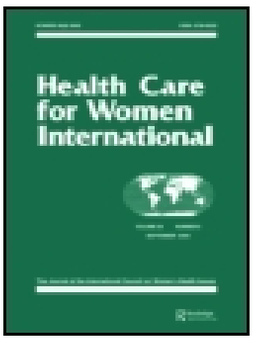

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The triple burden of disease, destitution, and debt: Small business-women's voices about health challenges after becoming debt-ridden

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ABSTRACT

More than 115 million women across the world are borrowers of microfinance loans. However, there is concern that women from poor backgrounds who take loans may suffer from multiple challenges of physical and mental health burdens. In this qualitative study we aimed to identify the types of health challenges faced by active women borrowers of microfinance loans. Open ended questions were asked from 442 women across seven cities and four provinces of Pakistan. Categories were developed through the content analysis approach using NVIVO. We have been able to identify thirteen different health challenges faced by poor women borrowers under two broad headings of "environmental factors" and "healthcare delivery system." We recommend the introduction and expansion of different health and social development services by microfinance provider's to support the health needs of poor women clients. Women also need support from the Government of Pakistan in improving access to education, health coverage, and formal sector work opportunities. Our study implies increased health policy support for disadvantaged women borrowers of microfinance across the world.

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Microfinance loans for small business mobilization have been touted by the international community as the solution to women's poverty across the Global South (Viola, Shi, & Murthy, 2013). This is why 83% of the microfinance loans globally are distributed to women; comprising of a client base of 115 million women (Microfinance Barometer, 2018). However, there is evidence to suggest that poor women may not always gain from small loans due to inability to emerge from poverty or escape from debt cycles (Banerjee & Jackson, 2017). In addition, there is evidence that women in

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debt may be suffering from multiple diseases related to physical and mental health (Meessen et al., 2003). The absence of basic health infrastructure and substandard public health services in developing countries further aggravates the health conditions of poor women (Mitroi, Sahak, Sherzai, & Sherzai, 2016). There is need for continued research to understand the types of health challenges women face across developing regions, since each region is influenced by their own social and environmental circumstances. This study adopts a qualitative design to identify the health challenges faced by poor women borrowers after assuming debt and uses a theoretical framework to assign health challenges under two broad categories of "environment" and "healthcare delivery system." We intend to recommend improvements in health policies offered to women clients by microfinance providers, and also highlight the role of the global microfinance community in guiding regulatory bodies to secure health and social development features for women clients. Our findings also draw attention to (i) the partnership between microfinance and the state in individual nations for the holistic health and wellbeing of women in the Global South and (ii) the implication of debt on health problems faced by poor women across the world.

Background

The microfinance industry has been providing crucial loan injections to support impoverished women (Banerjee & Jackson, 2017). Of the 170 million microfinance clients in the world, 115 million are women borrowers, who mostly belong to developing regions like South Asia (MicroRate, 2013). Microfinance loans for small businesses are the only options for poor populations who cannot avail loans from conventional banks, as they neither have savings accounts or collateral for bank loans. The microfinance loan is short-term and there is close coordination between the borrower and loan officer during the repayment period in order to support business needs and timely repayment (Siwale & Ritchie, 2012). Originally, the Grameen Model of microfinance included strong social development features, such as compulsory group borrowing, skill and development, savings, and health insurance, which promoted the holistic health and wellbeing of women borrowers (Kabeer, 2017). However, microfinance providers (MFPs) are increasingly adopting policies of commercialization and abandoning social welfare initiatives in order to stay in business and prevent risk of closure (Rosengard, 2004). The SMART Campaign, which is an international consortium of microfinance stakeholders, has laid out seven principles for client protection, but there is no mention of health specifically in the guiding principles (The SMART Campaign, 2018).

Some studies have shown that microfinance has had a positive effect on women's reproductive health and child nutrition (Gichuru, Ojha, Smith, Smyth, & Szatkowski, 2019). Access to loans and the ability to start a business has helped women in improving their decision-making, household sanitation, and access to medical facilities (DeLoach & Lamanna, 2011). Conversely, other literature suggests that women borrowers are not gaining with regard to health due to inability to emerge from poverty and lack of social development features provided by MFPs (Miled & Rejeb, 2015). There is also extra burden on women in entrepreneurial work and loan repayment, as they do not have assistance in home and child care (Fernald, Hamad, Karlan, Ozer, & Zinman, 2008). It is because of these mixed results that scholars have recommended that more research is needed to generate ideas for improved regulation and supervision of social development and health services of the microfinance industry (Christen, Lyman, & Rosenberg, 2003; Pouchous, 2012). The global microfinance community includes groups such as: The Consultative Group to Assist the Poor; The International Institute for Sustainable Development, Trade Knowledge Network; Microfinance Information Exchange; Department for International Development; Asian Development Bank; The Smart Campaign; and The Social Performance Task Force. Local bodies in Pakistan that influence regulation and social performance of MFPs include: The State Bank of Pakistan; Pakistan Poverty Alleviation Fund; Securities Exchange Commission of Pakistan; National Bank of Pakistan; National Rural Support Programme (NRSP); and Pakistan Microfinance Network.

Women in debt have been found to face greater health challenges such as sleeplessness, low energy, headaches, general aches and pains, cardiovascular disease, and increased visitation to doctor (Blázquez & Budría, 2015). Research also describes the link between debt and complex mental health problems, including depression, self-harm, and suicide (Gunasinghe et al., 2018). Main reasons for the coexistence of poverty, debt and disease in women, include: (1) Social, economic and political discrimination (O'Donnell, 2007); (2) Suffering the triple shift burden (bearing three different burdens simultaneously, including: (a) managing the home and children, (b) working for paid income inside or outside the home, and (b) providing emotional care) (Thresia, 2018); and 3) Pressure of maintaining small and low-yield businesses with high installment rates (McHugh, Biosca, & Donaldson, 2017).

Pakistan is situated in South Asia and is the sixth most populous country of the world. Founded in 1947, the constitution of Pakistan supports a democratic form of Government. However, the country has been ruled for 30 years by military dictatorships, which has left the country unstable and without consistent development (Israr & Islam, 2006). An estimated 60

million people are poverty ridden in the country (World Bank, 2017). Majority of Pakistani women, at 55%, live below poverty lines (Mahmood, Hussain, & Matlay, 2014). The literacy and crude labor participation rates for women are low, at 51.8% and 14.5% respectively, with the problem compounded as literacy rates do not reflect enrollment in higher education and majority of the working women are part of the informal sector of the economy (Pakistan Bureau of Statistics, 2019). Women in Pakistan face multiple health challenges such as low life expectancy, high morbidity, high maternal mortality, undernutrition, burden of infectious and non-communicable diseases, and domestic violence and injury (Zaidi, Saligram, Ahmed, Sonderp, & Sheikh, 2017). Only 11% of Pakistani women are banked and eligible for loans, indicating that majority women depend on MFPs for loans and savings schemes (State Bank of Pakistan, 2019).

