, “microcredit\$”, “micro credit\$”, “micro-finance\$”, “microfinance\$”, “micro finance\$”, “microsaving\$”, “micro-saving\$”, “micro saving\$”, (Bangladesh and BRAC), (IMAGE adj2 (scheme or intervention or initiative)), Pragati, “Bangladesh Rural Advancement Committee”, “Grameen Bank” and “credit union”.

Box 3. Social Sciences Citation Index and Conference Proceedings Citation Index search strategy

Titles and abstracts of articles published between 1 January 1980 and 29 February 2016 were searched for the following terms: “micro-credit\$”, “microcredit\$”, “micro credit\$”, “micro-finance\$”, “microfinance\$”, “micro finance\$”, “microsaving\$”, “micro-saving\$”, “micro saving\$”, IMAGE adj2 (scheme or intervention or initiative)), Pragati, “Bangladesh Rural Advancement Committee”, “Grameen Bank”, “credit union” and (Bangladesh and BRAC).

Table 1. Summary of the studies included in the systematic review of group-based microfinance schemes

Study no.	Publication	Country and study design	Follow-up period	Intervention and target population	Study participants	Comparison group(s)	Outcome measures	Quality ^a
1	Bhuiya and Chowdhury ²¹	Bangladesh, controlled before-and-after study	1988–1992 and 1993–1997	BRAC, ^b poor women	13 549 children of poor women	Children of poor non-members and children of rich non-members	Infant and childhood mortality rates, recorded as survival status on set date for two birth cohorts	Higher
2	Bhuiya et al. ²²	Bangladesh, controlled before-and-after study	1982–1996	BRAC, poor women	Children of poor women from 12 000 households	Children of poor non-members	Childhood mortality rates, recorded as cumulative child survival probability by household	Higher
3	E-Nasreen et al. ²³	Bangladesh, case-control and qualitative case studies	NA	BRAC, poor women	117 neonates born 1999–2000 who died within first 28 days of life	Live children	Neonatal death	Lower
4	Ahmed et al. ²⁴	Bangladesh, post-intervention study	NA	BRAC, poor women	Poor women from 3817 households	Non-member households that met eligibility for BRAC, and rich non-eligible households	Self-reported illness episodes over last 15 days and health-seeking behaviour	Lower
5	Hamad and Fernald ²⁵	Peru, post-intervention study	NA	PRISMA, ^c poor households	1593 adult female members	Long-duration members and short-duration members	Depressive symptoms, contraceptive use, cancer screening: in last year, self-reported days sick in last month	Lower
	Moseson et al. ²⁶				511 adult female members and 596 of their children aged < 5 years	Long-duration members and short-duration members	Child length-for-age, weight-for-age, anaemia, questions on respiratory infections and diarrhoea in child last 6 months, food security	Lower
	Hamad and Fernald ²⁷				1593 adult female members	Long-duration members and short-duration members	Age-adjusted BMI, haemoglobin levels and food insecurity	Lower
6	Pronyk et al. ²⁸	South Africa, cluster-RCT with qualitative component	2 years	IMAGE, ^d poor women	5156 residents of intervention villages aged 14–35 years	Matched controls from waiting-list villages	Rate of unprotected sex: occurrence at last intercourse with a non-spousal partner in past 12 months, HIV incidence	Highest

	Pronyk et al. ²⁹				220 female members aged 14–35 years	Matched controls from waiting-list villages	HIV-related communication, access to voluntary counselling and testing, rate of unprotected sex at last intercourse with non-spousal partner	Highest
	Kim et al. ³⁰				860 women from intervention villages, as 430 matched pairs of members and non-members	Matched controls from waiting-list villages	Physical and sexual violence by spouse or other intimate partner within last year, women's empowerment	Highest
7	Schuler and Hashemi ³¹	Bangladesh, controlled before-and-after study with ethnographic component	Single time-points in 1991 and 1993	BRAC and Grameen Bank, ^g poor women	1305 poor rural married women aged < 50 years	Eligible non-members and non-eligible non-members	Respondent or partner currently using any form of contraception	Higher
	Schuler et al. ³²				1305 poor rural married women aged < 50 years	Eligible non-members and non-eligible non-members	Relative mobility, economic security, ability to make purchases, freedom from domination and violence, political and legal awareness, participation in political spheres	Higher
8	Souverein et al. ³³	India, longitudinal study	2005–2008	Pragati, ^f female sex workers	20 330 female sex workers	No comparator – women followed up from first point of contact with scheme until last point of reported contact	STI incidence from syndromic surveillance data, condom use at last paid sex	Higher
9	Amin et al. ³⁴	Bangladesh, post-intervention study	NA	5 small or medium-sized credit NGOs that adopted loan system of Grameen Bank, NS	3564 rural women, aged < 50 years	Non-loanees from NGO areas and women from non-NGO areas	Current contraceptive use, freedom to manage household expenses, autonomy in movement, authority in family affairs	Lower
	Amin and Li ³⁵				3564 rural women, aged < 50 years	Non-loanees from NGO areas and women from non-NGO areas	Child immunization, infant and child mortality rate	Lower

