



International Journal of Health Care Quality Assurance

Improving maternal healthcare utilisation in sub-Saharan Africa through micro-finance

Gordon Abekah-Nkrumah Patience Aseweh Abor Joshua Abor Charles K.D. Adjasi

Article information:

To cite this document:

Gordon Abekah-Nkrumah Patience Aseweh Abor Joshua Abor Charles K.D. Adjasi, (2011), "Improving maternal healthcare utilisation in sub-Saharan Africa through micro-finance", International Journal of Health Care Quality Assurance, Vol. 24 Iss 8 pp. 601 - 610

Permanent link to this document:

<http://dx.doi.org/10.1108/09526861111174170>

Downloaded on: 25 March 2015, At: 22:20 (PT)

References: this document contains references to 52 other documents.

To copy this document: permissions@emeraldinsight.com

The fulltext of this document has been downloaded 834 times since 2011*

Users who downloaded this article also downloaded:

Walter E. Block, (2012), "Micro-finance: a critique", Humanomics, Vol. 28 Iss 2 pp. 92-117 <http://dx.doi.org/10.1108/08288661211228870>

Rusdy Hartungi, (2007), "Understanding the success factors of micro-finance institution in a developing country", International Journal of Social Economics, Vol. 34 Iss 6 pp. 388-401 <http://dx.doi.org/10.1108/03068290710751803>

Patience Aseweh Abor, Gordon Abekah-Nkrumah, Kojo Sakyi, Charles K.D. Adjasi, Joshua Abor, (2011), "The socio-economic determinants of maternal health care utilization in Ghana", International Journal of Social Economics, Vol. 38 Iss 7 pp. 628-648 <http://dx.doi.org/10.1108/03068291111139258>

Access to this document was granted through an Emerald subscription provided by 471260 []

For Authors

If you would like to write for this, or any other Emerald publication, then please use our Emerald for Authors service information about how to choose which publication to write for and submission guidelines are available for all. Please visit www.emeraldinsight.com/authors for more information.

About Emerald www.emeraldinsight.com

Emerald is a global publisher linking research and practice to the benefit of society. The company manages a portfolio of more than 290 journals and over 2,350 books and book series volumes, as well as providing an extensive range of online products and additional customer resources and services.

Emerald is both COUNTER 4 and TRANSFER compliant. The organization is a partner of the Committee on Publication Ethics (COPE) and also works with Portico and the LOCKSS initiative for digital archive preservation.

*Related content and download information correct at time of download.



Improving maternal healthcare utilisation in sub-Saharan Africa through micro-finance

Improving
healthcare
utilisation

601

Gordon Abekah-Nkrumah and Patience Aseweh Abor

*Department of Public Administration and Health Services Management,
University of Ghana Business School, Legon, Ghana, and*

Joshua Abor and Charles K.D. Adjasi

Department of Finance, University of Ghana Business School, Legon, Ghana

Received 19 August 2009

Revised 19 October 2009

Accepted 12 May 2010

Abstract

Purpose – This paper aims to examine links between women's access to micro-finance and how they use maternal healthcare services in sub-Saharan Africa (SSA).

Design/methodology/approach – The authors use theoretical and empirical literature to propose a framework to sustain and improve women's access to maternal healthcare services through micro-financing.

Findings – It is found that improved access to micro-finance by women, combined with education may enhance maternal health service uptake.

Research limitations/implications – The paper does not consider empirical data in the analysis. The authors advocate empirically testing the framework proposed in other SSA countries.

Social implications – It is important to empower women by facilitating their access to education and micro-finance. This has implications for improving maternal healthcare utilization in SSA.

Originality/value – The paper moves beyond poor access to maternal health services in SSA and proposes a framework for providing sustainable solutions.

