Summer Training at
Urban Health Resource Centre,
Agra

To Study the Microcredit in Urban Slum of Agra City

By
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Under the guidance of
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MBA Hospital and Health Management
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The IIHMR University, Jaipur
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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr. Sampan Rattan** student of **MBA Hospital and Health Management** from the IIHMR University; Jaipur has undergone summer training at **Urban Health Resource Centre, Agra** from 1st April to 10th June, 2016.

The candidate has successfully carried out the study designated to her during summer training and her approach to the study has been sincere, scientific & analytical.

The internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours.

Col. (Dr.) Ashok Kaushik
Dean (Academics & Student Affairs)
IIHMR University, Jaipur

Dr. Mohan Lal Bairwa
Assistant Professor
IIHMR University, Jaipur

URBAN HEALTH RESOURCE CENTRE

Certificate of Internship

This is to certify that Dr. Sampan Rattan interned with Urban Health Resource Centre (UHRC), Agra from 1st April, 2016 to 1st June, 2016. Her work involved compilation of data from records of UHRC mentored slum women's groups, which included participation in meetings of women's groups.

Her work was satisfactory.

UHRC wishes her all the best for a bright future.

Siddharth Agarwal

Dr. Siddharth Agarwal

(Executive Director, UHRC New Delhi).

Maya Ram

Mr. Maya Ram Sharma

(City Program In-charge UHRC, Agra)

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ACKNOWLEDGEMENT

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I would like to express my deep sense of gratitude to my mentor at college, Mr.NirmalGurbani, and Dr. Mohan Lal Bairwa for their counsel. Without their unwavering and continuous guidance this project would have been but a thought.

A special thanks to Mr. Siddharth Agarwal, president of UHRC for allowing me to pursue my summer training from his esteem organization in Agra. He has been so helpful all the time and making this summer training an unforgettable experience.

I'm deeply in debt to Mr. Mayaram Sharma, Mr. Shyam Dhakreand Mr. Chalbihariof the field coordination team for guiding me throughout my field visits.

Finally and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents for their blessings and my brother and friends for their help and wishes for the successful completion of this training.

ABBREVIATIONS

UHRC- Urban health resource center

UHP- Urban Health Program

USAID -United States Agency for International Development

HIV- Human immune virus

AIDS- Acquired immunodeficiency virus

T.B – tuberculosis

EHP- Environmental health program

MDGs- Millennium developmental goals

SDGs- Sustainable Development Goals

AWCs- Anganwadi centers

NGOs- Non-governmental organizations

NIRPHAD- Naujhil Integrated Rural Project for Health Development

BRAC- Bangladesh Rural Advancement Committee

BRDB- Bangladesh Rural Development Board

JSY- Janini Suraksha Yojana

Rs.- Rupees

K.m. - Kilometer

BACKGROUND

UHRC is a non-profit nongovernmental organization which working to bring sustainable improvement in the health conditions of the urban poor by influencing programs and policies, thereafter empowering the slum communities. Urban Health Resource Centre further addresses health, nutrition and wellbeing of the backward urban dwellers through demonstration of programs, provide technical support to government and non-government sector, research, advocacy and knowledge dissemination through a consultative and partnership based approach.

Urban Health Resource Centre implements demonstration of health programs in sundry cities like Indore, Agra, North-East Delhi such that these programs may be adapted, replicated and up-scaled by government and non-governmental agencies.

Origin and History

To meet the health challenges faced by the growing urban poor population inIndia, USAID/India launched a new Urban Health Program (UHP) activity in March 2002 which was based on strategic planning decisions made in 2000-2001. While health activities in HIV/AIDS, TB, polio, or social marketing activities contribute to UHP objectives, initial UHP implementation has primarily been through the USAID Environmental Health Project (EHP), which was scheduled for completion at the end of October 2005. While preparing the EHP Delhi office began the transition of becoming a not-for-profit NGO, the Urban Health Resource Centre (UHRC).

In practical terms, the program began activities on 15 March 2002 when Dr. Siddharth Agarwal joined as country representative of the USAID Environmental Health Project (EHP). Through the main components of the Urban Health Program were implemented through October 2005, and a project office was opened soon thereafter, Urban Health Resource Centre (UHRC). Initial city-level activities began in the city of Indore.

VISION OF UHRC

“Our vision is an urban India were every resident enjoys optimal health and well-being, Realizes his/her full potential and contributes to the nation’s growth and development”

MISSION OF UHRC

“The mission of Urban Health Resource Centre is to bring about sustainable improvements in the health conditions of the urban poor by influencing policies and programmes and empowering the community.”

Main Objectives of the Organization are to:

1. Develop innovative urban health programmes in cities of different sizes which can be adapted by the government and non-government agencies.
2. Strengthen Urban Health programming approaches and capacities at different levels among the Government and Non- Government partners.
3. Increase availability of urban poor specific health information and programme experiences among various stakeholders through research, documentation and dissemination.
4. Advocate enhanced attention on urban health, targeted policies and increased allocation of resources for slum dwellers.
5. Demonstrate and advocate for empowerment of slum communities, especially women as a means to achieve and sustain improvements in health care.

Current field programs include:

a. Women’s empowerment, enhancing negotiation skills and improving access to services through training the self-help groups in Indore and Agra;
b. “Gender Resource Centre” and Enhancing Negotiation Skills of Community Volunteers in North-east Delhi;
c. District Resource Centre in North District, Delhi

d. Technical support to Government of Uttarakhand where State Health and Family Welfare Society in partnership with five NGOs is working on urban health program serving urban slums in four cities - Dehradun, Haridwar, Haldwani and Roorkee This program included facilitation of partnership including MoUs with NGOs, developing urban health plan for the four cities and city maps, development of practical guides/'How-to-modules' on different aspects of programming, thematic strategy documents and conducting capacity building workshops and even study tour to Agra program.

UHRC focuses on strengthening the social fabric in slums and address gender inequity, there is a intensive effort towards empowering slum-level women's groups and their federations, developing community-based health and building capacity of slum women to enable them take charge of processes that affect their health, nutrition and wellbeing and even of their families. Through empowered community groups, coordination with providers and synergizing hard work of stakeholders, programs that facilitate access of services and entitlements to the vulnerable, socially backward sections of society. These demonstration programs have provided valuable learning for the future operational aspects of training and utilizing services of health volunteers, enlisting involved NGOs in social mobilization, service delivery, and training women's groups to follow health coverage and manage health funds for the improvement of health in the slum areas.

UHRC IN AGRA

In 2004, UHRC under the funding of USAID, was designated by the Government of India as the coordinating agency for developing a sample health proposal for Agra city. The proposal was to guide the district health department and Municipal Corporation to expand health services to the large urban poor population in Agra. For this purpose the UHRC recruited and trained the community link volunteers (CLVs) to provide health information, counseling to slum women and mobilize the community and provide logistical support during health events such as outreach camps. Thereby leading to the formation of:-

1. Federations of women's groups:
    a. Parivartan Mahila Shahri Swasthya Samiti, Garhi Chandani
    b. Bhartiya Mahila Vikas Samiti, Narayich
    c. Vishal Shahri Mahila Vikas Saamiti, Ramnagar
    d. Chetna Mahila Vikas Samiti, Shyam Nagar
2. 50 Basti based Mahila Aroygya Samitis (Women's Health Groups) comprising10-15 active women in each slum were formed and strengthened by the activities of the NGOs.

Even though after withdrawal of the financial assistance of USAID, the organization continues with its work of training the above formed self-help groups (finance). These groups organize monthly meetings, which are platforms for discussing their health concerns and planning for outreach activities. In these monthly meetings members make small regular savings contributions and even provide micro-credits to people for any purpose especially for health costing burden.

MICROFINANCE

“Microfinance refers to small-scale financial services for both credits and deposits — that are provided to people who farm or fish or herd; operate small or microenterprises where goods are produced, recycled, repaired, or traded; provide services; work for wages or commissions; gain come from renting out small amounts of land, vehicles, draft animals, or machinery and tools; and to other individuals and local groups in developing countries, in both rural and urban areas.” A good definition of microfinance is provided by Robinson.

Microfinance is a type of banking service that is provided to unemployed or low-income individuals or groups who would or else have no other resources of gaining/acquisition financial services; it is basically a source of fiscal assistance for those who lack access to funding and related services. Microfinance is the provision of financial benefits to where low-income households are able to have permanent access to better quality and affordable financial services to income-producing activities, build assets, stabilize consumption, and protect against risks. Initially the term “microfinance” was closely associated with “microcredit”, very small loans to unsalaried borrowers with little or no collateral but now the term “microfinance” has since evolved to include a range of economical products, such as savings, insurance, payments, and remittances. The World Bank estimates that more than 500 million people who have directly or indirectly benefited from the support of microfinance-related operations.

WHO NEEDS MICROFINANCE

- Low Income individuals
- Employment in informal sector
- Low wage category cohort
- Lack of physical guarantee
- Closely interlinked household/business activities

Microfinance clients are basically low incomes and often self-employed in the informal economy, who are typically denied access to banks and other formal financial institutions. The microfinance clients are people who commonly run small stores or street stalls, create and sell items they make in their homes, they may be small-scale farmers and those who process or trade

crops and goods. Microfinance clients are often people who earn just below or above the poverty line, which is an earnings of US$1.25 a day. In these microfinance clients often women constitute a majority of borrowers.

UTILITY OF MICROFINANCE / GOALS OF MICROFINANCE

The goals of microfinance are:-

- Eradication of extreme Poverty & Hunger.
- Attainment of universal Education.
- Promoting gender equality and women's empowerment.
- Reduction of child mortality
- Combat against all diseases
- Develop entrepreneurial spirit

One of the realities of life for poor is that income may be irregular and undependable of poor people. People living below the poverty line need to access a wide range of monetary products and services that are tailored to their circumstances. Financial services can help people build assets through savings or funding income-generating activities, and can make it easier for them to manage shocks, such as medical emergencies, death, theft, or natural disasters. The problem remains that low-income people pay sometimes pay higher costs and rely on insecure, unpredictable, and unscrupulous options to access basic financial products and services, which is why the financial assistance is striving to encourage the delivery of a full range of financial products at fair prices and with minimizing the risks poor people face today.

