Master Thesis

Effects of Micro-Credit Programmes on Women's Health: A Critical Review of Impact Studies with Special Reference to Grameen Bank in Bangladesh

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Anindita Roy 31st August 2004

Abstract

Poor socio-economic conditions are responsible for health hazards and disease to a large extent. They leave the poor and the disadvantaged people almost unprotected against the various risk factors causing ill health. Considering the causal relationship between poor socio-economic status and health one can state that interventions for poverty alleviation generally have positive impact on the state of health of the recipients. This also applies for group-based credit programmes giving small credit to women in the rural areas to initiate income-generating activities. In rural Bangladesh, Grameen Bank has been operating in this direction since the seventies of the last century by establishing micro-credit programmes which are primarily targeted at poor women who constitute about 95% of their clientele. Due to this unique constellation, a number of researchers have tried to analyse the effects of micro-credit on the health status of female recipients of Grameen Bank.

The present study attempts to review these published data and the evidence presented in support of the postulated micro-credit benefits on the health of poor women critically. Applying explanatory research methods, this study evaluates selected publications from the Grameen Bank, the OECD, WHO and other supplementary sources. The main outcome of the analysis indicates that the majority of these studies have not - or only to a minor degree - designed their research and interpreted their findings within the framework of the holistic, now generally accepted approach of health as defined by WHO. They have rather focused on sub-sectors like nutrition, contraception and reproductive health, sanitation and safe drinking water. Several centrally important aspects have been widely neglected, such as food allocation during lean seasons, work-related health risks, environmental risks and unsafe sex. Yet another problem inherent in almost all studies undertaken so far is that the applied indicators for health and health risks have been defined by the researchers rather than by the women concerned.

KEY WORDS – women's health, micro-credit programmes, Grameen Bank, Bangladesh

Introduction

The findings of The World Health Report 2002 emphasize poverty as a risk factor for health and the burden of disease. Therefore it can be assumed that alleviating poverty would have positive effects on health. Among many approaches which have been tried to alleviate poverty - micro-credit is, perhaps, the most fascinating one. Micro-credit programmes have increasingly become one of the most common and important poverty alleviation tools in Bangladesh. All these programmes are characterised by some basic common features and strategies. Group-based rural credit programmes like Grameen[1] Bank and BRAC (Bangladesh Rural Advancement Committee) in Bangladesh *'are largely targeted at women from the poorest section of the population; they lend small sums of money to individuals as members of groups and rely on group liability to ensure loan repayment; they subsidize administrative costs rather than interest rates; the loans are repaid in weekly installments'* (Kabeer 2001). Interventions through micro-credit programmes are expanding and *'assessing the impact of participation in micro-credit programme has featured predominantly in the recent research agenda in Bangladesh'* (Mahmud 2000). The innovative approach, efficacy and gender centered policies of micro-credit programmes have fuelled considerable interest among social scientists and economists - which has over the years produced numerous studies to evaluate the impact of these programmes. These studies have covered practically all aspects, such as economic, social, educational and health in one way or the other. However, the debate on actual effectiveness and impact of these programmes still continues.

The objective of this paper is to review selected published studies which have analysed the role of micro-credit in improving the health status of poor women participating in these programmes. The main focus will be on those programmes initiated and run by Grameen Bank, the pioneer of micro-credit programmes in Bangladesh. The central question of this research is - whether the micro-credit programmes of Grameen Bank have any positive effect on women's health and if yes, to what extent - a result that was claimed by many researchers.

[1] Grameen means ‚Rural' or ‚Of the village' or ‚Village Bank'

Review of Grameen Bank's approach

'*The word "micro-credit" did not exist before the 1970s. Now it has become a buzz-word among the development practitioners*' (Yunus 2004). The Grameen Bank originated from a small action-research project undertaken in 1976 by Muhammad Yunus, at that time professor of economics, in a village called Jobra near the town of Chittagong, Bangladesh. Muhammad Yunus (2004) concluded the distinguishing features of micro-credit of Grameen Bank as follows:

- The credit programme of Grameen Bank was initiated as a challenge to the conventional banking system, which rejected the poor by classifying them to be "*not credit worthy*". As a result Grameen Bank rejected the basic methodology of conventional banking and created its own methods.

