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Is there any Impact of Microcredit on Women's Health? What about an Alternative Model?

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Abstract: *This paper, despite absence of empirical evidences of impact of microcredit on women's health – is an exploratory one. Therefore, an attempt has been made in this paper to draw logical inferences about the possibilities/impossibilities and possible pathway of impact of microcredit on the health status of borrower-women. First, an analysis has been made to understand who gets microcredit? Estimates show microcredit potentially reaches 37% of the population with 16.9% in the lower middle class ("near poor") and 20.1% in the upper echelon of the absolute poor ("upper poor") – almost all these households are food-poor viewed from multidimensional poverty measures. About 80% of the people in the absolute poor category do not have access to microcredit. Second, based on the above estimates and pertinent assumptions it is agued that impact of microcredit on women's health needs to be assessed for women borrowers in 4.4 million households. Third, it is reasonably argued that microcredit can impact on women's health mediated through increased income, changing pattern of expenditure, savings, knowledge and attitude, and changing choice behavior. However, it is also argued that since almost all borrowers are poor ('near poor + upper poor') and suffer from multidimensional poverty, they tend to spend most of their incremental income (attributable to microcredit) in mitigating household multidimensional poverty including food, chronic illness, and housing. Finally, it is argued that health-poverty reduction especially that of women's health is possible. And in order to make this possibility in to reality an alternative model is proposed. This model bespeaks in favor of conscientization-mediated development first coupled with pro-activating the public health care delivery system (which is both under-funded and not poor*

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friendly) and side-by-side with appropriate supply of economic inputs (microcredit, ownership and access to public resources, agricultural input, employment, marketing and so on). It is contended that microcredit can be a good instrument of taking care of women's health only if the following equation is followed: conscientization plus pro-active public health care system plus microcredit (including other economic inputs).

***Keywords**: Bangladesh, Microcredit, Beneficiaries, Impact, Health, Women's Health, Conscientization.*

Introduction

Microcredit has become a buzz word due to various reasons – known and unknown, understandable and non-understandable. Microcredit, according to many, is synonymous to development or synonymous to poverty reduction or synonymous to asset building for the poor. There is, however, others who hold critical positions on this due to various logically sound reasons. In this backdrop, providing precise answer to the question "Is their any impact of microcredit on women's health?" – is not easy, rather extremely difficult. The key reason behind this difficulty being lack of empirical evidence about how does microcredit impact on women's health(?), i.e., the pathway of impact, how much is the impact and on whom (?), and how much is the impact by women's preventive and curative health (?). These common sense questions take further complex shape due mainly to three reasons, namely (1) who gets microcredit i.e., which class of women in the economic ladder (?), (2) who commands over the benefits of microcredit i.e., whereas most microcredit takers are women a predominant part of users are men (i.e., incidence-benefit equation), and (3) the reality of health inequality in a class based society i.e., socio-economic class differentials in health outcomes (morbidity, malnutrition, and disease prevalence), health behavior (preventive and curative), and economic burden of ill-health.

Who Gets Microcredit?

Theoretically speaking – in absence of valid empirical evidences – it can be asserted that any developmental intervention including *microcredit* has the potential to positively impact human health including women's health. This is most likely because of the fact that microcredit – at least officially – is intended to raise income and build asset of the beneficiary poor. Once income is enhanced it is up to the beneficiary how s/he will spend that earning (or incremental earning). This is basically a problem of choice, meaning depending on the socio-economic status of the beneficiary, s/he can spend certain amount of the money