Keywords Maternal healthcare, Access, Sub-Saharan Africa, Micro-finance, Health services, Africa, Women

Paper type Conceptual paper

The maternal health situation in Sub-Saharan Africa (SSA)

Maternal health refers to women's health during pregnancy, childbirth and postpartum period (WHO, 1992). Global maternal mortality statistics are sometimes startling. In 2000, the United Nations (UN) projected global maternal mortality at 529,000, with less than 1 per cent occurring in the developed world. The WHO, UNICEF and UNFPA 2005 maternal mortality estimates put maternal deaths annually at 536,000, above the UN's estimates for 2000. About 95 per cent of these deaths were in SSA and Asia (WHO, 2007). Sadly, treatments for avoiding such deaths have been available since the 1950s. It is estimated that Africa has the highest maternal mortality burden in the world, with SSA contributing about 98 per cent (WHO, 2007). Mother's death risk is about 1 in 22 in SSA compared to 1 in 210 in Northern Africa; 1 in 62 in Oceania; 1 in 120 for Asia; 1 in 290 for Latin America and the Caribbean (WHO, 2007). At a time



International Journal of Health Care
Quality Assurance
Vol. 24 No. 8, 2011
pp. 601-610

© Emerald Group Publishing Limited
0952-6862

DOI 10.1108/09526861111174170

An earlier version of this article was presented at the 5th African Finance Journal Conference, Cape Town, South Africa, July 2008.

when other countries are experiencing decreasing maternal mortality rates (MMR), SSA leads with worsening maternal mortality (MM) indicators. The WHO (2007) estimates that about 70 per cent of all maternal deaths follow haemorrhagic complications (25 per cent), infection (15 per cent), unsafe abortion (13 per cent), eclampsia (high blood pressure leading to seizures – 12 per cent) and obstructed labour (8 per cent). These constitute major causes and we know that unavailable, inaccessible, unaffordable or poor quality care is primarily accountable for maternal deaths. This bizarre situation in SSA is exacerbated by dwindling state resources, reducing investment into critical health-related interventions such as maternal health. It is estimated that SSA investment into health is less than US\$10 a year per capita – contrary to a the US\$ 30-40 a year per capita requirement, which is the minimum amount needed to provide basic health programmes (WHO, 2007). The expectation is that individuals make up the shortfall especially in countries where fee for service is predominantly the financing strategy (the case in most countries). Unfortunately, poverty, social exclusion and marginalisation among women, based on outmoded traditions and culture, tend to constrain families, especially women's access to health services.

Empirical literature on maternal healthcare's socio-economic determinants is strong. Finance is linked to maternal healthcare service uptake (Obermeyer, 1991; Elo, 1992; Obermeyer, 1993; Becker *et al.*, 1993; Bhatia and Cleland, 1995; Pebley *et al.*, 1996; Raghupathy, 1996; Addai, 2000; Acharya and Cleland, 2000; Celik and Hotchkiss, 2000; Navaneetham and Dharmalingam, 2002; Mekonnen and Mekonnen, 2003; Chakraborty *et al.*, 2003; Gage, 2007). In addition to these studies, some authors show that poor maternal health causes problems in certain regions. What seems to be lacking is innovative and 'out-of-the-box strategies' to improve service utilization. Knowing that income is a major maternal health determinant, attempts to enhance women's incomes and, therefore, their ability to access maternal health services, could improve a region's maternal health. Our literature review, therefore, seeks to enhance strategies for improving maternal health services by developing a theoretical framework that links micro-finance (defined later) to maternal health services access.

Maternal healthcare service financing and access

Maternal healthcare service access has been identified as a major cause of maternal mortality in SSA. Interventions have been advocated to improve maternal healthcare services such as Safe Motherhood and Baby to Mother Packages (BMP). Evidence has been gathered from policy and academic standpoints (Abor, 2008; Obermeyer, 1991; Elo, 1992; Obermeyer, 1993; Becker *et al.*, 1993; Bhatia and Cleland, 1995; Pebley *et al.*, 1996; Raghupathy, 1996; Addai, 2000; Acharya and Cleland, 2000; Celik and Hotchkiss, 2000; Navaneetham and Dharmalingam, 2002; Mekonnen and Mekonnen, 2003; Chakraborty *et al.*, 2003; Gage, 2007). Common issues emerging in these studies seem to influence maternal health service access, including demographic, cultural and socio-economic factors. Socio-economic factors, income levels and access to services seem crucial, implying that financing methods that heavily subsidize service costs to households reduce financial barriers to healthcare access and thereby improve maternal health service access.