- Its mission is to help the poor[2] families to help themselves to overcome poverty. It is targeted to the poor section of the society, particularly poor women. Reaching the poor is its non-negotiable mission. Attaining sustainability is a directional goal. Micro-credit programmes must reach sustainability as soon as possible, so that it can expand its outreach without fund constraints.

- It is offered for creating self-employment, for income-generating activities and housing for the poor, as opposed to consumption.

- The most distinctive feature of micro-credit provided by Grameen Bank is that it is not based on any collateral or legally enforceable contracts. It is based on *'trust'*, not on legal procedures and system.

- All loans are to be paid back in installments (on a weekly or bi-weekly basis).

- In order to obtain loans a borrower must join a group of borrowers.

[2] The target group of Grameen Bank must not own more than 0.5 acre land

- Loans can be received in a continuous sequence. A new loan becomes available to a borrower if her previous loan has been repaid.

- More than one loan can simultaneously be received by a borrower.

- The credit from Grameen Bank comes with both obligatory and voluntary savings programmes for the borrowers.

- Grameen Bank's credit system keeps the interest rate as close as possible to the market rate prevailing in the commercial banking sector. In fixing the interest rate, market interest rate is taken as the reference rate.

- It gives special emphasis to the formation of *'human capital'* and is concerned about protecting the environment. These goals are incorporated in *"Sixteen Decisions"* (*see appendix*), which the borrowers have to learn before obtaining a loan and Grameen Bank encourages them to practice the *'decisions'* in everyday life.

- It provides services at the door-step of the poor - based on the principle that the people should not go to the bank, rather the bank should reach out to the people with its services.

Grameen Bank maintains that poverty is to a large extent caused by malfunctioning of institutions and inadequate policies surrounding them; it can be eliminated by inducing appropriate changes within those institutions and policies.

Background of the study problem

It is widely accepted that health is an important indicator of development. According to the WHO[3] (2002), *'the greatest burden of health risks is very often borne by the disadvantaged section in our societies. The vast majority of threats to health are commonly found among poor people, in people with little formal education, and those*

[3] World Health Organization

with lowly occupations'. To make a point on how health is linked to livelihood through the process of income OECD[4] argues, *'for poor people especially, health is also a crucially important economic asset. Their livelihood depends on it. When a poor or socially vulnerable person becomes ill or injured, the entire household can become trapped in a downward spiral of lost income and high health costs'* (OECD 2003).

The health and poverty situation is Bangladesh is typical of any poor nation. Poverty in Bangladesh is both a cause as well as consequence of poor health (Daiyan 1999). Due to poor socio-economic conditions people suffer from ill health in Bangladesh. Moreover, the gender inequality in Bangladeshi society creates further disadvantages for the poor women by preventing them from accessing health care and social protection. Among other criteria, maternal mortality rate is a strong indicator of the disparity in accessing the health care services. The maternal mortality ratio is 3.26 per 1000 live births in rural areas of Bangladesh (Health and Demographic Survey, BBS[5] 2000). The lower status of women in the society, coupled with their reduced access to health care, lack of food security in the family, lack of education and information and their lack of involvement in the labour force and especially denial of access to paid jobs make them prone to ill health. The identification and analysis of these factors have been the main reason for the plausible assumption that any improvement in socio-economic status of women through their participation in micro-credit programmes will inevitably lead to the better health.