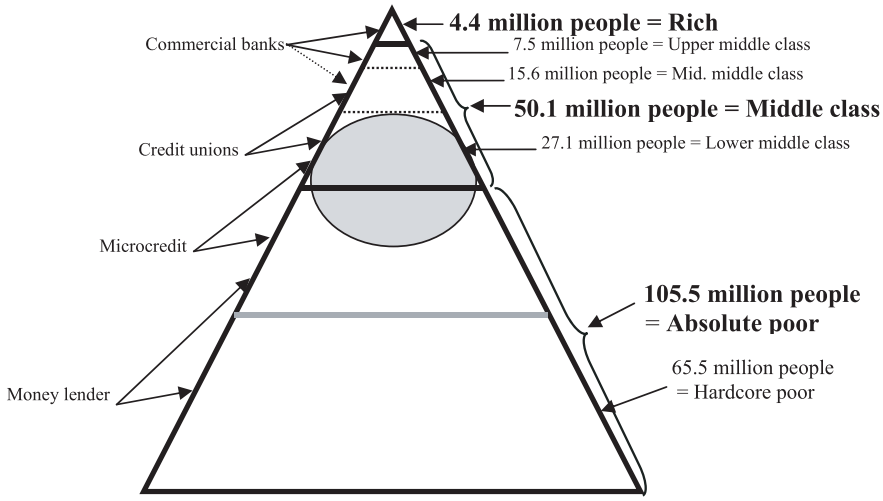
on food (if we are talking about a 'food poor' household) and/or some amount on other basic essentials including health, education, employment, cultural items, and so on.

Here the most pertinent key question would be – WHO GETS MICROCREDIT? Currently (in 2016), we have 160 million people in Bangladesh. Economically, these 160 million people are located in different positions of the wealth pyramid. The economic-class distribution of these 160 million people, according to my estimates, is as follows: 105.5 million people (66% of total population) is absolute poor, of which, 65.5 million (41% of total population) is hard core poor; 50.1 million people (31.3% of total population) belong to the middle class with 27.1 million people (16.9% of total population) representing lower middle class, 15.6 million people (9.7% of total population) are in the middle middle-class, 7.5 million people (4.7% of total population) are in the upper middle class; and 4.4 million people (2.7% of total population) represent the rich class in the wealth pyramid (Barkat 2017: 47-48). The fact is that the access to loan and credit market is not class neutral – 'rich' will never choose for microcredit and the poor have no access to commercial banks. This is not just an issue of ***choice***, rather an issue of ***access*** shaped by dominant market equation.

As shown in Figure 1, the reality of who/which class is 'entitled' to receive loans/credits from which institution (formal or informal) depends on the location of his/her class position in the wealth pyramid. Commercial banks have traditionally, and mostly still do, reach only the top of the pyramid (i.e., 11.9% of the total population). Credit unions, especially those based on community have done better in reaching further down the pyramid through their cooperative principles; they can potentially reach mid-middle class and part of the lower middle class (i.e., at best 15% to 20% of the population at the middle of the wealth pyramid). The microcredit system – whatever the theory is or intention is – do not reach ***all poor***. Information show a total of 20.4 million borrowers of microfinance as on June 2008 (Microcredit Regulatory Authority 2009: 3). To the best of my judgment and observation, microcredit reaches the upper echelon of the absolute poor and the lower middle class (who are situated just above the absolute poverty line). As shown in the shaded circle in Figure 1, microcredit reaches 37% of the total population with 27.1% in the lower middle class and the rest 10% in the upper echelon of the absolute poor. This implies that microcredit do not reach the majority poor including all hard core poor (41% of the total population) and a part of those above hard core poor (11% of the total population). If these estimates are close to reality – microcredit do not reach 70% of the absolute poor or, in other words, microcredit is inaccessible to about 73.5 million

poor people out of a total about 105.5 million poor in Bangladesh. Logically, it is therefore, if 70% of the poor in Bangladesh do not have access to microcredit, then question does not arise about any possible impact of microcredit on women's health for at least the same proportion of poor men and women.

Figure 1: Who gets LOANS from where?
(Total population in 2016 = 160 million)



Where to search the possible/potential impact of microcredit on women's health?