Unfortunately, economic difficulties in most SSA countries: poor growth, poverty and dwindling resources act together to constrain the government's capacity to

subsidize healthcare. Additionally, structural adjustment and economic recovery programmes in many SSA countries led to withdrawing subsidies while cost-sharing (fee-for-service schemes) were introduced as alternatives for financing healthcare (Abekah-Nkrumah, 2005). Evidence indicates that countries like Malawi, Uganda and Ghana, which hitherto provided funding for personnel and operating costs at public and mission facilities, are now changing their roles owing to reform (decentralisation, cost recovery and hospital autonomy) and shifting cost to local governments and consumers (Levin *et al.*, 2003). Unfortunately user-fee regimes in many developing SSA countries cannot be considered a great experience. Well-implemented exemption schemes for poor users have proven regressive, which adversely impact maternal care service uptake (Nanda, 2002). The claim that user-fees provide additional resources for improving service quality has also been criticised. Extra resources generated from user-fee schemes are absorbed by administrative costs and that increased resources in jurisdictions where they occur have not been associated with improved services (Bitrán and Giedion, 2003; Roberts *et al.*, 2004).

Developing alternative, financially sustainable strategies for priority health services especially maternal healthcare is essential for SSA health systems. Its importance is its ability to empower marginalized women to enhance their access to maternal health services (Huntington, 2004). Alternatives, such as employment-based health, universal, private and social health insurance are noted to increase healthcare service access and uptake. A Thai study indicated that providing universal insurance increased health service use by the poor (including emergency obstetrical services), (Tangcharoensathien *et al.*, 2002). The Bolivian Social Insurance for Mothers and Children impacted positively on antenatal care visits and institutional deliveries particularly for the poor (Dmytraczenko *et al.*, 1998). Compulsory employment-based insurance schemes in Indonesia record positive effect on access to out-patient (especially antenatal) care (Hidayat *et al.*, 2004), strongly suggesting that financial barriers to in-patient maternal care services are also reduced.

Our analysis indicates that insurance systems enhance women's healthcare access. Nonetheless, the difficulty is how marginalized groups and the poor in most SSA countries where poverty is high and almost endemic will be able to afford insurance premiums. In Ghana, where mutual health insurance premiums range from US\$7.2 to US\$40 per year, several pregnant women, especially the poor, cannot pay registration premiums. Obviously, the situation could be worse in countries still running fee-for service without social insurance schemes. Policy to confront these situations includes mechanisms that empower women financially so that whether healthcare provision for women is operated via an insurance system or fee-for service, the resources will be available for them to access maternal health service. Though different options could be explored, women's access to micro-finance seems a better alternative, since that has been researched and found to be an important tool for empowering women financially.

Women's access to micro-finance and its effect on their income levels

Micro-finance has, since McKinnon (1973) and Shaw's (1973) pioneering work in finance for development, gained importance especially in developing countries. According to Ledgerwood (1999), micro-finance has evolved as an economic development approach intended to benefit low-income people. The term also relates to financial services for low-income clients, including the self-employed. Financial services generally include

savings and credit; however, some micro-finance organizations also provide insurance and payment services. Loans, generally, are in three forms: consumption loans; working capital; and long-term investment (consumption loans and working capital are defined as flow credit (borrower's income flow) and long-term investment stock credit (borrower's asset-and-liability) (Udry, 1990). Micro-finance is popularised through the credit-focused peer-monitoring model targeted at poor women developed by the Grameen Bank of Bangladesh. However, important adaptations to the Grameen model have been developed and implemented in Asia, Africa and the Americas. Poverty alleviation or reduction has remained micro-finance's main goal. In short, micro-finance could be defined as not simply banking but making financial resources available to the productive poor.

Micro-finance is believed to have a significant impact on the beneficiaries' socio-economic status with the impact much stronger for women (Khandker, 1998). Micro-finance programmes present an opportunity to improve and sustain income generation. It has been argued that for women, there is a larger benefit – socio-economic empowerment – through greater self-confidence and self-worth. Hulme and Mosley (1996) in Bangladesh, following micro-financing, found significant breakthroughs from women contributions in social networks and communities. Hashemi *et al.* (1996) also found that at Grameen Bank, women beneficiaries were positively influenced by economic security, ability to make small and large purchases and political and legal awareness. Panjaitan-Drioadisuryo *et al.* (1999) noted that Indonesian women's income increased substantially, whilst repayment was also timely and punctual. There was a general improvement in family nutrition; women also had higher aspirations for their children's education and were more likely to reduce their childbearing.