Within this context it can be expected that micro-credit from Grameen Bank has such effects because it raises the income level for the credit recipients and thus the total household income (Rushidan Islam Rahman 2002). Keeping this line of argument, the study presented here similarly assumes that, since 95% of the credit recipients of Grameen Bank are women[6], their enhanced income through participating in micro-credit programmes enables them to acquire higher purchasing power, by which they can get access to sufficient nutritional value and other sources to maintain better health.

[4] Organisation for Economic Co-operation and Development
[5] Bangladesh Bureau of Statistics
[6] www.grameen-info.org

Objective and scope of the study

Objective

The main objective of this study is to understand the causal link between micro-credit and the prevailing health situation of female credit recipients by reviewing and analysing published literature. As far as the definition of health is concerned, this study resorts to the WHO which defines health as *'…a state of complete physical, social and mental well being, and not merely the absence of disease or infirmity'.* The research hypothesis is: micro-credit programmes run by Grameen Bank contribute to enhance the level of income of poor women recipients and therefore their purchasing power, by which they acquire sufficient opportunities for the maintenance of their complete *'physical and social well being'*. To understand the complete *'physical and social well being'*, this study will investigate more specifically the following questions:

- Which indicators were used in the studies to measure the impact of micro-credit on women's health?
- Who set the indicators?
- Have the micro-credit programmes of Grameen Bank enabled women to take care of their health by strengthening their income?
- Has the holistic perspective of women's health been approached in the studies done so far?

Scope

This study will attempt identifying areas for further research regarding impacts of micro-credit programmes on human capital such as health.

Conceptual framework

Gender subordination is an integral part of rural social arena in Bangladesh. Like most societies, in Bangladesh, men enjoy a better position due to their role as bread earners, while women's work is mostly devalued because of its non-economic aspect (household work). The 'purdah[7]' system, while claiming to protect women, is in fact rather severely inhibiting their mobility by defining specific spaces for women and creating a separation of the public and private sphere (Ahmed 1993). 'Purdah' ensures the isolation of women from the money economy thereby making them dependent on men. The lack of independent source of income, combined with little or no formal education leads women to believe that they are burden on their family. In rural Bangladesh girls learn to accept dependence and deprivation relative to male family members (Schuler et al. 1996). They learn to adapt low self esteem at a very young age, face deprivation from food, and receive minimal health care and education. One consequence is that *'infectious disease morbidity in Bangladesh is higher among women than among men'* (Schuler et al. 1996). All these disadvantages lead to behavioural outcomes that are unfavourable to women's well being (Mahmud 1994).

Interventions like micro-credit programmes, which are driven by twin objectives of poverty alleviation and empowerment of poor women, would provide women with the opportunity to take part in the money economy or labour force, to have an independent source of income and would improve the status of women within the household and in the society. The participation in money economy or labour force increases mobility. These changes or improvements would help them to establish behavioural patterns which are more favourable for their well being, their food consumption and calorie intake, mobility etc.

Concept of health risk caused by socio-economic status

According to the WHO (2002) poverty and socio-economic status are key determinants of the status of health. WHO in its annual report of 2002 attempted a global stratification of absolute poverty (<US$ 1, US$ 1-2 and > US$ 2 per day). The identified consequent

[7] The concept of ‚purdah' usually means seclusion of women or their veiling.

risk factors for health which are directly emanating from poverty have been outlined in the following WHO guideline which will be applied in this study with some minor modification:

- Childhood protein – energy malnutrition
- Water and Sanitation
- Lack of breastfeeding
- Unsafe sex
- Alcohol
- Tobacco consumption
- Overweight
- Indoor air pollution
- Urban air pollution

This study will cover only selected risk factors from the above mentioned guideline which are relevant to the women participating in micro-credit programmes run by Grameen Bank in the rural setting in Bangladesh.

Methodology

Explanatory research methodology will be used to analyse data. This is conducted when there are few or no published studies available which could be used to obtain information. Explanatory research is useful in gaining insight and familiarity with a particular subject as a basis for more rigorous research at a later stage. This method is a useful tool to analyse the causes or consequences (DeVaus 2002), as this study wishes to do for the causal interdependence between micro-credit and health related risk factors.

