Evaluating the Unintended Health Consequences of Poverty Alleviation Strategies

Or What Is the Relevance of Mohammed Yunus to Public Health?

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ABSTRACT

Public health researchers are increasingly shifting their attention away from merely documenting those factors that determine health – a solid evidence base on health determinants now exists – to improving our understanding of how various interventions influence population health. This paper argues for greater investigations of the potential unintended health benefits associated with participation in a poverty alleviation strategy (PAS) in low-income countries. We focus on microcredit, a PAS that has been spreading across the developing world. Microcredit aims to address the “credit gap” between the poor and the better off by offering an alternative for the poor to acquire loans: small groups are formed and loans are allocated to members based on group solidarity instead of formal collateral. We argue that microcredit corresponds with activities that will help build up health capital (e.g., greater access to resources) and describe the main pathways from microcredit participation to health. We advocate that microcredit and other potential pro-health PAS be included among the range of interventions considered by public health researchers in improving the health of the poor.

MeSH terms: Developing countries; poverty; women’s health

RÉSUMÉ

Les facteurs déterminants de la santé des populations sont désormais de mieux en mieux connus. L’attention des chercheurs et des professionnels de la santé publique tend ainsi à se porter davantage sur les effets d’interventions à visée collective et les mécanismes par lesquels ces interventions contribuent à la santé des populations. Cet article défend l’idée selon laquelle il conviendrait d’explorer de manière plus soutenue et plus systématique les effets sur la santé de la participation, dans des pays à faible et moyen revenu, à des activités de lutte contre la pauvreté. Le microcrédit, dont la diffusion est désormais très large, constitue l’une de ces stratégies. Il cible des populations pauvres qui, faute de pouvoir présenter des garanties suffisantes, ne peuvent accéder au crédit, et contribue ainsi à réduire les inégalités sociales. Typiquement, les participants sont réunis au sein de « groupes de microcrédit » solidairement responsables des emprunts réalisés par les membres. Nous soutenons que la participation à des groupes de microcrédit peut, même si ce n’est pas là son intention initiale, contribuer de manière sensible au « capital de santé » des membres des groupes, et explorons les divers mécanismes par lesquels cette contribution peut s’opérer. Nous proposons d’incorporer le microcrédit et les stratégies de lutte contre la pauvreté dans la panoplie des interventions que les acteurs de la santé publique devraient considérer pour promouvoir la santé des populations pauvres.

Mots clés : pays en développement; pauvreté; santé des femmes

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Public health researchers are increasingly shifting their attention away from merely documenting those factors that determine health – a solid evidence base on health determinants now exists – to improving our understanding of how various interventions influence population health.^{1,2} Given what is known about the social determinants of health, these types of inquiries need to extend past the evaluation of public health interventions to include policies and programs that exist outside of the health sector. In this paper, we confine our discussion to low-income countries, where there are high levels of unmet health needs combined with persistent poverty. We argue for greater investigations of the potential unintended health consequences associated with participation in a poverty alleviation strategy.

Poverty alleviation strategies (PAS)

There is a broad range of PAS, from macro-level (e.g., macroeconomic policies) to micro-level interventions (e.g., local income generation programs). PAS may be distinguished according to three broad categories of measures: 1) promotional, which are concerned with promoting real incomes and consumption, endowments, and entitlements, 2) preventive, which aim to directly avert deprivation in specific ways, and 3) protective, or safety nets, which are specific measures guaranteeing relief from deprivation.³ These categories are not meant to be exclusive, but rather can be viewed as moving from wider to narrower domains of specificity. The outer and largest circle, encompasses promotive measures and risk prevention, including macro- and meso-level approaches (e.g., primary education). These measures are oriented towards the poor, but may also benefit the general population. In the middle, preventive measures and risk mitigation are direct anti-poverty measures (e.g., employment creation). The smallest, inner circle includes specific measures providing relief or protection for groups that did not benefit from the other measures and risk coping – the last resort.

Microcredit

One particular PAS that has been spreading across the developing world is microcredit. The general principle of microcredit (a preventive measure) is to provide the poor access to credit to improve their

opportunities to engage in productive activities. The poor often turn to self-employed activities to generate income, yet face challenges in acquiring credit because they lack the necessary collateral (e.g., land) required by formal lending institutions. Microcredit aims to address the “credit gap” between the poor and the better off by offering an alternative for the poor to acquire loans: small groups are formed and loans are allocated to members based on group solidarity instead of formal collateral.⁴ This strategy appeals both to those on the political left, for it is based on redistribution principles, and to those on the right, for it promotes self-sufficiency and independence of the poor through capitalist activities.⁵ The thrust of the movement has been to engage all women groups, designed not only as a strategy for poverty alleviation, but also to increase women’s access to resources and their power in household decision-making.⁶