COMPONENTS OF MICROFINANCE

Microfinance is not merely micro-credits but it also constitutes of micro-savings and micro-insurance, which form an integral part of micro-financing. Microfinancing has extended itself from microloans to saving and insurance for the financial assistance for poor and enables them for a better quality of living.

MICROSAVINGS

A branch of microfinance, consisting of a small deposit account recommended to lower income families or individuals as an incentive to accumulate funds for future use. Micro savings accounts work in similar fashion as a normal savings account, however, are designed around smaller amounts of money. The minimum amount of balance required are often waived or very low, thereafter users are able to save small amounts of money and typically no charges for the service are taken. Micro savings are usually a way to encourage saving for education or other future investment. It prepares people to cope with any unforeseen expenses, which would usually harm lower income folks. Micro savings assure self-protection to reduce the probability of a hazard materializing through diversifying livelihoods, developing assets (e.g. making housing weather- and crime-proof) and building human capital (gaining qualifications, protecting health).

MICRO INSURANCE

A type of insurance that is defined by low premiums and low coverage that are catered to individuals that cannot afford for other expensive insurance plans. Micro insurance products that provide coverage to low-income households. A microinsurance plan ministers protection to individuals who have little savings and is modified specifically for lower valued assets and compensate for illness, injury or death. So basically microinsuranceis the protection of low-income people against specific perils in exchange for regular premium payment which is proportionate to the likelihood and cost of the future risks involved. Microinsurance, like regular insurance offers for a wide variety of risks that may occur in future. These future risks include both health risks (illness, injury, or death) and property risks (damage or loss). A wide variety of micro insurance products exist which includes crop insurance, livestock/cattle insurance, insurance for theft or fire, insurance for natural disasters, health insurance, death insurance, disability insurance, term life insurance, etc.

MICROCREDIT

It is also called as "micro lending" or "microloan". Microcredit is the concept of providing small loans to poor families and it has been widely attributed to Muhammad Yunus and his work with

the Grameen Bank which started in 1976. Microcredit became popular in the 1970s and 1980s through the Grameen Bank. So microcredit is an extremely small amount of loan given to impoverished people to help them. Microcredit is the extension of very small loans to poor borrowers who lack collateral, steady employment or a verifiable credit history. These are essentially small loans granted to the basic sectors, on the basis of the borrower's cash flow and other loans granted to the poor and low-income households for their financial assistance requirement which may be for microenterprises and small businesses to enable them to raise their income levels and improve their living standards. Research however demonstrates that microcredit is often used for a variety of purposes beyond business investment. Loans also aid people cope with unpredictable incomes by building funds available to meet their basic necessities and manage shocks like as death, illness and severe diseases.

WHICH INSTITUTION DELIVERS MICRO FINANCING SERVICES?

There are traditional operators such as microfinance institutions, credit unions, cooperatives, and banks, other entities, including mobile network operators, which bring these services to the poor, sometimes in partnership with existing financial institutions. Even then a microfinance client is not likely to be able to borrow from a large commercial bank for small amount but from an NGO microfinance institution or perhaps from a small rural or cooperative bank or from self-help groups (finance) in their neighborhood. Since microcredit are *typically unsecured* and for relatively short periods of time (6months to 1year) with monthly (or more frequent) amortizations of interest and principal, and require a joint or several guarantee of one or more persons.

MICROFINANCING AND HEALTH

Since poverty and ill-health are intertwined, the major factor denying healthcare to the vulnerable sections of the society is not affordable. Due to the escalation of healthcare costs and due to the inelastic nature of the fiscal resources there arises a necessity for alternative sources of financing health care, microfinacing to health care. The underprivileged use a variety of mechanism for financing direct health costs, most often borrowing, selling assets and avoiding health care which often results to negative consequences. Microfinance clients benefit from health-financing products such as health savings, health loans and health micro-insurance.

Every day thousands of microfinance workers travel to poor communities to provide microfinance services. These microfinance institutions are not only successful in offering services beyond business and financial management but an increasing number of them also offer health-related services, such as education, clinical care, and health financing (loans, savings and health insurance) to the extent of establishing linkages to public and private health providers to facilitate access to health care.

RATIONALE

As the world strives to achieve the MDGs "Health for all" one of the main challenge is to expand coverage to all, along with the protection from the costs of basic health services. Access to financial services is undeniably significant to poor families who have worse health outcomes and less accessible to health care compared to non-poor. This financial support can be through micro credits which are provided by private and government microfinance institution.

In addition to the direct costs of illness, there is also the loss of productive time for labor due to ill health or need to serve as caregiver for the sick family member further add to the burden of total health costs for poor families. Survey of many countries show that the range of non-user of health services is 20- 86 percent who avoid the treatment due to financial shortage or time constrains (Xu et al.2007; Chuma et al.2007; Russell 2004). According to the World Bank report, one of the major causes of poverty is illness (2002, Dying for Change).

There are numerous cases that confirm that access to microcredit at appropriate time improves children's health (Engle, 1995). Microcredit has also been known to lower infant mortality rates, death from diarrhea, increased immunization and nutrition level among children. Microfinance has benefited to women as well. There is seen an increase desire for health care, they seek birth attendants and tend to provide better nutrition for their children and themselves.

Pitt et al. looked at the consequence of Credit given by Grameen Bank, Bangladesh Rural Advancement Committee (BRAC) and Bangladesh Rural Development Board (BRDB) Rural Development program on the health status of children and women and found who were given a 10% credit increase, had a 6.25% increase in Mean Arm Circumference (MAC) in girls and also

increase in the height of girls and boys by 0.36 and 0.50 cm per year at the mean height. (Engle, 1995).

Microfinance protects against the pecuniary shocks of catastrophic illness. A California-based charity, Freedom from Hunger, in Benin and Burkina Faso found that 30% of the income generated was spent on combating against malaria. Microcredit to these families prevented them against the risk of sudden illness leading to bankruptcy and increases the willingness of individuals to seek for better health treatment.

Multiple studies show if Microfinance institutions provide health education along with financial services leads to behavioral change of individuals to health care practices. These behaviors are associated with positive health outcomes in diverse areas that are maternal and child health, and infectious disease and sexually transmitted diseases.

In Ghana, de la Cruz et al, saw that microfinance institutions effectively contributed to community and national malaria initiatives by disseminating knowledge and providing them microcredit for insecticide-treated bed net ownership and specially for the use by vulnerable members of the household (children under the age of five and pregnant women).

In Uganda, Barnes et al, establish that 32% of women getting education about HIV/AIDS prevention through the microcredit groups tried at least one of the HIV/AIDS prevention practice when compared to 18% of non-clients.

STATEMENT OF PROBLEM:

Does microcredit in health reduce the burden of illness, the associated costs and avoidable human suffering and is it being properly accepted and utilized in urban slums for improvement of health.

RESEARCH OBJECTIVES:

- Determine the individual behavior pattern for taking microcredit.
- Study demographic characteristics of individual taking health microloan.
- Study utilization pattern of health microcredit which are taken by beneficiaries.

RESEARCH QUESTIONS:

- Compare prevalence of micro credits taken for health reasons versus non-health reasons.
- Analyze demographic characteristics of individuals taking loan for healthcare.
- Evaluate the usage and different aspects of health micro loans.

METHODOLOGY

Study Design - Descriptive cross sectional study.

Study Locations- This study is done in slum areas of Agra district, Uttar Pradesh where the UHRC women federation are present. Federations of women's group area are Garhi Chandani, Narayich, Ram Nagar and Shyam Nagar.

Study Subjects - Subjects comprises of women population who have taken a microloan for health from Mahila Vikas Samiti from 1st Jan 2016 to 31st March 2016.

Sampling – Purposive (non-probability) sampling. Women are taken who have already taken micro loan for healthissue.

Sample size – The data was collected from 200 women out of 218 who had taken microcredit from the Mahila Vikas Samiti from 1st January 2016 to 31st March 2016.

Method of Data collection - Primary data was collected for research. The data was collected through structured questionnaire designed by intern. The questionnaire was filled in the field,

face to face from women who had come to pay their monthly installment for the microcredit they had taken.

DATA ANALYSIS (RESEARCH QUESTION WISE)

Compare prevalence of micro credits taken for health reasons versus non-health reasons.

Table 1. Current loans held from 1st January TO 31stDecember (n=200)

	No. OF LOANS HELD IN PERCENTAGE							
FEDERATION	HEALTH	EDUCATION	EMPLOYMENT	HOUSE	DEBT	MARRIAGE	PURCHASES	OTHERS
VISHAL	17.96	13.11	18.93	5.34	12.62	10.19	14.56	7.28
PARIVARTAN	33.15	8.43	24.72	0.56	7.87	6.74	10.67	7.87
BHARTIYA	45.93	9.76	24.39	0.00	0.00	6.91	12.20	0.81
CHETANA	14.29	9.52	14.29	9.52	12.70	7.94	19.05	12.70

Share of loans out of total loans from 1st January to 31st December 2016. The microcredits are taken for various purposes as shown above. The share of health in the number of loans is good in all the four areas which the federation covers. This is due to the increased burden of diseases and as well as the increased level of awareness among people. Bhartiya federation (Narayich area) has 45.93%, highest among all four areas, of the loans for health than any other purpose for which the microloan is taken.