In order to generate data this study will resort to published literature/articles in which the health situation of female credit borrowers' of Grameen Bank was analysed from a gender perspective. The articles were identified from various national and international journals, official publications of Grameen Bank, publications of WHO and OECD.

Review of literature on Grameen Bank

Before reviewing the major findings on women's *'physical and social well being'* published in the literature, we digress a little by reporting the indirect impact of micro-credit programmes on women's health. It is a well known fact that Grameen Bank's foremost objective is poverty alleviation. This study is looking at the indicators showing that improved financial status of women has empowered them in such a way that they have become able to eliminate the risk factors threatening health, which were summarised by the WHO. This indirect approach reflects the fact that health is a secondary consequence of a person's economic condition, which has led the WHO to classify poverty as a *'distal cause'* of disease. According to WHO, *'risks to health do not occur in isolation. The chain of events leading to an adverse health outcome includes both proximal and distal causes – proximal factors act directly or almost directly to cause disease, and distal causes are further back in the causal chain and act via a number of intermediary causes. The factors that lead to someone developing disease on a particular day are likely to have begun years previously, which in turn were shaped by broader socio-economic determinants'* (WHO 2002).

With the increase in number of female recipients of micro-credit from Grameen Bank, a large number of studies have been undertaken to measure the *'wider social impacts'* which included various aspects of their *'human capital'* such as nutrition, health, education as well as social networks that people draw on in their search for survival, security, and dignity (Kabeer 2003). To derive meaningful insights from the number of studies, this section will focus on exploring the criteria which the various authors have applied to verify the effects of micro-credit programmes on women's health.

Nutrition and health

Malnutrition deserves immense importance because *'the quality of human existence is the ultimate measure of development, and that among the factors affecting the human condition, food nutritional adequacy is perhaps the major determinant'* (Berg 1973). Protein energy deficit is one of the most serious public health problems in Bangladesh (Chowdhury and Khandker 1995).

Atiur Rahman (2002) summarised that the average food intake of a female Grameen Bank member is higher than that of a non Grameen Bank poor female in the same area where the Bank is in operation. Although female borrowers of Grameen Bank have higher intake of food than their counterparts in the control group (non-Grameen Bank females), they never surpassed the males within the Grameen Bank category.

Chowdhury and Khandker (1995) observed that participants of micro-credit programmes are generally in a better position to meet their calorie requirements. However, the calorie intake depends on who participated (men or women) in the programme. They found that, if women participated, they got more of a boost in meeting calorie requirements than men did. Conversely, men's participation helped men more than women. Although the difference is not huge in villages where Grameen Bank is active, the disparity was noticeable.

Use of contraception, reproductive and sexual health

Schuler and Hashemi (1994) observed that, although Grameen Bank does not provide family planning services directly, they influence the use of contraceptive by promoting family planning education, family planning norms and other relevant information. The female borrowers have to learn by heart the *'Sixteen Decision'* before obtaining a loan. One of the decisions' is to have a small family or keep the family small. The study done by Schuler and Hashemi (1994) suggests that *'Grameen Bank appears to have a significant effect on levels of contraception use in communities where the program has been established'.* Participation in the labour force or in the money economy is further factor leading women to apply family planning methods. This general tendency has also been observed with organisations other than Grameen Bank (Schuler et al. 1997). The knowledge of family planning is universal and Grameen Bank membership can effectively influence the use of contraception (Kamal et al. 1992, Rushidan Islam Rahman 1986, Mahmud 1994, Latif 1994).