A total of 42 MFPs are functioning in the country (Pakistan Microfinance Network, 2015), to provide loans to over 5.5 million borrowers, of which 2.7 million are women (Pakistan Microfinance Network, 2018). The total asset base of the microfinance industry is PKR 330 billion, which is 5% of the total financial sector in the country. Seventy percent of the MFPs are microfinance banks (MFBs), which have baseline profit objectives. The microfinance institutes (MFIs) do not have profit agendas, but are falling short in regulating and encouraging social development features like health and savings for women borrowers (Pakistan Microfinance Network, 2015). The Islamic MFPs in the country are providing loans on profit and loss share basis or are providing interest-free loans with documentation charges (Akhter, Akhtar, & Jaffri, 2009). MFPs in the country have been allowed to release loans up to PKR **500,000** since 2012, however, poorer populations are provided far less (Pakistan Microfinance Network, 2018). The interest rates are being calculated through both the flat and declining balance method across different MFPs.

As previous research has neglected the health of women borrowers of microfinance (Pouchous, 2012), we aim in this study to add to the empirical evidence regarding health challenges facing women. There is need for more qualitative research (Abed & Matin, 2007), as subjective experiences of women borrowers provide a deeper level understanding of the problem (Green & Thorogood, 2018). To the best of our knowledge, there are almost no studies from Pakistan about the health challenges faced by women borrowers of microfinance. Furthermore, there are benefits to analyzing qualitative data through a theoretical model (Hackett & Strickland, 2018). Development of a theoretical model for classifying health challenges for this study has been derived through the Framework for Assessing Behavioral healthcare (Phillips, Morrison, Andersen, & Aday, 1998). Two broad classifications for challenges influencing health behavior are

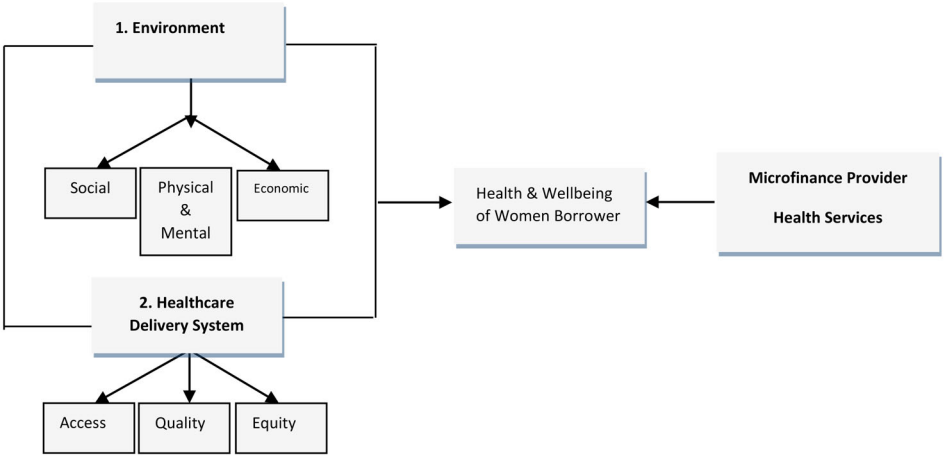

Figure 1. The theoretical model for this study showing two broad classifications of "environment" and healthcare delivery system' and the intermediary supportive role of microfinance provider.

proposed, as shown in Figure 1. First, "environmental factors" contribute to health challenges; including social, physical, and economic factors. Second, health challenges are also caused by the limitations of the "healthcare delivery system." For our study, the theoretical frame also helped to establish a link with the MFP, which can support the health needs of poor women clients.

Methodology

This paper is part of a mixed methods study assessing the health quality of life and social development of poor women borrowers of microfinance in Pakistan.

Ethics

Ethics approval was taken from the Institutional Review Board, Forman Christian College University. No names of women borrowers were recorded and informed consent was taken before data collection. Women were offered free counseling services in the event they suffered any psychological problems in recounting and sharing health experiences. Women were interviewed in safe and private spaces at the microfinance office. They were also assured that they could leave the research at any point during the proceedings.

Sampling

Our selection criterion for sampling was: (i) current women borrowers' part of a loan-cycle, and (ii) borrowers for more than one year. The pilot test for this project took place in Lahore in January 2018 with women

Table 1. Target and actual sampling breakdown across the provinces.

	Punjab	Sindh	Baluchistan	KPK	Total
Total Population	120,012,442	47,886,051	12,344,408	**35,525,047**	**215,767,948**
Population weightage	53.0%	23.0%	6.8%	17.2%	100%
Target sample	265	115	34	86	500
Final MFPs sampled	*4*	*1*	*1*	*1*	*7*
Final women sampled	*252*	*100*	*50*	*40*	*442*
Respondents sampled within each city	100 = Khanewal 100 = Sheikhapura 041 = Gujranwala 011 = Lahore	100 = Matiari	100 = Lasbela	40 = Abbotabad	

clients of a MFB. Twelve participants were sampled in the pilot and this number was deemed sufficient as it yielded the results needed to test the questionnaire and assess the comfort of the participants (Isaac & Michael, 1995). The results of the pilot test have not been included in the final results. The main finding from the pilot study was that women preferred a private room in the offices of the microfinance provider compared to their home for data collection. Women explained that they could give more time at the microfinance offices, as distractions by family and household matters were expected at home. There was also less space in the houses of poor women borrowers for data collection in privacy. Additionally, it was deemed safer and more expedient for women research assistants to collect data at the microfinance office.

A total of 500 women were targeted for data collection based on the population weightage of each province (Punjab = 265, Sindh = 115, Baluchistan = 34, and KPK = 86) as described in Table 1. A list of MFPs available by Pakistan Microfinance Network was used for random selection of providers (Pakistan Microfinance Network, 2015). Twenty MFPs were contacted through different methods: email, personal visits, and telephonic calls. We did not receive permission to share the names of MFPs in our sample due to organizational policies and privacy issues. A final 7 MFPs in 7 different urban cities across 4 provinces of the country were sampled, including: 4 MFBs, 1 MFI, 1 government MFP, and 1 Islamic MFP. The main conditions for loan eligibility include: a valid national identity card, no history of a criminal record, and two community guarantors. The women taking loans from MFBs and MFIs in our sample were receiving: (i) 1 year loans, (ii) loan between USD 71.98–1,079.76[1], and (iii) interest rates charged between 2.5% and 25%. The government MFP and Islamic MFP were also providing one year loans, but a smaller loan range between USD 143.97 and 359.92. Interest rate charged by the government MFP was 10%, whereas the Islamic MFP was not taking interest and only charging client's documentation fee of USD 10.80.