Table 2. Quantum of loans disbursed (n=200)

	QUANTUM OF LOANS DISBURSED IN PERCENTAGE							
FEDERATION	HEALTH	EDUCATION	EMPLOYMENT	HOUSE	DEBT	MARRIAGE	PURCHASES	OTHERS
VISHAL	18.77	11.51	17.86	6.89	11.06	16.14	10.56	7.21
PARIVARTAN	4.09	7.45	36.31	1.59	11.26	15.54	14.75	9.01
BHARTIYA	47.14	10.91	25.94	0.00	0.00	7.72	7.98	0.31
CHETANA	14.84	9.57	12.50	17.97	13.28	8.59	14.06	9.18

Quantum of loans disbursed from 1st January to 31st December. The quantity of money micro credited on health is a fair amount. In Bhartiya federation highest financial assistance for health

was required, around Rs. 531500 that is 47.14% of all the microcredit given in the three months. An alteration is seen in Parivartan federation (Garhi Chandani area) in which the number of loans for health purpose was high, 33.15% but the quantum of loan for health is poor around 4.1%.

Analyze demographic characteristics of individuals taking loan for healthcare

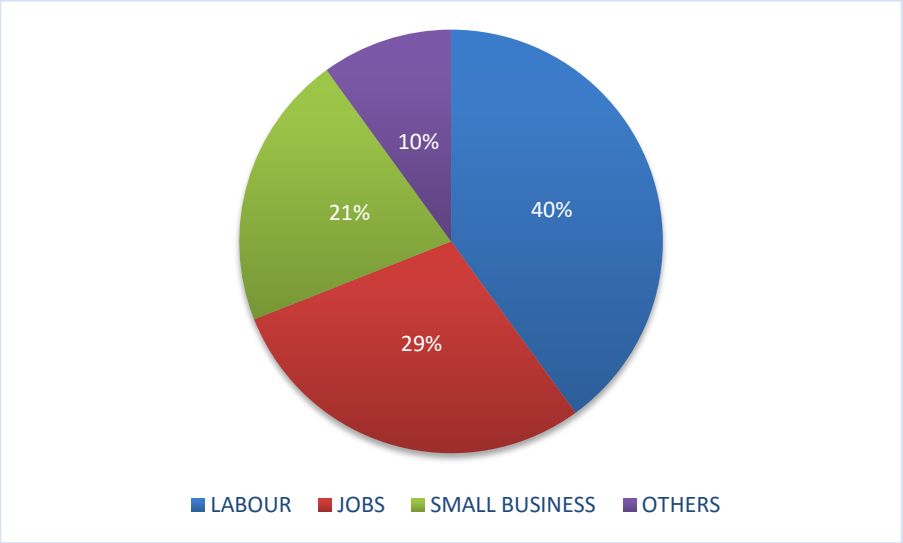

Figure 1. Distribution of the beneficiaries by their source of income

Out of the 200 sample size, 40% of the microcredit for health is taken mostly by the households whose source of income is the occupation of labour which generally includes the unskilled and semiskilled workers who have low wages. The labour, living in urban slum requires monetary aid even for primary healthcare services.

- LEVEL OF INCOME OF THE INDIVIDUALS WHO TAKEN MICROCREDIT FOR HEALTHCARE

1000-5000	5000-10000	MORE THAN 10000
92	98	10
46%	49%	5%

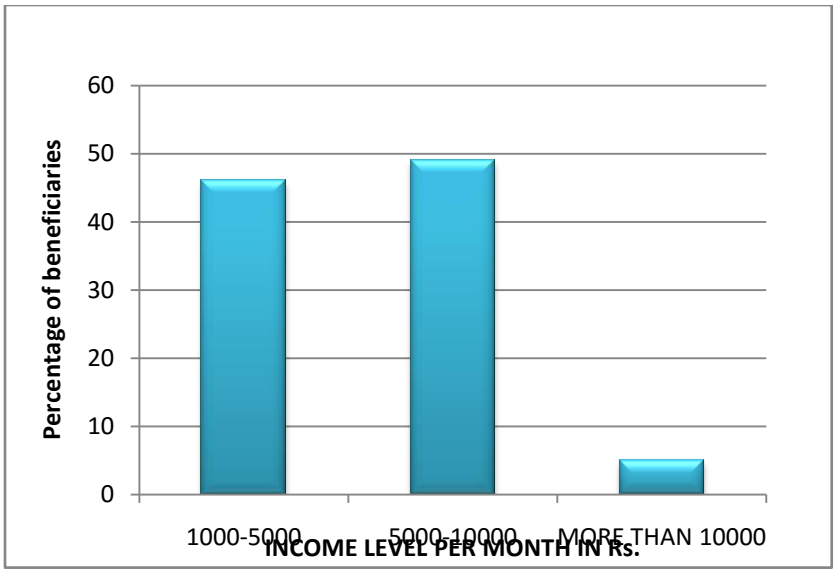

Figure 2. Level of income of the beneficiaries

Microloans for healthcare are taken by individual who are unable to collect a sum of money altogether. The individuals with basic earning of not more than 5000Rs. constitute 46% of the household taking microcredit and almost same is the condition with individuals earning more than five thousand but less than ten thousand constitute 49% of household that take microcredit for healthcare. The financial burden which is due to the escalation of healthcare costs is met by this microcredit. Although a better scenario is among the individuals earning more than 10000 Rs. as they are able to achieve a good quality of life and maintain their health.

- Socio-Economic Status Of The Individuals Who Taken Microcredit For Healthcare

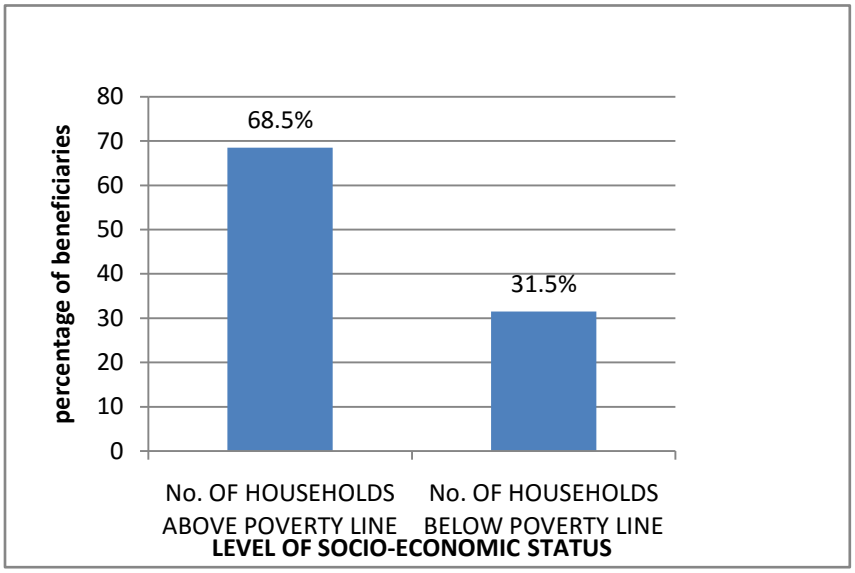

Figure 3. Socio-Economic Status of the beneficiaries

Only 31.5% of the household are below the poverty line who have taken a microloan for health while rest of the 68.5% of the household that is 137 individuals from are sample belong to household that is above poverty, yet require a microcredit for health to support cost bearing.

- PRIOR LOANS HISTORY OF THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR HEALTHCARE

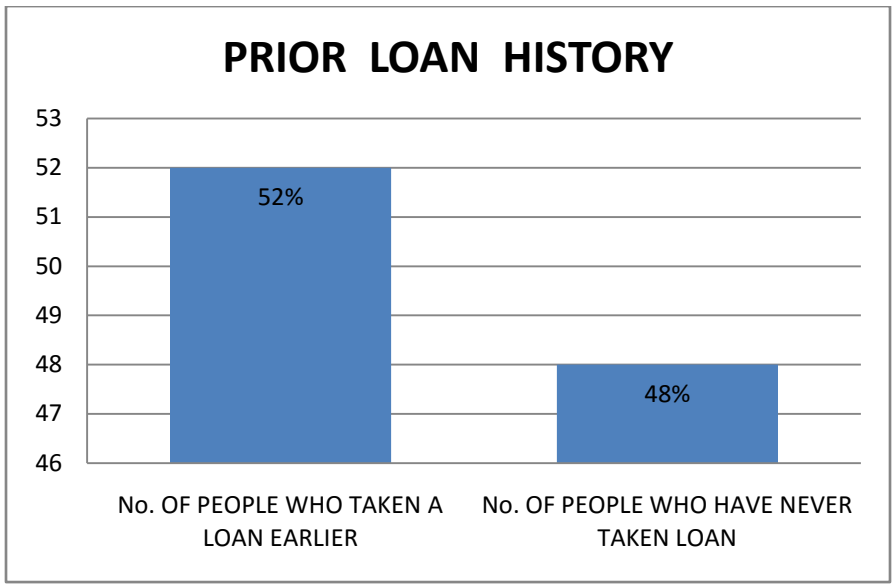

Figure 4. Prior loan history of the beneficiaries

The necessity for microcredit for health has been present among people for long and has even benefitted them, thereafter reutilization of loan for restoring and maintaining health. Around 104 individuals from the sample had already once used the monetary help given by the microcredit either from this institute itself or any other.