It is a matter of common sense that the impact of microcredit on women's health, if any, has to be searched among women in those households who have access to microcredit. As already stated, such access is evident in 37% of the population with 27.1% belonging to lower middle class (i.e., near poor) and 10% belonging to absolute poor – more precisely representing upper echelon of absolute poor (i.e., upper poor). Assuming, across socio-economic class the household size is more or less equal (nationally 4.4 person per household), the potential access to microcredit is applicable for 37% of the total households in Bangladesh representing 'near poor' (lower middle class) and 'upper poor' (upper echelon of absolute poor). However, since microcredit is primarily a rural credit phenomenon, the potential reach-ability will be about 28% and not 37% of the household – "near poor" plus 'upper poor'. Based on these parameters, the estimated numbers of 'near poor' and 'upper poor' households within the potential reach of microcredit would be 8.75 million (28% of total 31.25 million

households in Bangladesh). Assuming, a high rate of 50% of beneficiaries of microcredit at a given point in time (out of the "potential reach") – the estimated total number of poor rural households (*near poor* plus *upper poor)* who could be at the moment recipient of microcredit will be about 4.4 million households. Since 95% of the recipients are women, the total number of poor women ('near poor' plus 'upper poor') who constitute the beneficiaries of microcredit at the moment would be about 4.2 million. Therefore, the impact of microcredit on women's health needs to be assessed for these 4.2 million rural women in Bangladesh. This figure may be more than 4.2 million women due to two factors, namely (1) possibilities of inclusion of more than one women-beneficiary in some households, and (2) cumulative number of real beneficiaries' women.

Then what could be the possible impact of microcredit on women's health?

In absence of 'real' empirical data on changing health status of women beneficiaries of microcredit, the only way to understand possible or potential impact of microcredit on women's health is to draw logical inferences. However, before drawing such logical inferences it would be worth mentioning some of the pertinent key findings on impact of microcredit available in the research body of literature. The most pertinent findings are as follows:

1. NGO-MFIs (Micro-finance Institutions) are successful at reaching the wealthier poor; it is less successful at reaching the ultra hard core poor and destitute groups (Haque and Yamao 2008:670).
2. Microcredit is not an effective tool for poverty reduction particularly for the poor with previous indebtedness. Microcredit can reduce the poverty of that group of poor who have achieved a certain economic level without previous indebtedness (Haque and Yamao 2008:670).
3. "Increases in access to income are often at the cost of a heavier work loads" with "adverse effects on women's health and well-being" "as they struggle to combine income-earning with unpaid domestic responsibilities" (Mayoux 1999: 33).
4. Each additional 100 taka of credit to women increases total annual household expenditures by more than 20 taka: 11.3 taka in food expenditures and 9.2 taka in non-food expenditures. In stark contrast, there is no appreciable returns to male borrowing (Khandker 2005).
5. Impact on children's health – especially on children's nutritional status (height and arm circumference) – from women's borrowing is substantial,

but not from male borrowing, which had an insignificant or even negative effect (Pitt *et.al* 2003).

6. Grameen Bank plays a role in empowering women and affecting their fertility decisions in addition to providing funds for income generating activities (Sukontamarn 2007:16).

7. "Micro-borrowers often fail to break out of income poverty and many even get caught up in an increasing debt-burden syndrome and slide further into poverty, let alone moving on the significantly higher levels of income and living standards. Not much has happened in relation to women's empowerment through micro-credit. Only about 10% of the respondents have said that they are in full control of the economic activities run by using the micro-credit they take. About a quarter of the female borrowers currently face physical and mental torture from one member or another of her family, usually the husband. About 60% of them have said that the intensity of torture has increased since enrollment. In the families of 82% of the female borrowers, exchange of dowry has increased since their enrolment" (Ahmad (ed.) 2007: 47).

8. "There are no good studies to date that have looked specifically for effects of micro-finance participation on mortality or even morbidity (illness or injury)" (Dunford 2006:12).