Figure 2. The map of Pakistan indicating the seven cities, across four provinces, where data has been collected for this study.

None of the MFPs in our sample are offering mandatory schemes for health, savings, group loans, and monthly meetings with loan officers. Late penalties vary across the provider in rate and are allocated per day for all MFPs. The sampled cities within each province are indicated on the map, Figure 2. The number of women sampled across each city was: 100 from Khanewal; 100 from Sheikapura; 100 from Matari; 50 from Lasbela; 41 from Gujranwala; 40 from Abbotabad; and 11 from Lahore. Fewer women were sampled in KPK compared to the target due to regional instability and safety of women research team. It was decided to sample more women from Baluchistan to compensate for KPK, as Baluchistan is comparable to KPK in terms of underdevelopment. All women participants belonged to large urban cities of Pakistan and we were unable to sample rural areas due to lack of permission from MFPs. No incentives or gifts were offered to the MFPs or the women for participation in the study. We had a high response rate of 88.4%. We feel the response was high because: (i) women wanted to share information about their health circumstances, and (ii) women were encouraged by the privacy afforded by the MFP office.

Data collection

We required women data collectors with research experience to read out the questions on the survey and help write the answers for illiterate or

semi-literate women participants. Different universities and Non-Government Organizations were consulted near the cities for nomination of research assistants with a minimum of two years field research experience. A total of 7 group research leaders and 21 research assistants were part of the data collection team for this project. Each team was responsible for data collection in one city and consisted of 1 group research leader and 2 research assistants. The data collection teams were trained on research objectives, how to conduct the questionnaire, and ethical issues. All the group research leaders received training in Lahore, by the first and second author. The two research assistants from Lahore were trained in person, whereas, due to limited budget, the other 19 research assistants from other cities were trained through voice and video calls and by their respective group research leader.

The interviews took place at the microfinance office as and when women borrowers visited the office for loan interest repayment or meeting with loan officers. The data was collected between February to November 2018. The interviews lasted between 45-60 min. As the working and academic language in Pakistan is English, the data collectors were multilingual in English, the national language Urdu, and local languages where data was collected respectively. The data was collected through the researcher-administered technique and data collectors recorded the qualitative answers from women participants through audio recording or through notes on survey. Later, both the notes and audio-recordings were checked, verified and translated to English by different members of the research team.

As this paper was part of a mixed methods study, based on their willingness to participate, first the women were quantitatively sampled through a closed ended survey and later asked three open ended questions (Supplementary File 1). The open-ended questions for this study were derived through existing literature review and previous research experience of the first author (Jafree & Ahmad, 2013). Women borrowers were asked to describe the: (1) Health problems they faced in the last 12 months, (2) Barriers they faced in accessing health services in their community, and (3) Main problems which prevented them from being completely satisfied with their health since they had taken loan.

Analysis of data

The data was analyzed through the content analysis method with the help of NVIVO software (Boeije, 2002). Data from the surveys were transcribed and entered into Microsoft Excel by research assistants. This data entry was checked by two of the authors to ensure that all data entered was complete and recorded correctly. The data was then transferred to NVIVO and

codebooks for the two broader areas of "environment" and "healthcare systems" were assigned. Categories were identified and then similar categories were grouped together, until no new categories were detected. At second step sub-categories were generated under the two broad categories of "environmental" and "healthcare delivery system," based on the Framework for Assessing Behavioral healthcare (Phillips et al., 1998).

We ensured trustworthiness of our data as guided by scholarship (Schwandt, 2001). Dependability of data was secured through a data audit by the funding organization of this project. Confirmability was secured through triangulation and research member checks at regular intervals (Polit & Beck, 2010). Senior consultants from the fields of clinical health practice and social sciences were also consulted during each research step. The fixed semi-structured questions in the survey ensured that there was homogenous data collection. The final findings and themes were verified by: (i) the entire research team, (ii) four microfinance loan officers who had been meeting women borrowers bi-weekly and had knowledge of client life and health circumstances, and (iii) six current women borrowers of microfinance who had not participated in the study (Shenton, 2004).

Results

Demographic and loan characteristics of participants

A total of 442 women were part of the final study (Table 2). The age of the participants is between 18 to 49 years, with 17.6% between 18 and 20 years, 39.1% between 20 and 29 years, 30.8% between 30-39 years, and 12.4% between 40-49 years. Majority of the participants are uneducated, at 66%, and all women earn or have a household income of below $4.82 a day, which lies below the international poverty lines (Ravallion, 2017). Nearly all the sample at 93.7% is married and 61.5% have more than three children. The majority of women have last child born below the age of 15 years, at 78.9%. Majority women, at 62.9%, live in a house with more than 6 people. Though majority, at 74.4%, own their own house, nearly the same percentage (74.2%) are not satisfied with housing quality due to absence of: drainage, toilet with flush, clean water supply, and safe energy for cooking.

The breakdown of the type of business activities women are undertaking with their loan is shown in Table 3. More than 60% of women are involved in home-based activities such as agricultural production and embroidery and stitching. Some have taken the loan to pay rent or installments for ownership of shop businesses, at 24.2%, and others are paying installments for rickshaw ownership (7.2%) or sale of goods on stalls (6.8%).

Table 2. Demographic characteristics of women participants ($N = 442$).

Characteristics	*f* (%)
Age	
18–20 years	78 (17.6%)
20–29 years	173 (39.1%)
30–39 years	136 (30.8%)
40–49 years	55 (12.4%)
Education Status	
None	294 (66.5%)
Primary to Secondary (1–10 grade)	128 (29.0%)
Graduate	20 (04.5%)
Participant Income/ Per day[a]	
Less than PKR 166.7 (USD 1.20)	95 (22%)
Between PKR 166.7–666.7 (USD 1.20–4.80)	347 (78%)
Household Income/ Per day[a]	
Less than PKR 333.3 (USD 2.40)	315 (72%)
Between PKR 333.3–666.7 (USD 2.40–4.80)	127 (28%)
House Ownership	
Yes	329 (74.4%)
No	113 (25.6%)
Housing Quality[b]	
Satisfactory	114 (25.8%)
Unsatisfactory	328 (74.2%)
Number of People living in house	
1–5 people	164 (37.1%)
More than 6 people	278 (62.9%)
Marital Status	
Married	414 (93.7%)
Not married	28 (06.3%)
Parental Status	
No children	31 (07%)
Children	411 (93%)
Number of Children	
None	31 (07.0%)
1–2	139 (31.4%)
3 or more	272 (61.5%)
Age of Last Child	
Less than 5 years	157 (35.5%)
5–15 years	192 (43.4%)
16–24 years	62 (14.0%)

[a]Exchange Rate as at November ending **2018, 1** USD = PKR 138.92; source: .https://www.exchange-rates.org/Rate/USD/PKR/11-30-2018.