Evaluate the usage and different aspects of health micro loans(section wise)

SECTION B

- USAGE OF MICROCREDIT TAKEN BY INDIVIDUAL FOR HEALTHCARE

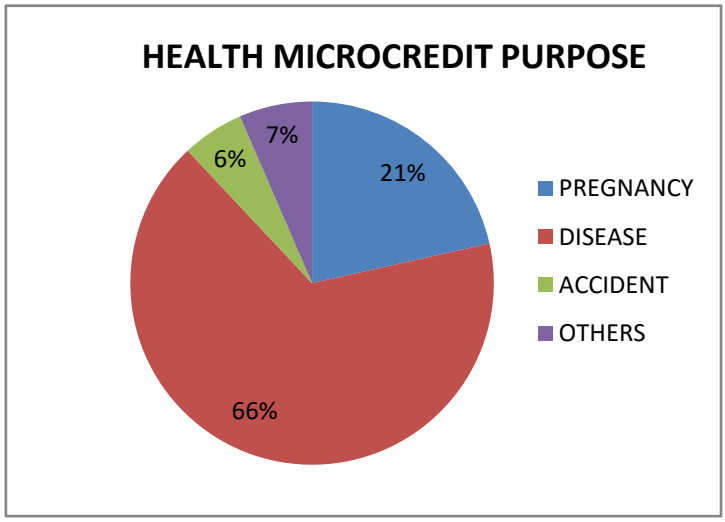

Figure 5. Distribution of the microcredit by the health purpose

Table 4. Distribution of the microcredit by the health purpose

PREGNANCY	DISEASE	ACCIDENT	OTHERS
43	133	11	13
21.%	66%	6%	7%

The health microcredit is used in diseases, pregnancies, accidents and other procedures (like abortion, sterilization, etc.). In the four areas covered by the women federation there seems to be prominence in diseases as out of all there were 133 individual who took microloan for diseases which were suffered by them themselves or by any of their family members. Multiple factors can be taken into account for the cause of the diseases like their living conditions, climatic change,

lack of knowledge about health and many more which are easily visible in these areas. 21% of health micro credits are used to aid the pregnant woman for their safe deliveries. Financial support for accidents and other medical procedure is provided. Thereby strengthening the MDGs.

- FREQUENCY OF QUANTUM OF MICROCREDITS DISBURSED

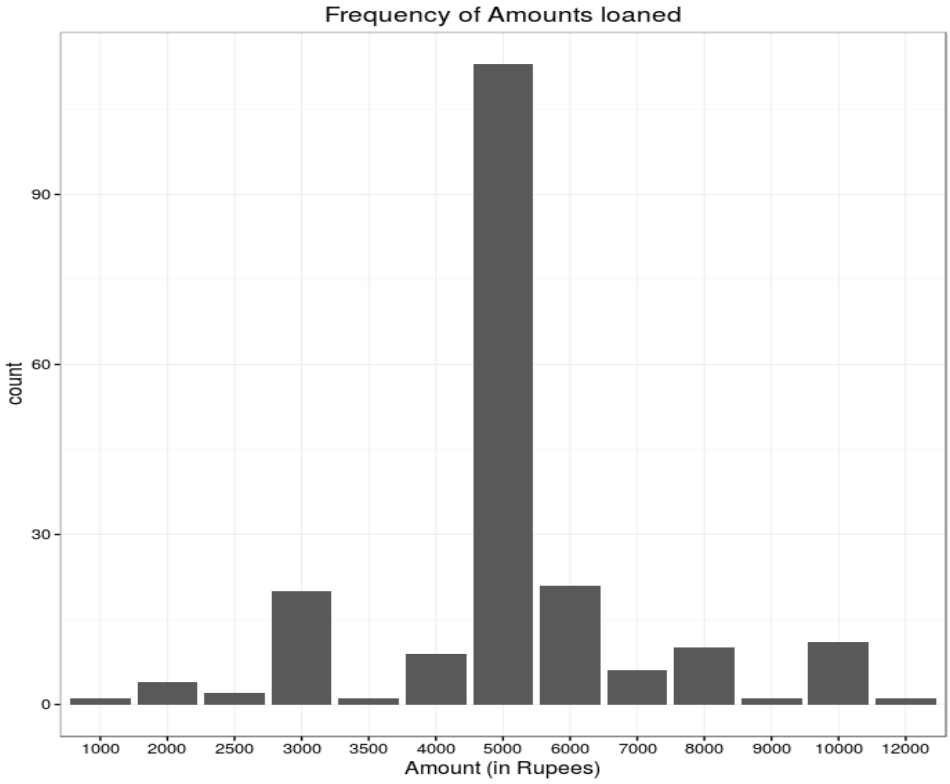

Figure 6. The distribution of frequency of quantum of microcredits disbursed

The quantum of microloans disbursed may vary according to the need of the debtor for the financial assistance of cost of the healthcare and according to the limit of the financial institution. In all the four federations the amount of microloan lies between Rs.12000 to 1000. The highest frequency of amount loaned is Rs. 5000.

SECTION C

- UTILITY OF MICROCREDIT TAKEN BY INDIVIDUAL FOR PREGNANCY PURPOSE

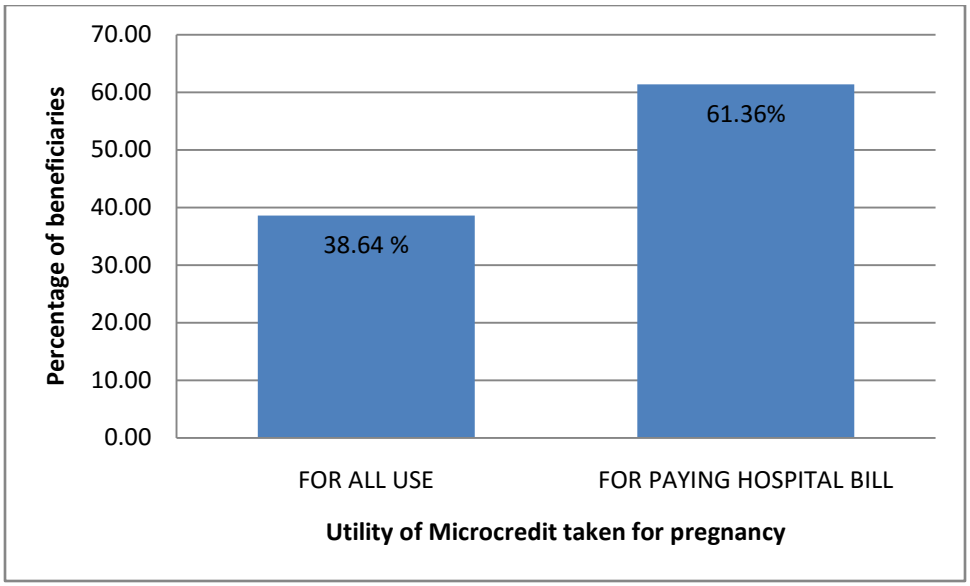

Figure 7. Distribution of utility of microcredit taken by beneficiaries for pregnancy purpose

Most of loans which were taken by the women for pregnancy purpose were to pay a part or whole of the hospital bills. Around 27 of the 44 individual who had taken microcredit for pregnancy were the individuals who required money for the payment of the hospital bill where the antenatal checkup, delivery, postnatal checkup were done. While the 17 individuals who had taken loan for all uses that were required during the pregnancy which even included expenses for transport, nutritional food, loss of cost of earnings during that period and other such expenses which indirectly form the part of pregnancy expenditure.

- ANTENATAL CHECKUPS

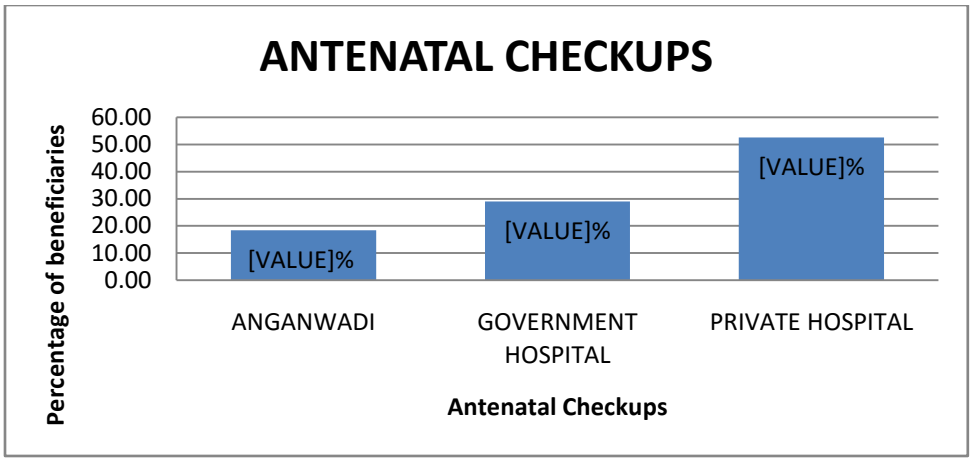

Figure 8. Institutions of antenatal checkups by beneficiaries

All the individuals who had taken loan for pregnancy had gone for antenatal checkup from various medical centers: anganwadi centers, government hospital and private hospital. The anganwadi centers and government hospital had no charges for the antenatal checkups but the fee for the private hospital was an added expenditure. Along with this the transportation overheads and loss of time for work by the caretaker becomes additional economic burden.

- OVERHEADS BEARED FOR MEDICINES DURING PREGNANCY BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT

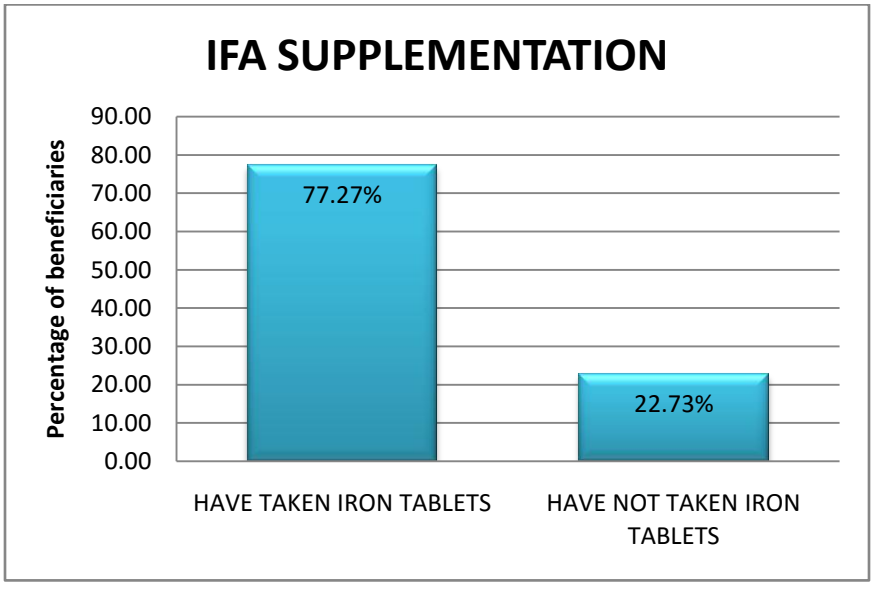

Figure 9. Beneficiaries who took IFA supplementation

The microcredit given as loan includes expenses done on medication which includes the intake of the pregnant women IFA tablets (iron tablets) which plays an important role in the health of mother and child. Even though individuals had access to finance, then to 10 individuals did not take the iron supplement.