Women's access to micro-finance in most situations affects power structures at the household level. Women use their access to credit as a bargaining chip for increasing household income and negotiating transfers with those who hold some social control. For instance, as Goetz and Gupta (1996) note, Bangladeshi women's economic contributions to the household are in labour and kind, and are invisible. However, with micro-finance, it is likely that such contributions are revaluated, which invariably increases women's economic status and net worth.

In West Africa, Charitonenko and Campion (2003) highlight Mali's Freedom from Hunger Project that targets rural women through its Credit with Education group-lending programme. They observed that participation in the programme increased women's profits, with the accumulated savings directly channelled toward food, medicine and school supplies. Women's self-confidence and status in the community ascended remarkably. In Uganda, after a two-year period, participants in three micro-finance programmes showed increased assets and savings compared to a non-participant group, and reported greater profits from their businesses (Barnes *et al.*, 2001). Evidence from Bangladesh indicates that village people participating in a micro-finance programme showed an 18 per cent poverty reduction as compared to a 13 per cent reduction for villages that did not participate in the micro-finance programme (Khandker, 2005). The study further revealed that, more than half the reduction in poverty for those inhabitants participating in the programme was directly attributable to the participation in the micro-finance programme.

Why should women be targeted substantially in micro-finance? There are opinions that micro-finance does little to alter gender relations that favour females that may

contribute to reinforcing existing gender imbalances. Amin *et al.* (1998) show that while BRAC membership in Bangladesh positively affected women's decision-making and their control over resources, it had little influence on their attitudes regarding marriage and child education. Indeed, women's ability to use financial services in the way they wish can be both constrained and facilitated by gendered socio-economic relations that operate at household, local business and national communities. On the whole, micro-finance benefits to women appear more convincing. Rogaly (1996) argues that it is not the case that micro-finance services are easily accessible to women; rather women are easily accessible because it is easier for micro-finance operators to reach them. In many countries, it is relatively easier to locate women, as they work in the home compound. They are perceived as more susceptible to repayment pressure in social network and training opportunity terms. Mayoux (1995, 1998) distinguishes between three main women-targeted micro-finance provision paradigms:

- (1) *Financial sustainability* – based on an instrumentalist, market approach, which focuses attention on women's high repayment rates as a means to achieve the wider goal – assisting individual entrepreneurs to increase their incomes.
- (2) *Poverty alleviation* – targets women as the poorest and more likely than men to spend increased income on their families.
- (3) *Feminist empowerment* – aims to enhance poor women's bargaining power and incomes, seeing gender equity as an inseparable part of any wider development goal. In this framework, without parallel interventions fostering women's access to markets, technology, decision-making structures, legal rights and social capital, the positive discrimination inherent in targeted credit tends to cease.

There is empirical evidence about micro-finance's importance to women. In Ghana, women participants demonstrated increased empowerment after their involvement in micro-finance programmes (MkNelly and Dunford, 1998). Women's decision making increased, particularly family planning and children's education. Also, other family members' participation in housework increased significantly as women spent more time on their businesses and contributed more to household income. Access to micro-finance services, bundled with education from Freedom from Hunger in Ghana and Bolivia, positively impact health knowledge and women's status. Evaluating these programmes found that in both countries, participants had better knowledge about breastfeeding practice, diarrhoea treatment and immunisation (MkNelly and Dunford, 1998; 1999). Focus groups, held with Upper Manya Krobo Rural Bank clients, reported more women using local health clinic pre- and post-natal services. Based on the conviction that women's access to micro-finance provides an opportunity to increase their income levels, empowering should give them a bargaining chip concerning household decisions.

Micro-finance and maternal health service uptake

Access to micro-finance can influence women's ability to embark on income-generating activities. Through micro-finance, women can be self-employed, which may have significant implications for maternal health services. The literature showed that employment is an important factor influencing access to quality medical care and treating pregnancy complications. Women's involvement in economic activities

empowers them to take part in decision-making about family healthcare. Chakraborty *et al.* (2003) argue that women in gainful employment are more likely to use modern healthcare services to treat pregnancy complications. According to Desai and Jain (1994), working women are expected to have greater control over household resources. They are likely to have greater knowledge about pregnancy and childbirth owing to greater freedom outside the household and they are likely to seek information on services available for pregnancy during their work. However, it is argued that women's work in developing countries are poverty induced and therefore likely to negatively impact healthcare service use as it involves opportunity and monetary costs (Desai and Jain, 1994; Basu and Basu, 1991; Berman *et al.*, 1997). Navaneetham and Dharmalingam (2002) found that non-earning women were less likely to use maternity services compared to earning women in India. Their findings suggest that earning capacity could influence maternal healthcare service uptake and this could be achieved by empowering women economically.