10	Desai and Tarazi ³⁶	Ethiopia, controlled before-and-after study	2003–2006	Two credit schemes combined with family planning activities, poor women	6440 women aged 15–49 years from poor households	Just the family planning component and just the credit component	Contraceptive use	Lower
11	Schuler et al. ³⁷	Bangladesh, controlled before-and-after study with ethnographic component	Single time-points in 1991 and 1993	BRAC and Grameen Bank, poor women	1305 poor rural married women aged < 50 years	Eligible non-members and non-eligible non-members	Physical beating by husband in last year, relative mobility, economic security, ability to make purchases, freedom from domination and violence, political and legal awareness, participation in political spheres	Higher
12	Chin ³⁸	Bangladesh, post-intervention study	NA	BRAC, BRDB and Grameen Bank schemes, NS	1843 rural women	Eligible non-members and non-eligible non-members	Spousal violence directed at women – ever and in last year	Lower
13	Ahmed ³⁹	Bangladesh, post-intervention study	NA	BRAC, poor women	2044 poor women who were or had been married	Non-member households that met eligibility for BRAC	Violence against women from their husbands in preceding 4 months	Lower
14	Dalal et al. ⁴⁰	Bangladesh, post-intervention study	NA	BRAC, BRDB, Grameen Bank, PROSHIKA or any microcredit organization, NS	4465 women aged 15–49 years who were or had been married	Non-members	Moderate physical, severe physical, sexual and any interpersonal violence in last year, economic empowerment	Lower
	Dalal et al. ⁴¹				4925 women aged 15–49 years who were or had been married	Non-members	Last delivery at home without skilled birth attendant or with institutional delivery services, economic empowerment	Lower
15	Bajracharya and Amin ⁴²	Bangladesh, post-intervention study	NA	BRAC, BRDB, Grameen Bank, PROSHIKA or any microcredit organization, NS	4195 married women aged 15–49 years	Matched non-members	Physical and sexual against women by their husbands in last year	Lower

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16	Imai and Azam ⁴³	Bangladesh, household panel survey	1997–1998, 1998–1999, 1999–2000 and 2004–2005	Any microfinance scheme, NS	Women from > 3000 households in 91 intervention villages	Women from neighbouring villages without microfinance	BMI	Higher
17	Khatun et al. ⁴⁴	Bangladesh, controlled before-and-after study	3 time-points in 1995–1996	BRAC, poor women	576 children of poor women, aged 6–72 months	Children of poor non-members and children of rich non-members	Stunting, recorded as height-for-age compared with reference median	Higher
18	Jalal and Frongillo ⁴⁵	Bangladesh, controlled before-and-after study	3 time-points in 1995–1996	BRAC-based CFPR-TUP initiative, poor women	3551 women and 4131 children from households with child aged 6–60 months	Children and women from non-member households	Nutritional status of women and pre-school children	Higher
19	Deininger and Liu ⁴⁶	India, pipeline comparison of current and future members	NA	Indhira Kranthi Patham programme, ^g poor women	Poor women from 1964 households	People who later joined programme when it came to their village	Energy intake, protein intake and food consumption over last 30 days, social capital, economic empowerment, political empowerment	Higher
20	Doocy et al. ⁴⁷	Ethiopia, post-intervention study	NA	WISDOM World Vision Microfinance Institution, ^h poor households	Clients from 819 rural households and their children aged 6–59 months	Similar incoming clients and community controls	Arm circumference	Lower
21	MkNelly and Dunford ⁴⁸	Ghana, repeat cross-sectional study	1993–1996	Credit with Education scheme, poor rural households	308 mother-and-child pairs from poor rural households that had participated in scheme for at least 1 year, with each child aged < 3 years	Non-participants in microfinance areas and waiting-list controls	Child's weight-for-age and height-for-age plus maternal BMI, self-confidence, vision for the future, status and bargaining power within the household, status and networks in the community	Lower

22	Mohindra et al. ⁴⁹	India, post-intervention study	NA	Self-help groups, poor women	928 poor women aged 18–59 years	Women who had been members for > 2 years, women who had been members for < 2 years, non-members living in house with a member and non-members living in a house without a member	Self-assessed physical and mental health, exclusion from health care in last year, whether or not husband is sole decision-maker	Lower
	Mohindra ⁵⁰				928 poor women aged 18–59 years	Women who had been members for > 2 years, women who had been members for < 2 years, non-members living in house with a member and non-members living in a house without a member	NA	Higher
23	Ahmed et al. ⁵¹	Bangladesh, post-intervention study	NA	BRAC, poor women	Poor women, from 3 624 households, who were or had been married	Non-member households that met eligibility for BRAC and rich non-eligible households	Three specific questions about emotional stress and its consequences	Lower

ASA: Association for Social Advancement; BMI: body mass index; BRDB: Bangladesh Rural Development Board; CFPR-TUP: Challenging the Frontiers of Poverty Reduction – Targeting Ultra Poor; HIV: human immunodeficiency virus; IMAGE: Intervention with Microfinance for AIDS and Gender Equity; NGO: nongovernmental organization; NA: not applicable; NS: not specified; RCT: randomized controlled trial; STI: sexually transmitted infection.

^a Assessed using procedures tailored to social interventions in community contexts.¹⁶

^b The aims of the BRAC scheme are to improve health and socioeconomic condition through group formation, skill training and collateral-free loans for income-generating activities.

^c Scheme based on loan groups run by a nongovernmental organization.

^d Includes a large health promotion component related to human immunodeficiency virus.

^e The Grameen Bank is a bank for poor rural people that focuses on women.

^f Multicomponent microfinance scheme with empowerment approach.

^g Largely based on the creation of self-help groups.

^h Promotes community banking and solidarity group lending.

Fig. 1. **Flowchart showing the selection of studies on group-based microfinance schemes**