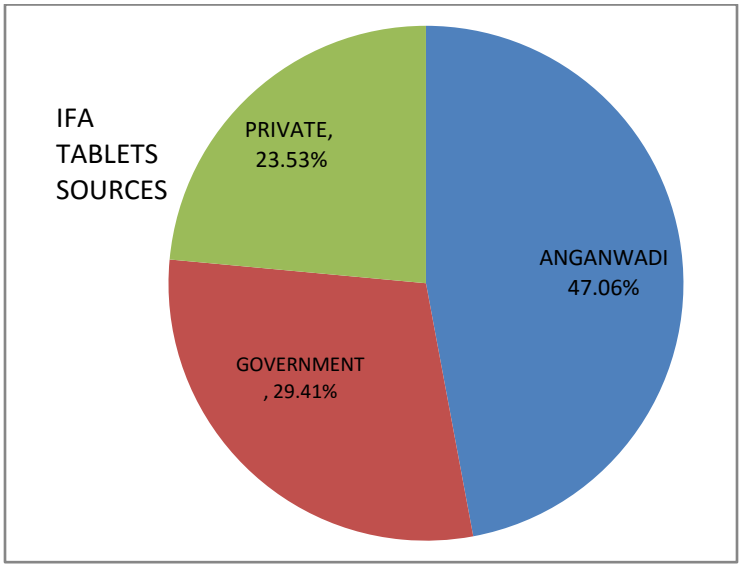

Figure 10. Sources of IFA tablets

The IFA tablets were obtained from anganwadi centers, government pharmacy and private pharmacy. Maximum of the individuals had got the iron tablets from the Anganwadi worker or ASHA, who herself had arrived at the doorstep of the household of the urban slum dweller. Then the government pharmacy gave them as free of any cost like anganwadi center. Individuals who got the IFA tablets from private pharmacy due to doctor's advice or to save time from the queue at the government pharmacy.

- EXPENDITURE OF DELIVERY BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT

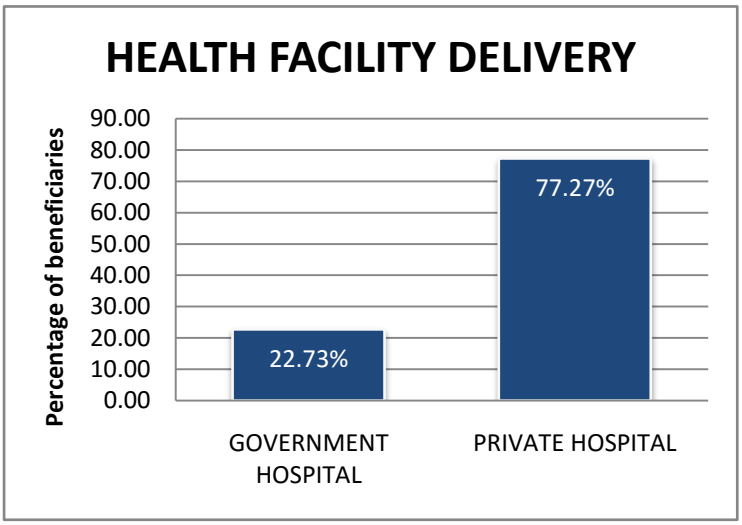

Figure 11. Health seeking institute by the beneficiaries

Most of the delivery occurred at private hospital around 34(77.27%) individuals. The people considered it to safer than government hospitals even though the cost of delivery increased. And along with that the distance from the government hospital was more than 10km for all the four slum areas thereby making it a little inconvenient for individuals.

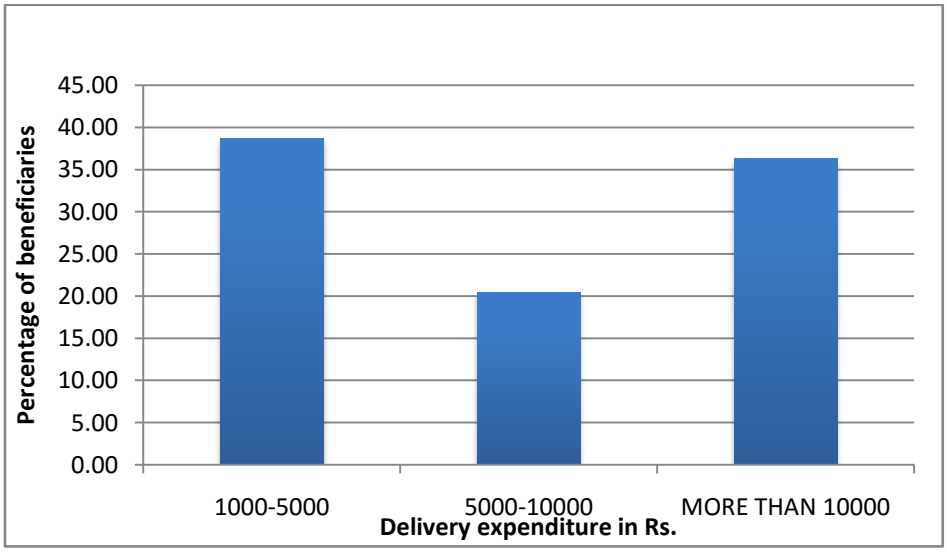

Figure 12. Expenditure on delivery

The expenditure of delivery not only includes the direct cost of the hospital bill but also the expenses of the required transport, medicine, blood and all. Since most of the deliveries are done in private hospitals so the expenses vary from Rs. 1000 to more than Rs.10000. This amount also

includes the normal deliveries along with complicated deliveries which require surgical intervention. The microcredit has aided in all these areas and along with providing a large sum of money reducing the stress and encumbrance from the shoulder of the individual earning member of the household.

- UTILITY OF GOVERNMENT AIDED SCHEME FOR PREGNANT WOMAN AND ITS EFFECT ON MICROCREDIT: JANANI SURKASHA YOJNA

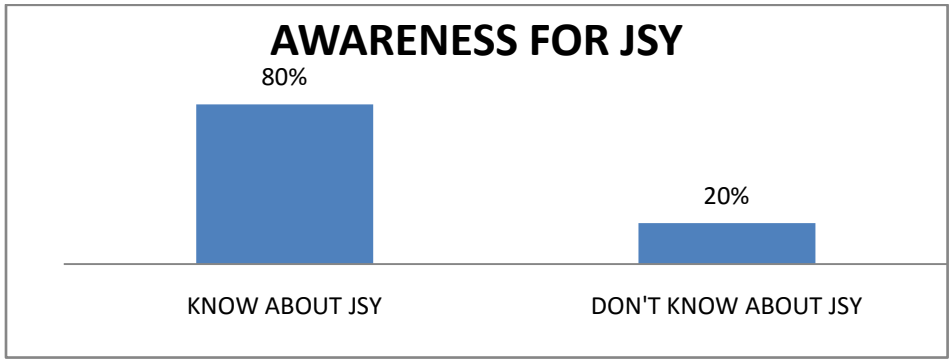

Figure 13. Degree of awareness of JSY among beneficiaries

About 80% of the 44 individuals of the individuals who had taken microloan for pregnancy purpose had a knowledge about government's scheme JSY for the maternal and child healthcare but about 9 individuals still had no clue about it.

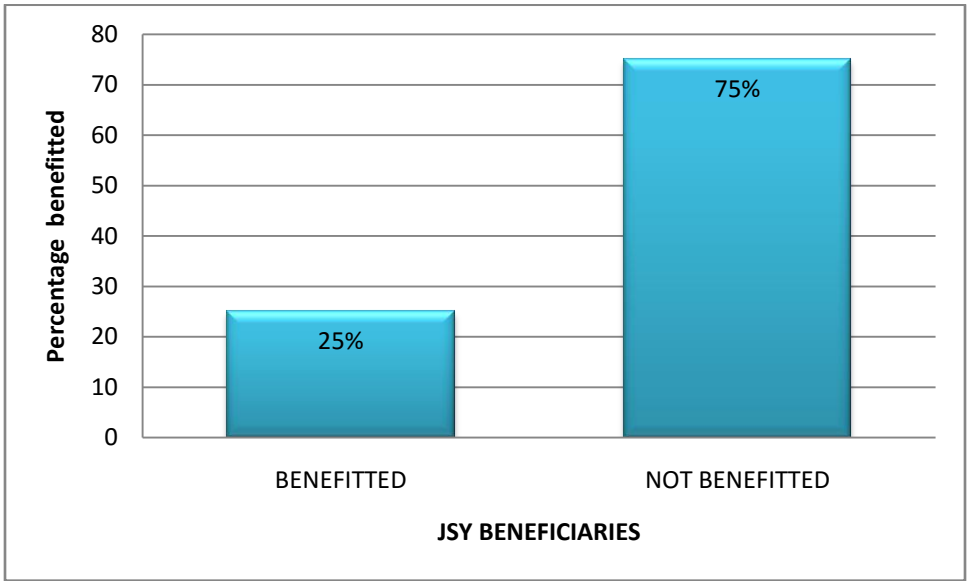

Figure 14. Beneficiaries benefitted from JSY

Out of all the people who had knowledge about JSY only 11 individuals got benefit from the scheme largely those who had their delivery in government hospital. The rest remain inaccessible to the facility provide by government. The microcredit hence supports the under fortunate.