Whatever little empirical data are available, it would be safe to draw some contradictory conclusions that MICROCREDIT

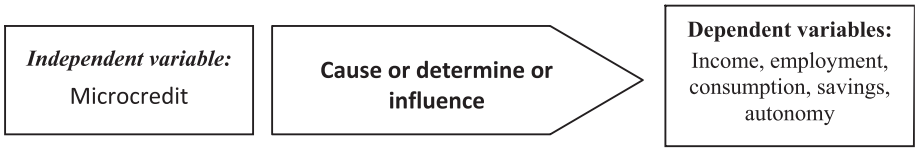
- Is less successful in reaching the "lower echelon of poor"
- Is less efficient for poor with previous indebtedness
- Is instrumental in increasing debt-burden syndrome
- Is instrumental – within patriarchy and poverty – in increasing women's workload, thereby, adversely affects women's well-being (including health)
- Is a reason for increasing physical and mental torture, and dowry
- Is instrumental in increasing dependency on multiple credit-agencies (each microcredit recipient women receives loan from 3-4 NGOs)
- Is one of the means to accelerate the process of women's empowerment (in terms of increasing autonomy, mobility, enhancing group solidarity, participation in decision making, building awareness, building confidence, increasing household expenditures)

- Is instrumental in changing health status of children, especially children's nutritional status.

The extent of impact of microcredit on mortality and morbidity (illness, injury etc) is not known, at least empirically (Dunford 2006:12). It is also not known (also empirically) as to what is the precise impact of microcredit on women's health, and how that impact generates (i.e., the pathway of impact). Let it be clear that maternal health including maternal nutrition, ANC, safe delivery, PNC is just a part (critical part) of women's health; women's health is not just absence of diseases, but encompasses complete physical, mental and social well-being of women; and women (especially women from poor household) suffer much from *diseases of poverty* including maternal mortality and morbidity, UTI, STI, STD, tuberculosis, malaria, arsenicosis (Barkat 2008). Viewing from this complex perspective of women's health, it would be even logically difficult to establish direct linkages between microcredit and reduced burden of ill-health of women.

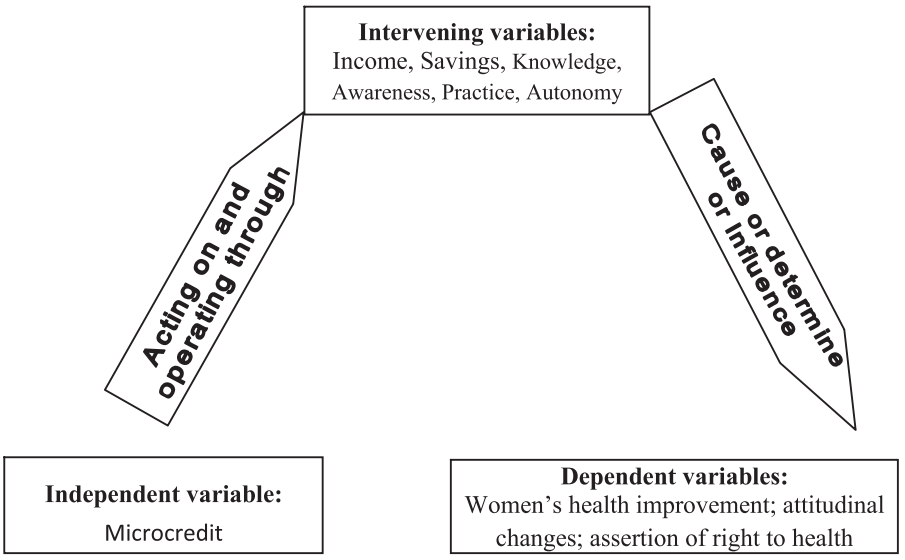
Theoretically speaking, the answer to the questions as to whether or not there is any impact of microcredit on women's health (specifically health of the women beneficiaries of microcredit) – could be both YES and NO! The answer can be *yes* only if there is an evidence of *microcredit-mediated women's health-poverty reduction,* and if that evidence is not just sporadic or not mostly attributable to factors other than associated with microcredit. Such causal relationships with microcredit as `cause' (independent variable) and improved women's health status as `effect' (dependent variable) can be a possibility. Theoretically, such causal relationship can be both direct and indirect. For example, if microcredit increases women's real income and changes expenditure pattern towards health care of women-then the causal relation is direct (Figure 2). However, if health status of

Figure 2: Model showing *direct* relationship between microcredit and improved health status of women



women improves due to intervening variables (such as income, savings, health knowledge and awareness, autonomy etc.) caused by microcredit then the causal relation is indirect (Figure 3). These are just theoretical possibilities, albeit complex, without empirical evidence to substantiate.