[b]The housing quality variable is a compounded variable which includes 1. drainage system, 2. toilet with flush, 3. drinking water supply, and 4. source of energy for cooking.

The loan characteristics of women borrowers are shown in Table 4. Many women, at 74.9%, are attending monthly meetings with loan officers. However, less than 42% of women are borrowing in groups, less than 35% are availing health insurance schemes, and less than 29% are availing savings schemes. Few at 53.6% and 40.0% have received skill and development training or health awareness from loan officer, respectively. Most of our participants at 80.3% are receiving a loan amount between USD 71.98–287.94 a year; while a significant number at 30.5% are paying interest rates per month of 11% to 25%.

Health challenges

Women from all MFP types reported at least seven or more types of health problems and thus differences in health challenges faced by women

Table 3. Business activities from microfinance loans of women participants in our study ($N = 442$).

Type of business activity	*f* (%)
Agricultural business from home Purchase of livestock, agricultural fertilizers and agricultural equipment.	161 (36.4%)
Home-based business Preparing room within house for rent; Setting up tuition center within home; Material and equipment for stitching and embroidery for sale; Buying ingredients to prepare food and bakery items for sale.	109 (24.7%)
Shop business Paying for shop ownership installments or rent. Shop businesses included: electricity, shoe, tailoring, clothes, mat-work, cap-making, and beauty parlor	107 (24.2%)
Rickshaw business Loan taken to pay rickshaw installment for rickshaw tax service	32 (07.2%)
Vendor business Loan taken to purchase vegetables or cloth for sale on stalls	30 (06.8%)
Miscellaneous businesses Purchase material for painting and marble, for sale of paintings and marble-work	3 (00.7%)

Table 4. Loan characteristics of women participants ($N = 442$).

Characteristics	*f* (%)
Borrowing in groups[a]	
Yes	183 (41.4%)
No	259 (58.6%)
Attending monthly meetings	
Yes	331 (74.9%)
No	111 (25.1%)
Availing health insurance scheme[a]	
Yes	154 (34.8%)
No	288 (65.2%)
Availing savings scheme[a]	
Yes	126 (28.5%)
No	316 (71.5%)
Received skill and development training	
Yes	237 (53.6%)
No	205 (46.4%)
Received awareness for health awareness from loan officer	
Yes	177 (40.0%)
No	265 (60.0%)
Loan Amount	
PKR 10,000–20,000 (USD 71.98–143.97)	154 (34.8%)
PKR 21,000–40,000 (USD 151.17–287.94)	201 (45.5%)
PKR 41,000–**100,000** (USD 295.13–719.84)	87 (19.7%)
Interest Rate	
2.5–10%	307 (69.5%)
11–20%	54 (12.2%)
21–25%	81 (18.3%)

[a]Services only provided by MFBs and MFIs.

according to MFP type have not been reported separately. Health challenges have been reported using the theoretical framework of this study, which categorizes problems according to "environment" and "healthcare delivery system." "Environmental" health challenges are further sub-divided under "social," "physical and mental," and "economic" challenges. For the "social" sub-category, we found that women faced the following health challenges: (i) unsupportive loan officers, (ii) communicable diseases, and

Table 4. Summary of categories found for health challenges faced by poor women borrowers of microfinance, ($N = 442$).

Category	Sub-category	*f* (%)
Environment		
Social		
	Unsupportive loan officers worsening health conditions	250 (56.6%)
	Communicable diseases	205 (46.4%)
	No permission to seek healthcare	190 (43.0%)
Physical and mental		
	Stress and Anxiety	412 (93.2%)
	Injuries	328 (74.2%)
	Non-communicable diseases	154 (34.8%)
Economic		
	Poverty	337 (76.2%)
	Small loan and high installment rates	328 (74.2%)
Health delivery system		
Access		
	Access to health centers	377 (85.3%)
	Access for maternal healthcare	184 (41.6%)
Quality		
	Overcrowding and bad conditions of centers	260 (58.8%)
	Inability to communicate with health specialists	242 (54.8%)
Equity		
	Discrimination from family members for health financing	388 (87.8%)
	Shortages in resources at public health centers	388 (87.8%)

(iii) lack of permission to seek healthcare. Under the "physical and mental" sub-category we found that women face health challenges related to: (i) stress and anxiety, (ii) injuries, and (iii) non-communicable diseases. Under the "economic" sub-category we found two health challenges: (i) poverty and (ii) small loans and high installments rates.

The "healthcare delivery system" category is further divided into "access," "quality," and "equity" challenges. Under the "access" sub-category we found that women faced health challenges related to: (i) access to health centers, and (ii) access for maternal healthcare. Under the "quality" sub-category we found health challenges related to: (i) overcrowding and bad conditions of centers, and (ii) inability to communicate with health specialists. Under the "equity" sub-category we found that women face: (i) discrimination from family members in getting out-of-pocket expenses for health and (ii) shortages in resources at public health centers.

Environmental factors causing health challenges

Social

Poor women borrowers ($n = 250$, 56.6%) complained about how the microfinance loan officers were rude and inflexible with the women borrowers with regard to repayment schedules, even when they were unfit health-wise to make timely payments. This caused compounded physical health and mental stress problems for women: "I dread going for meetings with loan

officers … they are not receptive of the health problems I face and this causes more deterioration in health."

Women expressed health challenges related to high frequency of communicable diseases ($n = 204$, 46.4%). Common infectious diseases named by the participants included flu viruses, inflammation of lungs, and gastroenteritis. Women further listed known causes for risk to infectious disease including limited availability to unadulterated water, bad housing conditions, and rise of air pollution: "There is no week in the month when I or one of the children does not have flu or an upset stomach."

Women also complained of lack of permission from family members to seek healthcare from trained practitioners and health clinics ($n = 190$, 43.0%). Many of the women are running a business from home and are not given permission from husband or in-laws to seek healthcare from trained practitioners. Instead they are encouraged to seek healthcare from home remedies or community healers: "We work from home. We are rarely allowed to leave the house and there is no permission to visit health centers or hospitals."

Physical and mental

Stress and anxiety were listed as mental health problems in women ($n = 412$, 93.2%), caused mainly by the compounded pressures of poverty, small business maintenance, and loan repayment. Women described how they were not able to comfortably sleep at night and that there life revolved around the stress of timely repayment on due dates. Significant stress was also caused by the inability to sustain and grow business and expected dependency on repeat loans in the future: "I am barely able to keep the business profitable. Stress of loan repayments keeps me worried … then there is additional worry that I would have to retake loan after this cycle if I want to keep the business alive."