SECTION D

- TYPE OF DISEASES OF THE INDIVIDUALS WHO HAVE TAKEN MICROCREDIT FOR HEALTHCARE

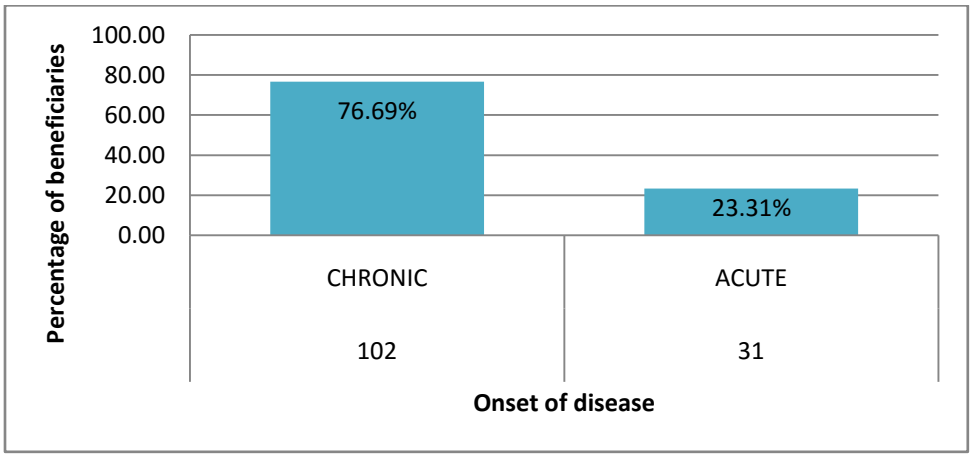

Figure 15. Distribution of diseases according to the onset of disease

Chronic onset of diseases seems to be more prominent when compared to acute one. This may be because the unprivileged people tend to ignore the early signs and symptoms of their diseases, especially in urban slums where the diseases are taken as common and there is a shortage of finance to take help of medical professional.

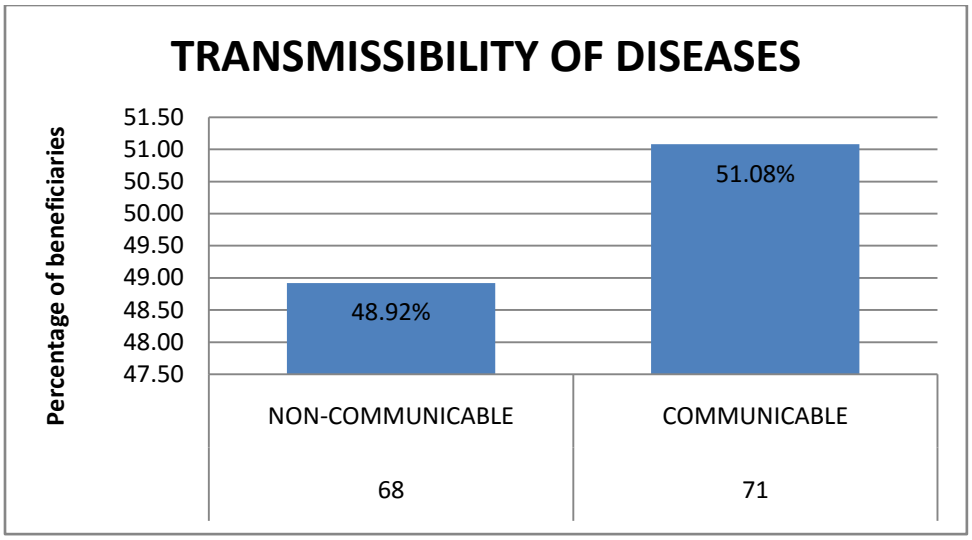

Figure 16. Distribution of diseases according to the transmissibility of disease

Microcredit is taken almost equally for both communicable and non-communicable, with the increase in the non-communicable diseases. The expense for both communicable and non communicable is bear by the microcredit.

- UTILITY OF MICROCREDIT TAKEN BY INDIVIDUAL FOR DISEASE/ACCIDENT/OTHER PURPOSE

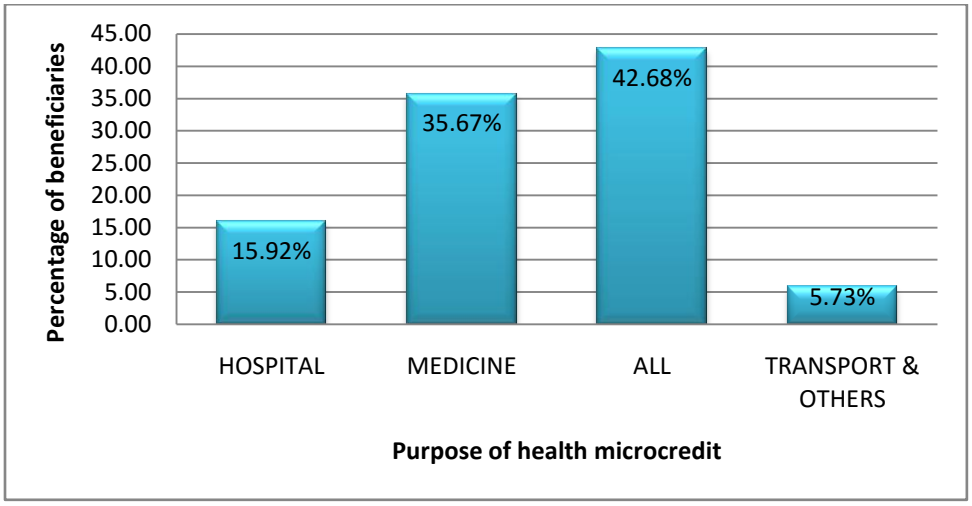

Figure 17. Distribution of utility of microcredit by the beneficiaries

One can keenly observe that the microcredit taken to cure the condition was for the payment of medicines bills, hospital bills, transportation and any other use which may be require during the treatment or may be for all the above mentioned purposes together. 157 individuals took

microloans for financial assistance required to treat the disease or accident or any other condition. Out of which 67 of them took the microcredit for all purpose. While 57 individuals of the 157 take microloan for paying for medication only during the whole recovery phase. The hospital bill or part of the bill was paid by 25 people from the loan.

- HEALTH SEEKING INSTITUTE BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR DISEASE/ACCIDENT/OTHER HEALTH PURPOSE

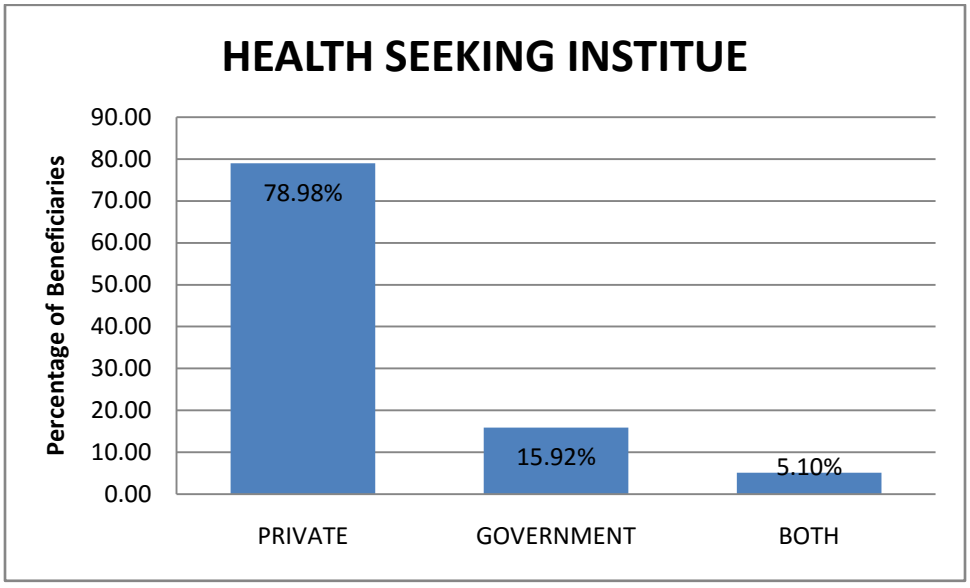

Figure 18. Health seeking institutes by the beneficiaries

The general tendency of individuals of these slum areas seem to be to seek health from private institute rather than government. This may be due to the distance which plays an important part here as most of the population in these slum don't have their own convince and along with belief that government profession do not provide proper care. 124 individuals from the sample only choose to get their treatment done from private hospital mostly nearest to their house to save work day and a few around 25 choose the government institution. While a few around 9 individual took the healthcare from both for various reasons.

- DISTANCE OF THE MEDICAL INSTITUTE FROM THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR DISEASE/ACCIDENT/OTHER HEALTH PURPOSE

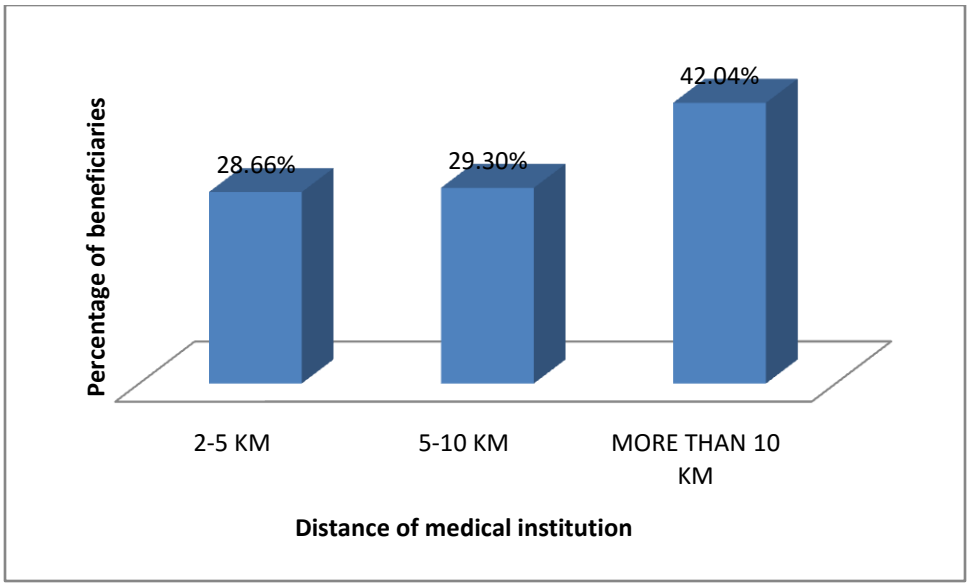

Figure 19. Distance of medical institute

Since the distance factor plays a major role in opting for the institution for treatment a close reading of the graph shows 45 and 46 individuals respectively that is 29% had a medical institutional distance of 2-5km and 29.30% had an institutional distance of 5-10km. But 66 individuals choose medical institutions that had a distance of more than 10 km. One of cause of this was 31 individuals had went to government hospital which is present in the middle of the city but distant from the many slum areas specially these four slum areas. The other reason might be the treatment required was not available in the nearest medical facilities.