Figure 3: Model showing *indirect* relationship between microcredit and improved health status of women



The opposite to my above positive argument is that microcredit has no impact on health of the women beneficiaries; and may have even negative impact due to physical and psychological stresses associated with meeting the repayment schedule (with high interest rates) coupled with hard work of complying with unpaid domestic responsibilities (which are never monetized, never recognized as useful labor, and treated as "love economics"). My assertion of saying 'No' is relatively stronger than accepting the theoretical proposition 'Yes'. The key reasons for my strong inclination toward 'No' are as follows:

First: In reality, the recipients women of microcredit are mostly drawn from the 'near poor' and 'upper poor' households who represent a distinct food-intake poor households (i.e., consume around 2,122 k.cal/day/person). Even if these women beneficiaries manage to increase their real income attributable to microcredit they spend most of the incremental income to mitigate their household food-poverty aiming at reducing nutrition-poverty. In their choice of spending the incremental income, sectors like health and more so their own health (i.e., women's health) obviously is not a priority. This is more so true for preventive health as compared to curative health. However, if somehow these women manage to increase their income and contribute to address their

household food-poverty status that has value in terms of enhancing nutrition status, which, in turn might contribute to their body resistance (due to higher energy intake in terms of kilocalories) and, therefore, improved health status. But in no way this should be treated as positive impact of microcredit on women's health. This is more so because empirical evidences show some betterment of nutritional status of children associated with microcredit.

Second: Even if microcredit somehow reaches those who are still not reached – the lower echelon of poor; the poorest of the poor; the ultra poor; the hard core poor; the asset less and landless marginalized women and men (representing 53% of the total population and 80% of the poor) – the likelihood is high that the health status of these women will not improve. This is mainly because of the fact that food-poverty is more acute in these households. This is most likely that all incremental income of these households mostly spend on purchasing essential food items.

Third: It is already widely recognized that, to a large extent, the money taken by women as microcredit is being handled by males (husband, brother, father). Therefore, in large part, women become a passive recipient of microcredit – whose job is to attend the group meetings, receive the money, and repay the loans as per schedule. Therefore, the real command over the microcredit lies with the male. And this has already been proved that there is no appreciable return to male borrowing (Khandker 2005). In many instances, this active-passive borrowing situation causes tension in the family, and may potentially cause ill-being for the borrower-women.

Fourth: Women's health is not only a complex and broad area, but also an issue of human rights, Constitutional rights and justiciable rights. Both from the view points of human rights and complexity – addressing women's health should rightfully be the domain of the State to deal with as public good through public health care system. As part of this, public-private/public-NGO partnership may be of high utility, if designed appropriately.

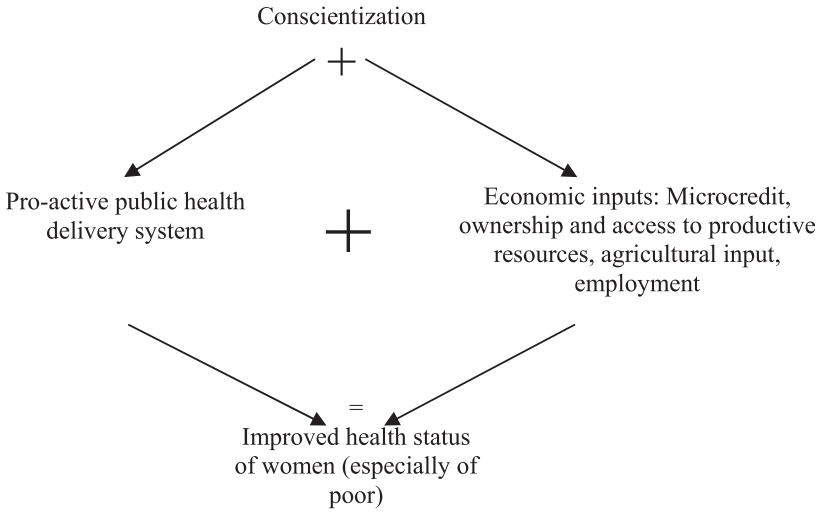
An alternative model towards betterment of women's health: Conscientization *plus* microcredit