A significant number of women also listed cooking injuries ($n = 328$, 74.2%) as a recurring health challenge as they balanced both paid work and home responsibilities. The lack of water pipes and gas supply meant that many women had to collect water from community taps and collect firewood to cook food. Both these tasks caused women injuries, back pains, and breathing problems. Additionally, the extra time required in water and firewood collection, and food preparation, became a barrier for health maintenance and aggravated the triple shift burdens on women: "There is no water and gas facility, carrying water from far and cooking on fire takes more time and energy. I suffer from back pains and breathing problems and am barely able to manage the business and the home simultaneously."

Women participants also identified health problems of non-communicable nature ($n = 154$, 34.8%). Despite being diagnosed as having high blood pressure or diabetes, many women participants were not taking regular medication due to lack of finances for medicines required in chronic health conditions. Women were also not committed to regular checkup, monitoring of chronic ailments or alteration of lifestyle for health. Those who had been diagnosed with heart disease mentioned that they only took their medicine when symptoms worsened: "I keep some heart pills the doctor advised me to take daily as emergency stock. If I feel pain or uneasy, I take one pill."

Economic

A significant challenge preventing health-seeking behavior faced by women was extreme poverty ($n = 337$, 76.2%). Impoverished women participants did not belong to the formal sector and consequently did not have benefits such as: health insurance, health loans, and investment in savings schemes. There was also the problem of inadequate and inefficient public healthcare services. Ultimately, paying for consultancy, medication, and traveling to the health center became an individual burden for women. Women mentioned that they had heard about the better quality of private hospitals, but that they could not avail private services due to high costs, and also because they were debt-ridden: "There is no money left for health after household expenses, business expenses, and debt repayment."

Another cause for lack of health finances was listed as the small loan amount and high interest rates ($n = 328$, 74.2%). The small loan amount prevented women from developing businesses with profits and the high interest rates drained them of any savings left for healthcare. Many women insisted that if the loans were bigger and the interest rates less oppressive, they would be able to buy more food and adopt healthier lifestyles. In addition, frequent losses in business and the strict schedule of repayment added to the burden of disease for women, specifically mental health: "A bigger loan would have enabled me to buy additional livestock for our family milk business, and I could have left my second job as a cleaner. I know that the numbness in my feet is from overwork and I have no money or time for tests."

Health delivery system causing health challenges

Access

Access to health centers is a considerable hurdle preventing poor woman from receiving healthcare services ($n = 377$, 85.3%). Women participants described the difficulty in accessing public healthcare services mainly due to: non-availability and distance of center, and non-availability of specialist

practitioners. Women borrowers complained about the lack of advance health facilities in the community like specialists for heart disease and high risk pregnancies. Delays or inability in accessing health centers meant consequent delay or absence of treatment and recovery for women and their families: "There is a government (primary) health unit in our locality, but the distance on foot is far. There is also no children's (pediatric) doctor or lady doctor there."

Women in the sample who were pregnant or had experienced pregnancies in recent years listed maternal health challenges such as: lack of or inadequate prenatal and postnatal healthcare services and lack of relief during maternity or lactation period as major health challenges ($n = 184$, 41.6%). The burden of having no reprieve from business duties during pregnancy caused women to fear conception. Some who had access to maternal health clinics mentioned their experiences, especially when the pregnancy period and delivery did not go as planned or presumed: "I am scared of getting pregnant again. Not only does it (pregnancy) mean difficulty in managing the business, but the maternal health services are far from my house."

Quality

Women participants were burdened by the inability to communicate with health specialists ($n = 260$, 58.8%). Majority women borrowers complained about the quality of services and treatment provided by the rural health centers and tehsil health center. Participants shared that the overcrowded and non-hygienic environment further aggravates the health conditions and mental state of the women. It was mentioned that the doctors and nurses gave less than five minutes to each patient and they had no time to discuss the diagnosis or treatment with women: "I am unable to wait for my turn or consult with the government doctors, because there is too much rush and lack of space."

Women participants who visited health centers and public hospitals described that they remained unsure about the instructions provided by the healthcare practitioners due to lack of understanding or informed communication by practitioner ($n = 242$, 54.8%). Women remained unaware of how to adopt optimal health seeking behavior and bad experiences with the practitioner made them reluctant to pursue follow-up: "The doctor does not explain the diagnosis or treatment, and I am unable to completely understand what to do when I return home … or how or when to take the medicine prescribed."

Equity

Women participants described suffering from discriminatory behavior at the hands of family and the health sector ($n = 388$, 87.8%). Women shared

that their business initiatives were seen as rebellious behavior by conservative family members who frowned on working women: "Though I hardly earn enough and I work for my children's betterment, I am regularly taunted about my "independent nature." When I needed money for medicine, I was told by my husband, "*dont you have enough from your successful business?*". Private healthcare is only accessible for the wealthy and most public centers are short of resources and supplies: "There are limited or no supplies at the government health centers. Only the rich can get medical services in Pakistan."

Discussion

The sampled women borrowers in this study belong to the lowest income strata of Pakistani society and are living in extreme poverty. Our sample of large urban cities, allowed us to put into perspective the relationship between poverty and urbanization (Batty, 2006). We found that despite living in large urban cities women perceived unfavorable settlement burdens, including: infectious diseases, lack of access to health centers and specialist practitioners, bad quality state healthcare, bad living conditions and housing quality, and few opportunities for business development and profitability. Other researchers from the country confirm that due to rapid urbanization, large cities in Pakistan are housing the poor in urban slums, which have critical problems of pollution, disease burden, corruption, weak governance, and financial insecurity (Jamal, 2005). We can imply that if health circumstances and economic opportunities for poor women are unfavorable in the larger urban cities', the situation may be worse for women in the remote, rural, village, and smaller city areas; because health budget allocations and access to health services in rural areas is far inferior in Pakistan compared to the urban areas (Akram & Khan, 2007).

Most of the women in our sample are working from home and do not have state or employer support for health coverage. Furthermore, majority of the illiterate or semi-literate women in our sample have limited knowledge about public health, hygiene, and basic sanitation. This may be why we found high incidence of communicable disease in women borrowers. Other scholarship confirms that Pakistan is facing rising infectious disease burdens due to environmental pollution and changing climate conditions, overcrowding and transport emissions, and unhygienic water and poor sanitation (Sultan & Khan, 2013). We also found that women suffer from injuries due to use of wood and fires for cooking and having to collect water from far. Most poor families from developing regions live in houses without gas and water supply and consequently suffer from injuries due to bad housing quality (S. Siddiqui & Mehfooz).