Anastasi (1995) conducted a qualitative study among Grameen and non-Grameen women to investigate their knowledge and understanding regarding RTI[8]s, STD[9], STI[10]

[8] Reproductive Track Infection

and HIV/AIDS[11] and their prevention. Although the sample size was too small (30 respondents) to *'claim ground-breaking new insights'*, it is probably the only study done so far exploring in a broader sense the relationship between women's involvement in Grameen Bank and their personal control over their sexual lives. The study also examined women's (both Grameen and non-Grameen) decision making process and their influence on condom use as well as their attitude towards condoms.

Anastasi's study also reveals that most of the interviewees suffered from gynaecological problems (white discharge, abdominal pain, abnormal bleeding, weakness, discomfort or disinterest in sex, genital irritation) but at the same time they were feeling shy to seek medical help. Most of the interviewees considered the above mentioned problems as part of their womanhood. Although the HIV/AIDS epidemic is a pending threat to Bangladesh, knowledge of RTIs, STD and HIV/AIDS is severely lacking among women. An adverse attitude is prevalent among the interviewees. In her study Anastasi noted that *'clearly majority of women lack power and self-determination in their personal sexual experiences, and are dominated by men in the sexual sphere. This not only limits their personal freedom and rights, but also puts them at immense risk if sexual disease begins to spread.'* Although Grameen Bank membership increases economic power of women and improves their status within the family, and makes them more assertive in general, it has only very little positive impact on their sexual empowerment.

Violence

Abuse and violence are major causes of the burden of disease worldwide (WHO 2002). Men's violence against women impairs women's health and well-being in a wide variety of social settings (Schuler 1992, Heise 1995). Schuler et al. (1996) pointed out that violence against women in Bangladesh, although originating at home, represents a symptom of a system of female subordination. The authors concluded that group-based credit programmes can reduce the violence against women *'by making women's lives more public'*. This is in a way related to the concept of empowerment which has claimed that the pure fact of increased mobility of women in the public spheres will enhance their

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[9] Sexually-Transmitted Disease
[10] Sexually-Transmitted Infection
[11] Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus

status and well-being, even within the family. The study tried to establish a basic link between women's empowerment through the access to financial sources and a consequent reduction of being maltreated. However, Schuler et al. were careful to state that male violence against women is so deeply rooted in the society that further extensive interventions would be needed to induce significant changes.

There are, however, reports which seem to prove exactly the opposite, namely that the incidents of the violence increases with women's participation in micro-credit programmes. Bhuiya et al. (2002) reported that women members of micro-credit programmes had higher odds of being subject to domestic violence than non-participants. Another study done by Rushidan Islam Rahman (2000) suggests that domestic violence did not decline with the duration of the membership in micro finance institutes. A study done by Aminur Rahman (1999) supports this view. Several examples were found in the village where the study took place where *'women borrowers were not only asked or influenced by males but were forced to join the loan group and acquire funds for male usage'* (Aminur Rahman 1999). This (most probably physical) exertion of force might be a strong indicator of existing domestic violence. Another – though indirect - aspect of violence is that a significant proportion of women's loans are in fact controlled by their male relative which is exactly the opposite of the intended goal of micro-credit programmes (Goetz and Gupta 1996).

Sanitation and safe drinking water

'The quality of latrine facilities does indicate the extent of hygienic living' (Atiur Rahman 2002). Adverse health outcomes are associated with lack of access to proper sanitation. Grameen Bank put emphasis on installing proper sanitary latrines in order to control the diarrhoeal disease. The bank encourages its participants to install sanitary latrines in order to ensure better sanitation in the rural areas in Bangladesh (Islam et al. 1989). Grameen Bank beneficiaries are also encouraged to boil their drinking water or drink water from deep tube wells. Atiur Rahman (2002) observed that most Grameen Bank members use tube well water as source of drinking water. However, the bank is lagging behind in terms of health awareness campaigns (Hossain, PRPA[12] research report 078).

[12] Program for Research on Poverty Alleviation

Health awareness is an important part in reducing the incidence of diseases. It would be of great advantage if the health workers of Grameen Bank could make better and more effective use of their opportunity to disseminate information on health either on field level or in the clinic.