The 2006 winner of the Nobel peace prize is economist Mohammed Yunus and his Grameen Bank. In 1974, Yunus lent 27 dollars to a group of 43 families in order that they could produce and sell small-scale items. The idea for providing access to credit among the poor stemmed from conversations he had with villagers, such as the conversation presented in Box 1.⁷ This initial lending scheme turned into the Grameen Bank, which now has over 5 million borrowers, who are predominantly women. Yunus is credited with popularizing microcredit not only in Bangladesh, but across the developing world. Microcredit programs are sprouting up in Asia, Africa, Latin America and the Caribbean, and the Middle East. As of December 31, 2004, 3,164 microcredit institutions have reported reaching 92,270,289 clients, 84% of whom are women.⁸ The second phase of the Microcredit Summit Campaign, which aims to ensure that 100 million of the poorest have access to microcredit, was launched in November 2006 in Halifax, Nova Scotia with two new goals (see Box 2). The growing popularity of microcredit across the developing world and the high participation rates of women – thereby avoiding errors of previous anti-poverty schemes, which marginalized women – seems to us to suggest that assessing the potential health effects of microcredit is a

Box 1

Conversation between Mohammed Yunus and a female villager in Bangladesh⁷

“Do you own this bamboo?” I asked.
 “Yes.”
 “How do you get it?”
 “I buy it.”
 “How much does the bamboo cost you?”
 “Five taka.” At the time, this was about twenty-two cents.
 “Do you have five taka?”
 “No, I borrow it from the paikars.”
 “The middlemen? What is your arrangement with them?”
 “I must sell my bamboo stools back to them at the end of the day as repayment for my loan.”
 “How much do you sell a stool for?”
 “Five taka and fifty poysha.”
 “So you make fifty poysha profit?”
 She nodded. That came to a profit of just two cents.
 “And could you borrow the cash from the moneylender and buy your own raw material?”
 “Yes, but the moneylender would demand a lot. People who deal with them only get poorer.”
 “How much does the moneylender charge?”
 “It depends. Sometimes he charges 10 percent per week. But I have one neighbour who is paying 10 percent per day.”
 “And that is all you earn from making these beautiful bamboo stools, fifty poysha?”
 “Yes.”

Box 2

New goals of Microcredit Summit launched at the second phase of the campaign in Halifax, Nova Scotia, November 12-15, 2006

- Goal 1: Working to ensure that 175 million of the world’s poorest families, especially the women of those families, are receiving credit for self-employment and other financial and business services by the end of 2015. (With an average of 5 in a family, this would affect 875 million family members.)
- Goal 2: Working to ensure that 100 million of the world’s poorest families move from below US\$1 a day adjusted for purchasing power parity (PPP) to above US\$1 a day adjusted for PPP, by the end of 2015. (With an average of 5 per family, this would mean that 500 million people would have risen above \$1 a day, nearly attaining the Millennium Development Goal on halving absolute poverty.)

particularly relevant endeavour for the twenty-first century.

Microcredit and health

Microcredit corresponds with activities that will help build up a woman’s health capital, notably through her access to resources and better capacity to use health inputs (e.g., enhanced female autonomy). Four possible pathways may lead from microcredit participation to health: economic, social, psychosocial, and political.⁹ With regard to the economic pathway, participation can lead to the maintenance and restoration of health through the following mechanisms: increased access to economic resources, better access to collective resources or public goods and services, and overall improvements in material conditions. The social pathway operates by maintaining and protecting health through the provision of social support, the changing of social norms to influence health-related behaviours, and increasing social participation. The psychological pathway operates via the provision of opportunities for women to engage in activities or gather information which may help them develop their “self”, potentially leading to greater

self-efficacy and a stronger sense of coherence. And the political pathway may lead to women developing greater “voice”, helping to gain power and access to public resources.

Thus far, there have been pieces of evidence linking participation in microcredit and better health outcomes. Microcredit participation was found to be significantly and positively associated with maternal/child health outcomes, including contraceptive use, pre- and postnatal care awareness, and child growth and survival.¹⁰⁻¹⁴ Studies have also explored other dimensions of women’s health: compared to non-participants, female participants were more likely to demand formal health care, face less exposure to domestic violence, and have better nutritional status in drought-prone areas.¹⁵⁻¹⁷ Despite these preliminary findings, the evidence thus far is limited in its scope, studies generally lack a theoretical framework, and the evidence has come predominantly from cross-sectional studies, precluding an assessment of causality.¹⁸ Moreover, most studies have examined the Grameen Bank and other well-known programs in Bangladesh; we know relatively less about microcredit pro-

grams in other regions of the world. There is a need for more (rigorous) studies that examine different programs in a variety of settings in order to assess the role of context in these types of studies and the conditions of implementation that may affect outcomes.

CONCLUSION

History has taught us that there is no magic bullet solution to improving the health of the poor nor is there any clear path to ending poverty.^{19,20} Microcredit is not a panacea for alleviating poverty,^{4,21} nor can it possibly address all the determinants of health. But microcredit can help to promote the health of women and their families and this should not go undetected by those concerned with improving population health in low-income countries. We advocate that microcredit and other potential pro-health PAS be included among the range of interventions considered by public health researchers in improving the health of the poor.

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