Through listening to participants it has been learnt that poor women are dependent on the services of the public health sector due to lack of finances for private healthcare. However, critical problems related to access and utilization of public health services were highlighted such as: lack of access, overcrowding and bad condition of facilities, inability to communicate with health specialists, and absence of state coverage or health insurance plans. Women in Pakistan are known to face problems of traveling to health centers due to distance and lack of permission to travel alone (Siddiqui, Hamid, & Siddiqui, 2000). Other local researchers have also confirmed that there is a shortage of specialized practitioners, staffing and resources, overcrowded hospitals, and bad behavior of health staff (Nishtar, 2010). All the women in our sample are of reproductive age and majority are married with more than three children. Many have indicated that they require more access and support for maternal health services. Other research confirms that maternal healthcare services in the country are not adequate (Bhutta et al., 2004). There is no universal health coverage by the state for the poor in Pakistan, and women who are unable to get services from the public sector face further vulnerabilities due to lack of out-of-pocket health finances for private healthcare (Afzal & Yusuf, 2013).

Women participants of our study also suffered from mental health problems and non-communicable disease burden. Stress and anxiety are exacerbated in poverty-ridden women due to burden of debt and small business maintenance; while blood pressure and diabetes were also listed as challenges. The concern is that women borrowers receive no support or social acceptance regarding seeking counseling for stress and anxiety. Other researchers have confirmed that women have high rates of mental health issues in Pakistan with almost no social support and acceptance for counseling (Niaz, 2004). We also found that lack of health awareness and poverty prevents women from the uptake of regular medication for chronic diseases. Non-communicable diseases are on the rise in Pakistan, and other developing regions, and are paralleling the burden of infectious diseases, mainly due to rising financial burdens and regional political insecurity (Roshan, Hamid, & Mashhadi, 2018). The additional problem of populations with low health literacy is that they do not recognize the benefits of follow-up and care for chronic diseases, such as regular checkups, consistency in medication, and continuum of care.

We found that participants perceive inability to emerge from poverty and spend money on health due to lack of profitability from small loans and high interest rate installments. Other scholars also confirm that MFPs may be exploiting the poor with high interest rates and deluding vulnerable populations into believing the returns will not be taxing on their overall quality of life (Mitra, 2009). Our results lead us to believe that negligible

loans prevent women from developing their businesses and securing larger returns, and high installments leave them with bare incomes to manage household expenses and business running costs. Loan and debt pressure, thus, leaves little money for sustaining and improving health and wellbeing of women borrowers. In fact, destitution and debt can amplify the disease burden in a vicious cycle for women in the Global South (Blázquez & Budría, 2015). Women borrowers are further crippled by lack of support by MFPs with regard to provision of mandatory health insurance, health loans, or saving schemes. Reasons for many MFPs not providing these services is due to lack of profitability and fears of installment defaults in these features (Bateman, 2010).

Our findings help us to decipher that in this period of destitution, debt, and disease, women are not supported by either family or loan officers for health expenditure or optimal health behavior. Many families do not give permission or provide financial support to women for health seeking behavior, and loan officers are dismissive of discussing anything apart from payment schedules for loan installments. Women specifically complained about the rude and abrupt behavior of both loan officers and health practitioners. Other research confirms that loan officers can be extremely rude and unpleasant in forcing loan recovery from women clients (Islam, Karim, & Binti Ahmad, 2018); and that healthcare practitioners can be dismissive and arrogant with illiterate and semi-literate patients (Saqib et al., 2018). In this way, we may also conclude that women borrowers, despite operating small businesses and contributing to household income, are dependent on the cultural support, from family, healthcare practitioners, and loan officers, for their health and wellbeing.

Limitations of study

This is a qualitative study with the limitation of having to depend on the perceptions and experiences of women participants. We were unable to sample rural areas due to inability to gain permission for data collection by MFPs. The research team was unable to take audio recordings from all participants due to permission issues. Thus, some of the results and participant quotes are dependent on the notes taken by the research assistants and not direct quotes from audio recording. In future studies we hope to interview family members of borrowers for a deeper understanding about health challenges faced by family and to pursue an intervention based research project to assess the impact of health interventions by MFPs on health improvements in women borrowers. However, we feel the current study contributes to the scholarship by: (i) listening to poor women borrower's voices with regard to the health challenges they face, (ii) providing a

theoretical framework to classify health challenges within the socio-economic structure of society, and (iii) providing a description for how microfinance providers can support the health needs of their poor women clientele. We also believe our findings are of relevance when considering the health needs of women in the Global South and LMIC, and also for poor women living in the developed world.

Concluding recommendations

Based on our study findings we recommend the extension of women consumer protection laws of the microfinance sector by introducing mandatory health services, such as: (i) health insurance, (ii) health loans, (iii) savings schemes, (iv) house loans for home improvement (water and gas lines) and (v) supportive loan officers and group borrowing (for health support), (vi) flexible loan repayment schedules, lower interest rates and larger loans, and (vii) maternity allowances. With regard to the last point, we encourage the development of a maternal benefits policy for pregnant women borrowers working in the informal sector, considering features such as: (i) maternal healthcare coverage, (ii) payment for institutional delivery, (ii) lactation supplementation, (iii) flexible repayment schedule after birth of child, and (iv) savings scheme for child's health and education.

Health camps and regular awareness sessions by the MFP on how to deal with: (i) mental health problems (stress and anxiety), (ii) business losses and cycles, and (iii) health and wellbeing (basic hygiene, avoiding infection, regular checkups and medication for chronic ailments) are also recommended. Health camps by the MFP would help disadvantaged women access healthcare services, specialist consultancy, and medication which are currently not available to them. Health awareness sessions and health camps have been successfully introduced in other countries like India and Bangladesh (Hamid, Roberts, & Mosley, 2011; Saha, 2011; Saha, Kermode, & Annear, 2015). Awareness sessions can also play a dual role in raising awareness for cultural support from the family, spouse, and in-laws, in recognizing the importance of women monitoring their health and seeking health from trained healthcare practitioners. For conservative countries like Pakistan where women's health decisions are controlled by family members, it is even more important to have awareness sessions with family members (Mustafa et al., 2015).

There is fear that despite improvements in health features provided by microfinance sector, poor women will not benefit holistically. Ultimate poverty elimination and holistic social development of poor women in the Global South is dependent on the collaboration between the state and society to remove both cultural and structural barriers preventing the capacity

expansion of women. An increase in the health budget, from the current low of 0.5% is critically needed (Ahmed & Shaikh, 2008). With regard to the interim problems of the public health sector, the following measures are needed: (i) cultural competency of healthcare practitioners, (ii) health literacy and public health campaigns, (iii) travel allowances to access health services and availability of mobile health services for women, (iv) availability of specialist practitioners and maternal healthcare, and (v) financial protection for disprivileged women. In the long-run poor women's health must be secured through systematic and consistent: rights to universal and higher education, equitable and timely health access and universal health coverage, and formal sector employment opportunities.