Main findings of the study

The findings of this study indicate that so far most of the research on micro-credit programmes and women's health has been performed using nutrition, contraceptive use and reproductive health, access to safe drinking water and sanitation as key indicators to measure impacts on health or health awareness. The studies which focused on violence did not explicitly address the violence related health risks in details. Most of the studies related violence with empowerment but ignored its immense impact on health. Evaluations attempting to relate calorie intake or nutrition to participation in micro-credit programmes usually neglected the important aspect of food allocation within the household during lean seasons. This would be essential since it has been observed that *'in Bangladesh calorie intake of poor people varies with the season'* (Chowdhury and Khandker 1995). Furthermore, the evaluations tend to ignore women's access to adequate nutrition when there is shortage of food within the family. In Bangladesh *'the widespread intra household disparity of food allocation is a general concern among nutritionists'* (Rushidan Islam Rahman 2000).

There are very few studies - probably only one study conducted by Anastasi (1995) - which explored the knowledge of the female participants of Grameen Bank (and that of non-Grameen Bank women as well) about sexual disease and HIV/AIDS. However, there are numerous attempts to evaluate the impact of micro-credit on women's reproductive behaviour and contraceptive acceptance (Mahmud, 1994, Schuler et al. 1996, Latif, 1994, Khandker & Latif, 1995). The disadvantage of this rather narrow approach was pointed out by Germain (1995); *'the risk of over emphasising reproductive health and family planning is that, they do not meet the requirement of older women and young girls aged 5 – 16'.* The studies establishing the link between the membership of micro-credit programmes and contraceptive behaviour tend to claim the lion share of success for the increase in contraceptive prevalence rate among Grameen women. In Bangladesh the government recognised the problem of increasing population and

invested a lot of money and personnel in family planning programmes. The government of Bangladesh has been working in this field since mid 70's and brought family planning at women's doorsteps to make women aware and sensitize them about the positive effects of a small family. Besides family planning programmes, the government extensively used mass media and interpersonal communication to promote the small family norm. Probably micro-credit programmes complemented the government's effort to disseminate information on family planning and encourage women to keep their family small, but they cannot be solely responsible for the increase in contraceptive prevalence rate. Demographers and social scientists tend to believe that a strong supply side policy coupled with several *'beyond family planning measures'* i.e. employment/ self employment of women, income generating interventions may be attributed to the decline of fertility in Bangladesh (Kamal et al. 1992). The same result has been reported by Amin et al. (2001).

In Bangladesh mostly women are the centre and clients of family planning programmes. Here micro-credit programmes can play an important role by providing women with information on STD, STI and HIV/AIDS and counsel them to influence their husbands to play an active part in family planning. It will, at least, make them aware that keeping their family small is not entirely a female responsibility and help to decrease the spread of sexual disease.

In general the findings and the interpretations of the studies reveal a common weakness. A conceptual clarity of health and a reliable general definition of health are missing while analysing the impact of micro-credit programmes run by Grameen Bank on women's health. Many authors individualised the notion of health and their approach fails to relate their results to a holistic picture of *'well-being'* as defined in the WHO declaration. Furthermore, it is not clear from the studies which criteria were adopted to set the indicators. The authors' concept of health mostly revolves around nutrition, reproductive behaviour and access to safe drinking water and sanitation. Undoubtedly these are important prerequisites for health. However, restricting a survey to these criteria does not give us an overall picture of women's health and their well-being. Through such restricted data one can at best arrive at the conclusion that micro-credit programmes run by Grameen Bank provide women with the access to more food, better sanitation, access to safe drinking water and cause a significant change in their reproductive

behaviour. However, this approach does not tell us whether women participating in Grameen Bank ever reach to *'physical and social well-being'* in the all comprising sense of this concept.