- EXPENDITURE ON THE HOSPITAL/DOCTOR BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR DISEASE/ACCIDENT/OTHER HEALTH PURPOSE

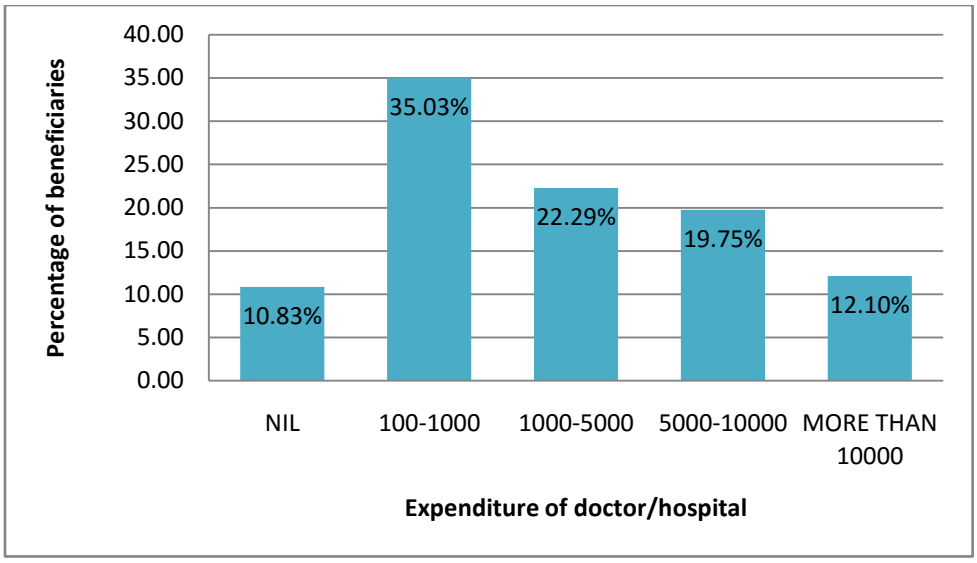

Figure 20. Distribution of expenditure on hospital/doctor by beneficiaries

Out of the 157 individuals who had taken loan for some disease, accident or any other medical condition only 17 did not have to pay a single penny for the doctor or hospital fee as the medical institution they had got their treatment done was basically government or an NGO operated service. While 55 individuals went to private hospital/doctor who fee were less than one thousand and 35 individuals had to pay less than 5000Rs. but about 31 people had to pay more than 5000Rs. but less than Rs.10000 and in same conclusion few even paid more than 10000Rs. for a severe disease like cancer or an emergency road accident. Though the federation couldn't minister the whole of the bill in many cases tried to reduce the burden as much as its limits could adheres it to.

- EXPENDITURE ON MEDICAL EXAMINATION BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR DISEASE/ACCIDENT/OTHER HEALTH PURPOSE

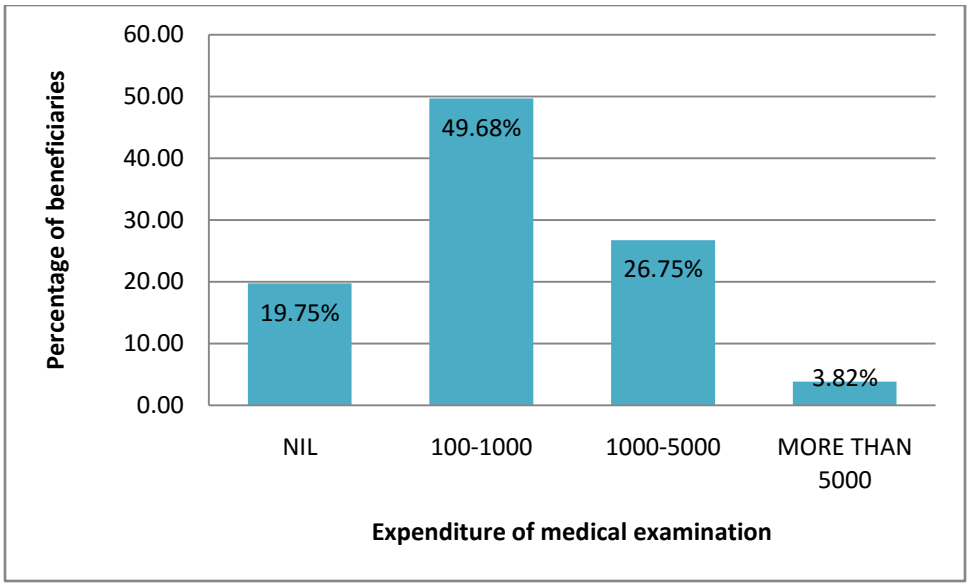

Figure 21. Distribution of expenditure on medical examination/test by beneficiaries

The medical examination expenditure included cost of blood, urine, ultrasound, x-ray and any examination that was required for the diagnosis of the condition. 31 individuals did not need any medical examination for the diagnosis of their condition so they didn't have to pay anything. Whereas 78 individuals only require minor medical tests that charge less than 1000. 42 individuals spend less than 5000Rs. for multiple test for complicated health conditions and 6 who required more than 10000.

- EXPENDITURE ON MEDICATION BY THE INDIVIDUALS WHO HAD TAKEN MICROCREDIT FOR DISEASE/ACCIDENT/OTHER HEALTH PURPOSE

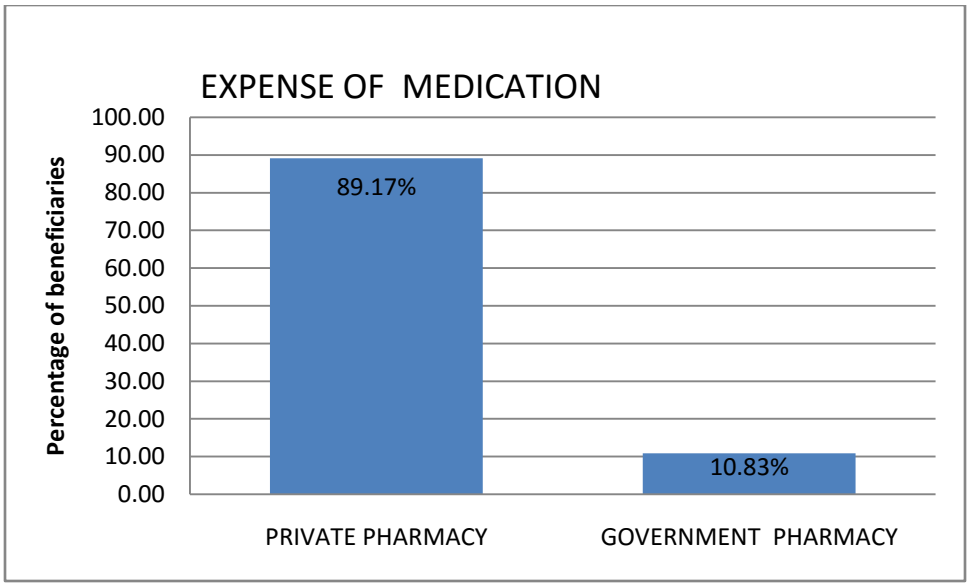

Figure 22. Distribution of expenditure on medication by beneficiaries

Maximum number of individuals had bought the medicine from the private pharmacy where the cost of medicine is little on the higher side when compared from the government pharmacy where most medication is free. 140 individuals bought from the private due to the ignorance along with misbelieve in the government institution.

SECTION E

- SHORTAGE OF MICROCREDIT IN PROVIDING COMPLETE AMOUNT OF MONEY FOR THE PREGNANCY/ DISEASE/ ACCIDENT OR OTHER HEALTHCARE CONDITION

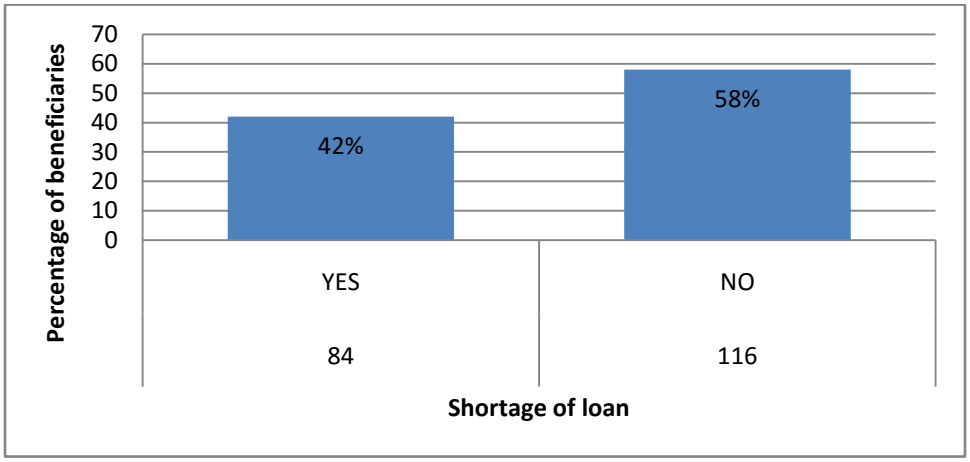

Figure 23. Shortage of microcredit

The complete overheads of the health were supposed to be fulfilled by the microloans taken by the individuals but yet in many cases it was unable to do so. With reference to this 84 individuals were satisfied as the complete expense of all were covered by this microcredit only and saving then from further harassment from the lack of funds. While 116 individuals had to face with the issue of financial aid even after taking this microcredit.