Note

1. Pakistan Rupees (PKR) for this paper have been converted to US Dollars (USD) at the official exchange rate as at November ending 2018, which was 1 USD = PKR 138.92; source: https://www.exchange-rates.org/Rate/USD/PKR/11-30-2018

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References

Abed, F. H., & Matin, I. (2007). Beyond lending: How microfinance creates new forms of capital to fight poverty. *Innovations: Technology, Governance, Globalization*, *2*(1-2), 3–17. doi:10.1162/itgg.2007.2.1-2.3

Afzal, U., & Yusuf, A. (2013). *The state of health in Pakistan: An overview*. Paper presented at the The State of Health in Pakistan: An Overview" with Anam Yusuf, paper presented at the Ninth Annual Conference on Management of the Pakistan Economy, Lahore School of Economics. Paper published in the Lahore Journal of Economics: Special Edition.

Ahmed, J., & Shaikh, B. T. (2008). An all time low budget for healthcare in Pakistan. *Journal of the College of Physicians and Surgeons-Pakistan : Jcpsp*, *18*(6), 388–391. doi: 06.2008/JCPSP.388391

Akhter, W., Akhtar, N., & Jaffri, S. K. A. (2009). *Islamic microfinance and poverty alleviation: A case of Pakistan*. Proceeding of the 2nd CBRC, Lahore.

Akram, M., & Khan, F. J. (2007). *Health care services and government spending in Pakistan*, Pakistan Institute of Development Economics. Islamabad, Pakistan.

Banerjee, S. B., & Jackson, L. (2017). Microfinance and the business of poverty reduction: Critical perspectives from rural Bangladesh. *Human Relations*, *70*(1), 63–91. doi:10.1177/0018726716640865

Bateman, M. (2010). *Why doesn't microfinance work?: The destructive rise of local neoliberalism*. London, UK: Zed Books Ltd.

Batty, M. (2006). *Hierarchy in cities and city systems Hierarchy in natural and social sciences* (pp. 143–168). New York City, NY: Springer.

Bhutta, Z. A., Gupta, I., de'Silva, H., Manandhar, D., Awasthi, S., Hossain, S. M. M., & Salam, M. A. (2004). Maternal and child health: Is South Asia ready for change?. *Bmj (Clinical Research ed.)*, *328*(7443), 816–819. doi:10.1136/bmj.328.7443.816

Blázquez, M., & Budría, S. (2015). *The effects of over-indebtedness on individual health*. Retrieved from: http://ftp.iza.org/dp8912.pdf

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity*, *36*(4), 391–409.

Christen, R. P., Lyman, T. R., & Rosenberg, R. (2003). *Microfinance consensus guidelines: Guiding Principles on regulation and supervision of microfinance*, The World Bank Group, Washington, USA. Retrieved from: https://www.cgap.org/sites/default/files/CGAP-Consensus-Guidelines-Guiding-Principles-on-Regulation-and-Supervision-of-Microfinance-Jun-2003.pdf.

DeLoach, S. B., & Lamanna, E. (2011). Measuring the impact of microfinance on child health outcomes in Indonesia. *World Development*, *39*(10), 1808–1819. doi:10.1016/j.worlddev.2011.04.009

Fernald, L. C., Hamad, R., Karlan, D., Ozer, E. J., & Zinman, J. (2008). Small individual loans and mental health: A randomized controlled trial among South African adults. *BMC Public Health*, *8*(1), 409. doi:10.1186/1471-2458-8-409

Gichuru, W., Ojha, S., Smith, S., Smyth, A. R., & Szatkowski, L. (2019). Is microfinance associated with changes in women's well-being and children's nutrition? A systematic review and meta-analysis. *BMJ Open*, *9*(1), e023658. doi:10.1136/bmjopen-2018-023658

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. California, CA: Sage.

Gunasinghe, C., Gazard, B., Aschan, L., MacCrimmon, S., Hotopf, M., & Hatch, S. L. (2018). Debt, common mental disorders and mental health service use. *Journal of Mental Health*, *27*(6), 520–528. doi:10.1080/09638237.2018.1487541

Hackett, A., & Strickland, K. (2018). Using the framework approach to analyse qualitative data: A worked example. *Nurse Researcher*, *26*(3), 2–39. doi:10.7748/nr.2018.e1580

Hamid, S. A., Roberts, J., & Mosley, P. (2011). Evaluating the health effects of micro health insurance placement: Evidence from Bangladesh. *World Development*, *39*(3), 399–411. doi:10.1016/j.worlddev.2010.08.007

Isaac, S., & Michael, W. B. (1995). *Handbook in research and evaluation: A collection of principles, methods, and strategies useful in the planning, design, and evaluation of studies in education and the behavioral sciences*. California, CA: Edits Publishers.

Islam, R., Karim, M. A., & Binti Ahmad, R. (2018). Forced Loan-recovery technique of the microfinance institutes in Bangladesh and its impact on the borrowers: An empirical study on Grameen Bank, BRAC and ASA. *Journal on Innovation and Sustainability. RISUS ISSN 2179-3565*, *9*(3), 75–93. doi:10.24212/2179-3565.2018v9i3p75-93

Israr, S. M., & Islam, A. (2006). Good governance and sustainability: A case study from Pakistan. *The International Journal of Health Planning and Management*, *21*(4), 313–325. doi:10.1002/hpm.852

Jafree, S. R., & Ahmad, K. (2013). Women microfinance users and their association with improvement in quality of life: Evidence from Pakistan. *Asian Women*, *29*(4), 73–105. doi:10.14431/aw.2013.12.29.4.73

Jamal, H. (2005). In search of poverty predictors: The case of urban and rural Pakistan. *The Pakistan Development Review*, *44*(1), 37–55. doi:10.30541/v44i1pp.37-55

Kabeer, N. (2017). Economic pathways to women's empowerment and active citizenship: What does the evidence from Bangladesh tell us?. *The Journal of Development Studies*, *53*(5), 649–663. doi:10.1080/00220388.2016.1205730

Mahmood, S., Hussain, J., & Z. Matlay, H. (2014). Optimal microfinance loan size and poverty reduction amongst female entrepreneurs in Pakistan. *Journal of Small Business and Enterprise Development*, *21*(2), 231–249. doi:10.1108/JSBED-03-2014-0043

McHugh, N., Biosca, O., & Donaldson, C. (2017). From wealth to health: Evaluating microfinance as a complex intervention. *Evaluation*, *23*(2), 209–225. doi:10.1177/1356389017697622

Meessen, B., Zhenzhong, Z., Damme, W. V., Devadasan, N., Criel, B., & Bloom, G. (2003). Iatrogenic poverty. *Tropical Medicine and International Health*, *8*(7), 581–584. doi:10.1046/j.1365-3156.2003.01081.x

Microfinance Barometer (2018). *Microfinance and profitabilities*. Retrieved from http://www.convergences.org/wp-content/uploads/2018/09/BMF_2018_EN_VFINALE.pdf.