Furthermore, the indicators to measure the impact of micro-credit programmes on health were determined by the investigators, not by the women concerned. Sen (1995) drew our attention to the fact that *'perception'* of health or disease plays a major role in making objective assessments on health. The differences between how health and disease are perceived by the individuals examined in a study as well as the influence of varying circumstances should be made the focus of research to a much greater extent than it has been so far. Strictly speaking it could be unethical on the part of the researcher if they would impose their concept of health on their subjects and at the same time neglect the concepts their subjects have of their own health. Similarly, the studies considered women as a homogeneous group and measured the impact within this biased assumption. Mayoux (1998) pointed out that, *'women are not a homogeneous group as assumed in many impact studies'.*

The studies measuring the impact of micro-credit programmes on women's health also largely ignored other additional risk factors of central importance for women's health and their well-being. These risk factors are:

Environmental risks

The environment in which we live greatly affects our health (WHO 2002). Human exposure to the indoor pollution caused by solid fuel poses great threat to health, especially for women, because women in rural Bangladesh take the responsibility for preparing the meals and other household chores. Many households in rural areas use solid fuels such as dung, wood, agricultural residues or coal for cooking or heating purposes. This problem has not been articulated in any of the studies measuring the impact of micro-credit programmes on *'human capital'* such as health. Anderson et al. (2002) have suggested that human and social capital enhanced through micro-credit programmes can improve environmental conditions and awareness. However, the authors are careful to point out that more empirical research will be needed to demonstrate actual impacts.

Work related health problems

The report of the UN expert group meeting on *'Women and Health'* (1998) states that *'the nature of female labour itself may effect women's health.'* The triple burden, i.e. the multiple demands of productive work, household maintenance, and childbearing and rearing, often leave many poor women with persistent fatigue or chronic pain (Germain 1995). Schuler et al. (1996) observed that women are regarded as economically unproductive and their husbands and in-laws often feel it is wrong from the women's side to incur expenses, even for medical care. To cite one typical striking example of a woman's statement from the article: *'I'm not in a position to tell anyone if somebody in the household gets sick. All I can do is nurse the sick one. Especially, if I get sick myself I never say anything to my husband'.* In one village the author observed that if women want to stay in their husbands' households, they have to work constantly. Women, who are in poor health and tend to often fall sick are then perceived as a burden for their relatives. Still they will have to work to make everybody, especially their husbands, happy. This workload could make women exhausted and could be quite debilitating especially when it is carried out with inadequate resource. Sometimes household chores and caring for others leave women with no or very little time to take care of their own health. Beside this *'triple burden'*, female recipients of Grameen Bank credit have another responsibility of repaying the credit on weekly basis. Sharma and Zeller (1997) have looked at repayment performance of micro-credit programmes in Bangladesh and concluded *'that if basic principles of prudential banking are adhered to, repayment rates can be good even poor and remote communities'.* While this is at first glance a positive result, particularly for the institutions providing loans, it can also be interpreted as an indicator of the pressure arising from the repayment obligation. All these burdens are causes for intensifying workload and fatigue of participating women, and lead the female recipients to chronic discomfort. Work related health issues and chronic diseases specific to women were not part of any of the published studies analysed. Therefore, this aspect certainly calls for an in-depth examination.

Unsafe sex

HIV/AIDS is the fourth biggest cause of mortality in the world (WHO, 2002). A report done by BIDS[13] stated, *'HIV/AIDS is one of the most complex human development problems of recent times. The spread of this complex phenomenon is fuelled among others by poverty, subordinate status of women, illiteracy and socio-cultural customs'* (BIDS 2003). According to USAID[14], the HIV/AIDS epidemic is still at a rather low level in Bangladesh. However, without major changes in behaviour pattern and increase of knowledge about the disease, the illness can spread rapidly in Bangladesh. According to Anastasi (1995), poverty, geographical proximity of Bangladesh to high prevalent of HIV/AIDS nations namely India, Myanmar and Thailand, a large migrant labour force (within and outside the country) with consequent disintegration of families, prostitution industry, sexual inequality within the couples, high rates of illiteracy, lack of information, low condom use etc. could put Grameen Bank female beneficiaries (as well as non-Grameen women) at high risk. An in-depth investigation of knowledge about HIV/AIDS among Grameen Bank participants is needed.