- QUANTUM OF MICROCREDIT SHORTAGE BY THE INDIVIDUAL WHO HAD TAKEN MICROCREDIT

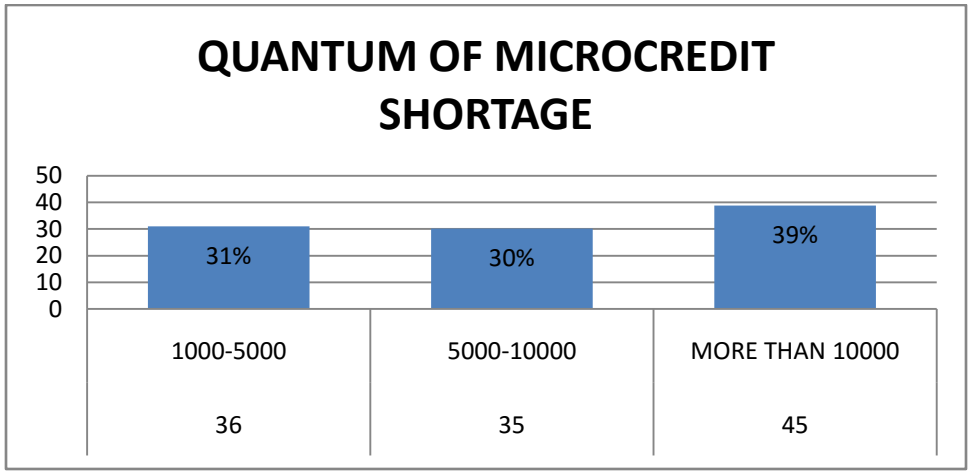

Figure 24. Quantum of microcredit shortage suffered by beneficiaries

For 31% the people who had suffered from shortage of loan, the microloan was short for amount less than 5000Rs. and 30% suffered the shortage for less than 10000Rs. which forms the population of 36 and 35 people respectively of the 116 people. Against this 45 individuals from 116 people lacked more than 10000Rs. for the healthcare.

- SOURCE TO UNABRIDGED THE MICROCREDIT SHORTAGE OF INDIVIDUALS WHO EXPERENCED INSUFFICIENCY OF MICROLOAN

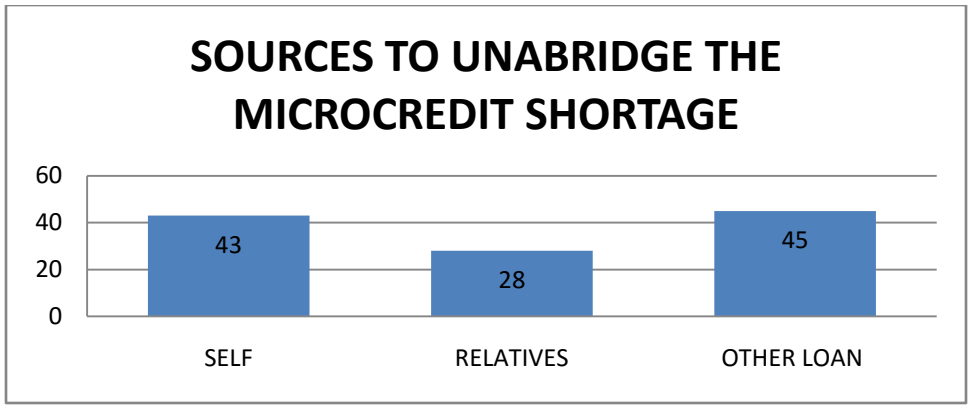

Figure 25. SOURCE TO UNABRIDGED THE MICROCREDIT SHORTAGE

The people who had experience from further lack of funds had to search for alternative means to supplement it for the healthcare. For doing so, individuals fulfilled the remaining amount of money from themselves only, using their saved up money which accounts for 43 people. And 28 took it extra cash from their relatives or their know ones. Whereas the rest had no other option but to take an additional loan from this same institution or any other.

CONCLUSION

Healthcare is amongst the highest purpose for which the microcredit are taken for, by the individuals who lack collateral, steady employment or a verifiable credit history, and require funds urgently at the time of requirement.

A microcredit can vary in amount from Rs.1000 to Rs.30000 to provide financial assistance in case of pregnancy, diseases, accidents and other health purpose. In case of pregnancy the microloans not only aid in paying the hospital bills but also paying for the medicines, transport, postnatal checkups and immunization and more. In case of diseases and accidents and other health issues to pay for doctors, medicines, transport, and even for medical examinations and tests. In many cases the microcredit is unable to fulfill the amount of financial aid required by the individuals.Microcredit have shown capability to improve health-care capacity and health outcomes by providing individuals with finance to seek for resources. Thereby contributing to achievement of the SDGs (number 1, 2, 3&5) that utilizes microcredit platform to reach poor and underserved populations.

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Annex I

QUESTIONNAIRE

SECTION A

□ □ Name:
□ □ Age:
□ □ Address:
□ □ Social background:
□ □ A.P.L/ B.P.L:

□ □ Level of Income per month:
-Below 5000 - 5000 – 10000 -10000-20000 -Above 20000

□ □ Occupation:
-Farming/livestock production
-Labour
-Small business
-Job
-Other

□ □ Do you know about small amount of loans?
-Yes -No

□ □ What is the source of this information
-Friends -Neighbours -Relatives -Others

□ □ According to you which is most common used purpose for which small amount of loan are taken
-Health
-Marriage
-Education
-House repairing
-Others

□ □ Have you ever taken small amount of loan from any organization other than Mahila Vikas Samiti?
-Yes -No

□ □ If yes name of the organization:
□ □ If yes at what rate of interest:

SECTION B

1. Do you know about Mahila Vikas Samiti?

-Yes -No

2. Have you ever taken a loan from Mahila Vikas Samiti?
-Yes -No

3. If yes how much amount?
-0-5000 -5000-10000 -10000-20000

4. If yes for much time did you take the loan?
-less than 6 months
-6 months to 1 year
-1year to 2 year

5. If yes at what rate of interest?

6. Did you take loan for any health issue?
-Yes -No

7. If yes for above, which of the following did you take loan for?
-Pregnancy/delivery
-Disease
-Road Accident
-Other health reason

SECTION C (To be filled if loan taken for pregnancy/delivery)

1. In which month of pregnancy did you take the loan?
- 1st trimester (1-3)
- 2nd trimester (4-6)
- 3rd trimester (7-9)

2. Did Mahila Vikas Samiti provide you information in regard to taking care during pregnancy?
-Yes -No

3. During pregnancy for what purpose did you take loan for?
-Hospital
-Medicine
-Transport
-All of the above
-Other reasons

4. Did you register in anganwadi center during pregnancy?
-Yes -No

5. Did you get antenatal checkups during pregnancy?
-Yes -No
If yes

A.) From whom
-A.N.M.
-PrivateDoctor
-Government Doctor

B.) How many antenatal checkups did you have during your pregnancy?
-One
-Three
-More than three

6. Did you get full dose of T.T.?
-Yes -No

7. Did you take IFA (iron) tablets during pregnancy?
-Yes -No
If yes

A.) Where did you get the iron tablets?
-Anganwadi
-Private hospital/ dispensary
-Government hospital/ dispensary

B.) How much did you pay for the iron tablets?
-0
-10-100
-100-500

8. Where did you give delivery?
-Home
-Private hospital
-Government hospital

9. How much did you pay for the delivery in hospital?
-0
-1000-5000
-more than 10000

10. If any other expenses (blood, medicine, etc) occurred during the pregnancy, how much did they cost to you?
-0
-1000-5000
-more than 10000

11. Do you know about Janani Suraksha Yojana?
-Yes -No
If yes

A.) Did you get the profit of the scheme?
-Yes -No

12. Did you get postnatal checkup done?
-Yes -No

13. Did you get your child immunized?
-Yes -No
If yes
A.) From where?
-Anganwadi
-Government hospital
-Private hospital

SECTION D

1. For what health issue did you take the loan for?
-Disease
-Accident
-Other reason

2. If loan is taken for the disease, then name of the disease?

3. If loan is taken for the disease, is the disease communicable or non communicable?
-Yes -No

4. If loan is taken for the disease, is the disease chronic or acute?

5. In disease/ accident/ others for what purpose did you take the loan for?
-Hospital
-Medicines
-Transportation
-All of the above
-Other reasons

6. Where did you get your check-up done from?
-Private hospital/doctor
-Government hospital/ doctor

7. How many times did you get you check up done?
-1- 2 times
-more than 2 times

8. How much amount of money was spent on the hospital/ doctor fee?
-100-5000
-5000-10000
-more than 10000

9. What test/ medical examination were done during the treatment?
-Blood
-X-ray
-E.C.G
-Ultrasound
-Other test

10. How much amount of money was spent on the test/medical examination fee?
-100-1000
-1000-5000
-more than 5000

11. What is the distance between your house and hospital/clinic?
-2-5 k.m
-5-10 k.m.
-more than 10 k.m.

12. During treatment from where did you buy the medicines?
-Government hospital
-Private hospital
-Private dispensary

13. How much amount of money was spent on the medicines?
-100-1000
-1000-5000
-more than 5000

SECTION E

1. Do you think the loan was helpful?
-Yes -No

2. Did the micro loan cover whole of the expenditure for the pregnancy/disease/ accident/other reasons?
-Yes -No

3. If no, for the above question how much amount of money was the microloan short of?
-1000-5000
-5000-10000
-more than 10000

4. To fulfill the shortage of micro loan, from where did you take the rest of the money for the treatment?
-Self
-relatives
-loan from other organization