MicroRate (2013). The State of Microfinance Investment 2013. Retrieved from http://www.microrate.com/media/downloads/2013/11/MicroRate-The-State-of-Microfinance-Investment-2013.pdf.

Miled, K. B. H., & Rejeb, J.-E. B. (2015). Microfinance and poverty reduction: A review and synthesis of empirical evidence. *Procedia - Social and Behavioral Sciences*, *195*, 705–712. doi:10.1016/j.sbspro.2015.06.339

Mitra, S. K. (2009). Exploitative microfinance interest rates. *Asian Social Science*, *5*(5), 87–93. doi:10.5539/ass.v5n5p87

Mitroi, L. R., Sahak, M., Sherzai, A. Z., & Sherzai, D. (2016). The women's health care empowerment model as a catalyst for change in developing countries. *Health Care for Women International*, *37*(3), 275–289. doi:10.1080/07399332.2014.926903

Mustafa, G., Azmat, S. K., Hameed, W., Ali, S., Ishaque, M., Hussain, W., … Munroe, E. (2015). Family planning knowledge, attitudes, and practices among married men and women in rural areas of Pakistan: Findings from a qualitative need assessment study. *International Journal of Reproductive Medicine*, *2015*, 1–8. doi:10.1155/2015/190520

Niaz, U. (2004). Women's mental health in Pakistan. *World Psychiatry*, *3*(1), 60–62####62.

Nishtar, S. (2010). *Choked pipes: reforming Pakistan's mixed health system*. Karachi: Oxford University Press.

O'Donnell, O. (2007). Access to health care in developing countries: Breaking down demand side barriers. *Cadernos de Saude Publica*, *23*, 2820–2834.

Pakistan Bureau of Statistics. (2019). Labour Force Survey, 2017–2018. Retrieved from: http://www.pbs.gov.pk/sites/default/files//Labour%20Force/publications/lfs2017_18/Annual%20Report%20of%20LFS%202017-18.pdf

Pakistan Microfinance Network (2015). The Pakistan Microfinance Review 2015. Retrieved from http://www.pmn.org.pk/assets/articles/31f52030bd8d766abf95b80d2d35aeaf.pdf.

Pakistan Microfinance Network (2018). *Pakistan Microfinance Review 2017*. Retrieved from http://www.microfinanceconnect.info/assets/articles/da6af2f0f19ca541bbc04db2f158cf98.pdf.

Phillips, K. A., Morrison, K. R., Andersen, R., & Aday, L. A. (1998). Understanding the context of healthcare utilization: Assessing environmental and provider-related variables in the behavioral model of utilization. *Health Services Research*, *33*(3 Pt 1), 571–596.

Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, *47*(11), 1451–1458. doi:10.1016/j.ijnurstu.2010.06.004

Pouchous, A. (2012). The Regulation and Supervision of Microfinance: Main issues and progress. *The International Institute for Sustainable Development*. Retrieved from http://www.iisd.org/tkn.

Ravallion, M. (2017). *Poverty comparisons*. New York, NY: Routledge.

Rosengard, J. K. (2004). Banking on social entrepreneurship: The commercialization of microfinance. *Mondes en Développement*, *126*(2), 25–36. doi:10.3917/med.126.0025

Roshan, R., Hamid, S., & Mashhadi, S. F. (2018). Non-communicable diseases in Pakistan; A health system perspective. *Pakistan Armed Forces Medical Journal*, *68*(2), 394–399.

Saha, S. (2011). Provision of health services for microfinance clients: Analysis of evidence from India. *International Journal of Medicine and Public Health*, *1*(1), 1–6. doi:10.5530/ijmedph.1.2011.1

Saha, S., Kermode, M., & Annear, P. (2015). Effect of combining a health program with a microfinance-based self-help group on health behaviors and outcomes. *Public Health*, *129*(11), 1510–1518. doi:10.1016/j.puhe.2015.07.010

Saqib, A., Atif, M., Ikram, R., Riaz, F., Abubakar, M., & Scahill, S. (2018). Factors affecting patients' knowledge about dispensed medicines: A Qualitative study of healthcare professionals and patients in Pakistan. *PloS One*, *13*(6), e0197482. doi:10.1371/journal.pone.0197482

Schwandt, T. A. (2001). *Dictionary of qualitative inquiry*. California, CA: Sage Publications.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75. doi:10.3233/EFI-2004-22201

Siddiqui, R., Hamid, S., & Siddiqui, R. (2000). Analysis of non-conventional indicators of gender relations: Evidence from Pakistan. *The Pakistan Development Review*, *39*(4II), 913–929. doi:10.30541/v39i4IIpp.913-929

Siddiqui, S., & Mehfooz, B. (2017). *Influence of housing quality on public health in Lahore, Pakistan*. In Proc. of the Pakistan Academy of Sciences: B. Life and Environmental Sciences (Vol. 54, No. 3, pp. 237–257).

Siwale, J. N., & Ritchie, J. (2012). Disclosing the loan officer's role in microfinance development. *International Small Business Journal: Researching Entrepreneurship*, *30*(4), 432–450. doi:10.1177/0266242610373687

State Bank of Pakistan (2019). The journey of financial inclusion in Pakistan. Retrieved from http://www.sbp.org.pk/70/sup-7.asp.

Sultan, F., & Khan, A. (2013). Infectious diseases in Pakistan: A clear and present danger. *Lancet (London, England))*, *381*(9884), 2138–2140. doi:10.1016/S0140-6736(13)60248-2

The SMART Campaign (2018). The smart campaign consumer protection resource kit. Retrieved from https://www.smartcampaign.org/storage/documents/Consumer_Protection_Resource_Kit_05.15.2018.pdf.

Thresia, C. (2018). Health Inequalities in South Asia at the Launch of Sustainable Development Goals: Exclusions in Health in Kerala, India Need Political Interventions. *International Journal of Health Services*, *48*(1), 57–80. doi:10.1177/0020731417738222

Viola, D., Shi, Q., & Murthy, P. (2013). Microfinance safety net: Back to basics. *Health Care for Women International*, *34*(11), 1005–1014. doi:10.1080/07399332.2012.673657

World Bank (2017). Pakistan development update. Retrieved from http://documents.worldbank.org/curated/en/536431495225444544/pdf/115187-WP-PUBLIC-P161410-77p-Pakistan-Development-Update-Spring-2017.pdf.

Zaidi, S., Saligram, P., Ahmed, S., Sonderp, E., & Sheikh, K. (2017). Expanding access to healthcare in South Asia. *BMJ (Clinical Research ed.)*, *357*, j1645. doi:10.1136/bmj.j1645