Conclusion

Direct evaluations of effects of micro-credit programmes on women's health are practically non-existent, perhaps with the exception of reproductive health and nutrition. Another question is, whether or not, there is enough justification to make women's health a particular issue of specific importance. In 1995 Simkin has heralded a redefinition of women's health which she deduced from documented gender-specific effects of poverty and violence. *'We need a more inclusive definition of women's health, one that takes into account social, cultural, spiritual, emotional and physical aspects of well being.'* Such definition of health is needed to obtain a conceptual clarity to evaluate the implications of micro-credit programmes on women's health. If the researchers would take into account the WHO risk factors related to poverty as a guideline, at least those relevant for rural settings in Bangladesh, it may help to arrive at a more holistic picture of women's physical and social well being in future.

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[13] Bangladesh Institute of Development Studies
[14] United States Agency for International Development

In essence, after reviewing the literature analysing the impact of micro-credit on women's health, one cannot arrive at the conclusion that women beneficiaries acquire sufficient opportunities for the maintenance of their *'complete physical and social well-being'* due to their enhanced economic status through the participation in Grameen Bank. Furthermore, many of the effects of micro-credit discussed in this study may become more helpful if the targeted poor women are given more opportunities to get actively involved beyond their roles as passive recipients.

Before concluding, I would like to add a note of caution. The critical remarks are exclusively restricted to the narrow topic of this study. They are not meant to imply that the studies as such are of minor scientific value. It is clear that many of the studies were not primarily concerned with health effects of micro-credit programs and that the pertaining information on this topic is often a by-product depending on the design and goal of the respective studies. Similarly, this study cannot really present an unequivocal final picture. It is rather meant to be an incentive for further research which will incorporate some of the criticisms and recommendations presented here.

Limitations of the study

The major limitation of this study is the time constraint. Within this stipulated time limit reliable field study was not feasible which would have ideally given a more in-depth view. Hence this indirect method of resorting to the published secondary data was mandatory. Another limitation is the dependence on availability of published studies.

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Reference

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Appendix

Sixteen Decisions of Grameen Bank:

1. The four principles of the Grameen Bank – Discipline, Unity, Courage and Hard Work – we shall follow and advance in all walks of our lives.
2. Prosperity we shall bring to our families.
3. We shall not live in dilapidated houses. We shall repair our house and work towards constructing new houses at the earliest.
4. We shall grow vegetables all the year round. We shall eat plenty of them and sell the surplus.
5. During the planting seasons, we shall plant as many seedlings as possible.
6. We shall plan to keep our family small. We shall minimize our expenditures. We shall look after our health.
7. We shall educate our children and ensure that they can earn to pay for their education.
8. We shall always keep our children and the environment clean.
9. We shall build and use pit-latrines.
10. We shall drink water from tube wells. If it is not available, we shall boil water or use alum.
11. We shall not take any dowry at our sons' weddings, neither shall we give any dowry at our daughters wedding. We shall keep our centre free from the curse of dowry. We shall not practice child marriage.
12. We shall not inflict any injustice on anyone, neither shall we allow anyone to do so.
13. We shall collectively undertake bigger investments for higher incomes.
14. We shall always be ready to help each other. If anyone is in difficulty, we shall all help him or her.
15. If we come to know of any breach of discipline in any centre, we shall all go there and help restore discipline.
16. We shall introduce physical exercise in all our centres. We shall take part in all social activities collectively.

(Source: http://www.grameen-info.org/bank/the16.html)