Women's access to micro-finance empowers them in the household and community. The contention is whether such financial and decision-making empowerment can be translated into increased health service uptake, especially maternal health. Evidence in some jurisdictions indicates that access to micro-finance increases maternity service use. This impact arises where micro-finance is combined with education. Merely educating women on maternity services may not have the desired impact. McNelly and Dunford (1996) noted that, more reproductive-age women were immunised against tetanus and had greater knowledge of nutritional needs in areas where credit and basic social services were combined. Other studies such as Pitt *et al.* (2003) in rural Bangladesh also found that a 10 per cent increase in credit provided to females increases their daughters' arm circumference by 6.3 per cent, twice that expected from a similar proportionate increase in credit provided to men. Female credit is estimated to have large, positive and statistically significant effects on boys' and girls' height-for age.

Studies about interventions with Micro-finance for AIDS and Gender Equity (IMAGE), part-funded by DFID in South Africa, found that integrating HIV/AIDS components into existing micro-finance programmes helped reduce violence against women and HIV infection risk from male partners (House of Commons International Development Committee, 2008). Similar positive impact of micro-finance on health has been documented for Uganda. The FOCCAS (a micro-finance institution) clients, after receiving health education, had better healthcare practices than non-clients and 32 per cent tried at least one HIV/AIDS prevention, compared to 18 per cent of non-clients (Barnes *et al.*, 2001). Similarly in Bangladesh, members participating in micro-finance programmes for more than four years had higher contraceptive use (Khandker, 1998). Conceptually, therefore, we propose that women's education, combined with micro-credit, could enhance maternal health service uptake (Figure 1).

We propose a theoretical argument on micro-finance and maternal health service use by women based on three channels. The first, already argued in the literature, shows that women with access to education are likely to improve maternal health service uptake. The second shows that women with access to micro-finance are also likely to improve maternal health service use. The third argues that women with access to micro-finance and education are more likely to improve maternal health services. Indeed, we argue that access to micro-finance with education is a more likely and better

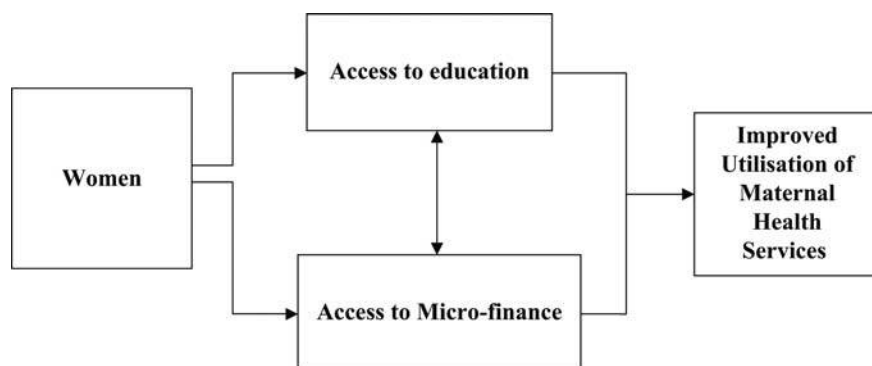


Figure 1.
Improving maternal
healthcare through
micro-finance

channel that leads to improved maternal health service uptake. Therefore, even though access to micro-finance can lead to improvements, just like the education channel, micro-financing alone may not be enough. Hence there is the need to augment access to micro-finance with education to optimize maternal healthcare service quality.