Microcredit should not be seen as a panacea. It should not be considered as a single most important pathway towards improving health status of the beneficiary

women. This does not necessarily mean that women's access to microcredit is unimportant. To the contrary, access to microcredit is important provided that access is instrumental in ensuring "true empowerment" and "active autonomy" – economic, social and political – of women. And to make this instrument work for the betterment of women's health status it is absolutely necessary to expedite the whole process of *conscientization* of women and men (especially the huge majority of poor and lower middle class 'near poor' comprising 128.4 million out of 160 million people of Bangladesh or 83% of the total population) and pro-activate the public health care delivery system (which is both under-funded and not poor-friendly; see details, Barkat 2008).

In order to accelerate the process of improvement in women's health status – women, especially poor women should be conscientized. Other factors including microcredit should follow the process of conscientization to generate added value towards improvement of health status of women. This alternative model of conscientization-mediated improvement in women's health (or health-poverty reduction) is schematically shown in Figure 4.

Figure 4: Model of conscientization-mediated improvement in women's health



It would be worth elaborating the alternative model depicted in Figure 4. "Health" is the most essential indicator of development; and 'people's health' should be seen as the most appropriate barometer of "success or failure' of a nation. And, development is about *right*- both Constitutional and *justiciable*. It is both about

knowledge about these human rights as well as about means and ways to apply these rights or realization of these rights by the poor and marginalized people for whom, under class society, consistent denial of these rights is a rule. The central argument I want to forward here is that *people's conscientization is the key to sustained development of the poor and marginalized.* This argument implies that true conscientization process has all-encompassing potential to set an empowerment process in motion through which it is possible to transform human deprivation into human development, through which poor and marginalized people's agency role in development realizes, and through which they can become proactive solicitor of rights rather than passive recipients of right-based services (including public health services). To set this process of conscientization in an active motion, imparting and sharing knowledge about rights (human rights, knowledge about fundamentalism, worldview etc.,) is a necessary precondition, and struggle towards attainment of rights is a sufficient precondition. This necessary precondition forms the basis for *internalization* and the sufficient precondition forms the basis for *informed action (praxis).* Implementation of these two preconditions is necessary to realize the conscientization-mediated development which enlarges opportunities for a full life to people, expands real freedoms that people enjoy, expands choices to lead lives people value, and establishes a dignified human life. In other words, this conscientization-mediated development should be seen as a route to crystallize the process of *development with dignity.*

Conscientization is a process by which the learner advances towards critical consciousness which is necessary for informed actions (social praxis) – the key goal of development education. Conscientization should not be equated to just consciousness raising because the latter may involve transmission of pre-selected knowledge in congruence with 'dominant culture', 'cultural hegemony', 'status quo' etc. Conscientization is the heart of liberatory education. Conscientization means breaking through prevailing mythologies to reach new levels of awareness-in particular, awareness of oppression, against being an 'object' of others' will rather than a self-determining 'subject'. This process of conscientization involves identifying contradictions in experience through dialogue and becoming part of the process of changing the world. It is based on the above analysis I argue that conscientization-mediated development is liberatory-development, and, thereby, forms the basis for real human(e) development.

Evidences, presented in Table 1, show that *conscientization–as route to development–works.* Conscientization as a process of liberatory learning and informed action works. The process of conscientization, as experienced by the

members of conscientization schooling, has been instrumental in their *internalization* of essence of human rights (including Constitutional and justiciable rights), knowledge about (anti) fundamentalism and worldview, and based on that prepared them for *informed actions*. As compared to the non-participants (of conscientization schooling), this conscientization-mediated development process has enlarged opportunities for a full life to the participants, expanded real freedoms that they enjoy, expanded choices to lead lives they value, and established a potential basis for dignified life. By being member of this c*onscientization schooling*, the participants have learned the causes and consequences of social, political and economic contradictions and injustices, which has paved the way for their breaking the '*culture of silence'*. They are now much more empowered than their counterparts, and have transformed from passive recipients of public services to pro-active demander of rights-based services (Table 1).

Table 1: Impact of conscientization on poor women who have passed through conscientization schooling and those who did not

Indicators	Women passed through conscientization schooling	Women did not pass through conscientization schooling
Overall conscientization score	72.5	33.4
Rights	80.3	32.3
Fundamentalism	83.0	50.0
Worldview	54.3	18.0
(Of rights) Demanding HEALTH	84.3	25.0
Access to power structure	25.9	11.5
Access to credit program	62.9	51.1
(Composite) Well-being score	49.6	37.2

Source: Barkat *et.al* 2008: 117, 129, 143, 297, 319, 333

Conscientization promotes collective action of the poor and marginalized. This is evident from the fact that many poor people passing through conscientization schooling have become so empowered that they contest the local government elections; many poor women not only participate actively in the local arbitration *(shalish)* but also act as a *shalishkar* (judge in dispute resolution); some participant groups have formed health watch committees to oversee public health service in the public health facilities, and so on.

Conscientization has the potential to "break culture of silence" at household level. Ideally speaking, every women has something to acquire through inheritance; women from landless and marginalized families have little or nothing to inherit. Whatever the case is, the reality is that property inheritance is dominated by patriarchy and primarily dictated by the religious personnel law (for Muslim women "Sharia" law, and for Hindu women "Daibhag" law). In rural Bangladesh (where 70% of the total population live) only 4% of the privately owned land (agricultural, homestead and water body), is effectively owned by women ('effective ownership' means: have deed of ownership, can command over the production process, and can take decision about selling land and output sales). The relevant interesting findings include: (1) as opposed to 64% of those out of conscientization schooling orbit a 94% women who passed through conscientization schooling said categorically that "there should be equal rights on inherited property", and (2) women who have passed through the conscientization schooling for ten years or more have inherited property at least two-three times more (8%-9% of the privately owned land) than women out of such schooling process (Barkat et.al 2008: 401). The health situation of the former (who have passed through conscientization process) is better than the later, and the former have more effective command over microcredit than the later.

Finally, it is also found that *conscientization efforts add more value to economic inputs in development.* It has been found that poor and deprived people who have passed through the conscientization process perform much better with subsequent economic inputs (credit, agricultural input, marketing etc.) as compared to those who receive economic input without passing through the conscientization orbit (Table 1). Economic input produces synergy if followed by strong conscientization schooling. This is most likely due to the reason that the process of conscientization empowers people politically, socially and culturally which act as essential ingredient for dignified life, and that forms a strong foundation for appropriate processing of economic inputs. Therefore, in ensuring true human development of the poor and the marginalized people, the process of conscientization must proceed before injecting economic inputs.

Some concluding remarks

Impact of microcredit on women's health is difficult to ascertain due mainly to lack of empirical evidences. Theoretically, such impact is both possible and impossible. The causal linkages of *possibility* can be both direct and indirect. Such possibility is mainly mediated through increased income, changing expenditure pattern, savings, knowledge, awareness, practice, empowerment, autonomy, and

changing choice behavior. *Impossibility* of improving women's health status attributable to microcredit is mainly related to the fact that in reality most microcredit recipients are drawn from lower middle class ('near poor') and upper echelon of absolute poor ("upper poor") representing food-poor households (i.e., those consuming around 2,122 k. cal/day/person). Even if the women borrowers of microcredit somehow manage to increase their income (attributable to microcredit) they spend (or force to spend) most of the incremental income to mitigate their household food – poverty. Spending the incremental income for health and more so for their (women's) own health is low in their expenditure choice ladder. Microcredit's potential possibility in reducing food – poverty and thereby in improving nutritional status of children (which has evidence) can be treated as a pathway of improvement in the health status of children in the borrowers' household. However, such contribution on health is limited, because among 105.5 million poor in Bangladesh 70% do not have access to microcredit. Therefore, nationally, impact of microcredit on poor people's health (more so on poor women's health) should be insignificant. These arguments should not be treated as non-necessity of microcredit. To the contrary, poor people's access to credit should be seen from the view point of 'right to credit'. This right to credit, however, should not be seen as the key pathway towards improvement in the health status of the borrower and members of their household.

The proposed conscientization-mediated development approach can be seen as an alternative model towards betterment of women's health and health-poverty reduction. This model presupposes that if women (and men) are conscientized first (i.e., they pass through organized conscientization schooling) to know about their rights, exert those rights, and break the 'culture of silence', and side by side public health delivery system pro-activates and economic inputs (microcredit, ownership and access to productive resources, agricultural input, employment) are poured into – then women's health, especially that of the poor and marginalized women will bound to improve. The process of conscientization self will create demand to pro-activate public health care system (which is currently both under-funded and not poor-friendly) as well as demand for justified economic inputs including microcredit (both through the NGOs and the Government institutions).

References

1. Ahmad QK (2007) (ed). *Socio-economic and indebtedness-related Impact of Micro-credit in Bangladesh,* Dhaka: actionaid bangladesh, Bangladesh Unnayan Parishad and The University Press Limited, ISBN 984-05-1778-3.

2. Barkat A (2017). *"Bangladeshe Daridro-Boishommo-Asomotar Karon-Parinam Uttaran Samvabona: Ekibhuto Rajnoitik Arthonitir Thotter Sandae"* (in Bengali), "Cause, Consequences and Transformation Possibilities of Poverty-Disparity-Inequality in Bangladesh: In Search of a Unified Political Economy Theory", Dhaka: MuktoBuddhi Prokasona.

3. Barkat A (2008). "Political Economy of Health Care in Bangladesh". *Plenary Lecture 14th Diabetes & Endocrine Conference*, organized by Bangladesh Diabetic Somity and Bangladesh Endocrine Somity, Dhaka: 20-22 November, 2008.

4. Barkat A, S Halim, A Poddar, A Osman and M Badiuzzaman (2008). *Development as Conscientization: The Case of Nijera Kori in Bangladesh, Dhaka: Pathak Shamabesh, ISBN 984-70212-0005-4*

5. Dunford C (2006). "Evidence of Microfinance's Contribution in Achieving the Millennium Development Goals", *Global Microcredit Summit,* Halifax, Nova Scotia, Canada, November 12-15, 2006.

6. Haque MS and M Yamao (2008). "Can Microcredit Alleviate Rural Poverty? A Case Study of Bangladesh", in *Proceeding of World Academy of Science, Engineering and Technology,* Volume 36, December 2008, pp. 663-671.

7. Khandker S.R (2005). "Microfinance and Poverty: Evidence from Panel data from Bangladesh". *World Bank Economic Review,* Vol. 19, No. 2, pp. 263-286.

8. Microcredit Regulatory Authority (December 2009). NGO-MFIs in Bangladesh, Volume 5, June 2008.

9. Mayoux L (1999). "From Access to Empowerment – Gender Issues in Microfinance". Draft Position Paper Presented to *CSD Virtual Conference 1999.*

10. Pitt M, S Khandker, OH Chowdhury and D Millimet (2003). "Credit Programs for the Poor and the Health Status of Children in Rural Bangladesh", *International Economic Review* 44, No. 1 (2003), pp. 87-118.

11. Sukontamarn P (2007). Micro-credit, Fertility Decision, and Women's Empowerment in Bangladesh.