Conclusion, implications and recommendations

Maternal health is a major problem in developing countries. Access to and the use of quality maternity services are, therefore, crucial for improved maternal-child survival. We examine channels through which programmes influence women's maternity service use. The first shows that women with access to education are likely to experience improvement in maternal health service uptake. The second shows that women accessing micro-finance are also likely to improve maternal health service uptake. The third argues that women accessing micro-finance and education are more likely to improve maternal health service uptake. Clearly, higher family income is associated with modern healthcare services (Elo, 1992; Fosu, 1994). Other authors show that household wealth has a positive and significant effect on women's maternal health service use (Celik and Hotchkiss, 2000). Gage (2007) suggests that maternal healthcare service uptake is negatively influenced by household poverty - implying that financing, which heavily subsidizes service costs, reduces financial barriers to access and thereby improves maternal health service uptake. We conclude, therefore, that micro-finance with education provides a better channel leading to improved maternal health service uptake.

We raise several key issues for future research. Sustaining micro-finance impact is important. Micro-finance should enable successful beneficiaries to exit schemes and move on to higher engagements. Following micro-financing beneficiaries, to determine if impacts are sustained after exiting micro-finance programmes, would be useful. As a follow-up to this review, country-level empirical studies could examine the effect of women's access to micro-finance on their maternity service uptake. Looking at how access to micro-credit combines with women's education to improve maternal health service use would also be helpful. Introducing national health insurance schemes in Ghana influences one's ability to access health services and this depends on whether women are enrolled in a health insurance scheme or prepared to pay out-of-pocket. Therefore, future studies could consider how women's access to micro-credit influences their participation in mutual health insurance schemes.

References

- Abor, P.A. (2008), "Socio-economic determinants of maternal healthcare utilisation in Ghana", unpublished MPhil thesis, University of Ghana, Legon.
- Amin, R., Becker, S. and Bayes, A. (1998), "NGO-promoted microcredit programmes and women's empowerment in rural Bangladesh", *Journal of Developing Areas*, Vol. 32 No. 2, pp. 221-36.
- Abekah-Nkrumah, G. (2005), "Organisational learning and organisational performance: a study of selected healthcare institutions in Ghana", unpublished MPhil thesis, University of Ghana, Legon.
- Acharya, L.B. and Cleland, J. (2000), "Maternal and child health services in rural Nepal: does access or quality matter more?", *Health Policy and Planning*, Vol. 15 No. 2, pp. 223-9.
- Addai, I. (2000), "Determinants of use of maternal-child health services in rural Ghana", *Journal of Biosocial Science*, Vol. 32 No. 1, pp. 1-15.
- Barnes, C., Gaile, G. and Kimbombo, R. (2001), *Impact of Three Micro-finance Programmes in Uganda*, AIMS, Washington, DC.
- Basu, A.M. and Basu, K. (1991), "Women's economic roles and child survival: the case of India", *Health Transition Review*, Vol. 1 No. 1, pp. 83-104.
- Becker, S., Peters, D.H., Gray, R.H., Gultiano, C. and Black, R.E. (1993), "The determinants of use of maternal and child health services in Metro Cebu, the Philippines", *Health Transition Review*, Vol. 3 No. 1, pp. 77-89.
- Berman, P., Zeitlin, J., Roy, P. and Khumtakar, H. (1997), "Does maternal employment augment spending for children's healthcare? A test from Haryana, India", *Health Transition Review*, Vol. 7 No. 2, pp. 187-204.
- Bitrán, R. and Giedion, U. (2003), *Waivers and Exemptions for Health Services in Developing Countries*, Social Protection Discussion Paper Series No. 0308, Social Protection Unit, Human Development Network, The World Bank, Washington, DC.
- Bhatia, J.C. and Cleland, J. (1995), "Determinants of maternal care in a region of South India", *Health Transition Review*, Vol. 5 No. 2, pp. 127-42.
- Charitonnenko, S. and Campion, A. (2003), "Expanding commercial micro-finance in rural areas: constraints and opportunities", available at: www.basis.wisc.edu/live/rfc/cs_05a.pdf (accessed 15 January, 2008).
- Celik, Y. and Hotchkiss, D.R. (2000), "The socio-economic determinants of maternal healthcare utilisation in Turkey", *Social Science and Medicine*, Vol. 50, pp. 1797-806.
- Chakraborty, N., Islam, M.A., Chowdhury, R.I., Bari, W. and Akhter, H.H. (2003), "Determinants of the use of maternal health services in rural Bangladesh", *Health Promotion International*, Vol. 18 No. 4, pp. 327-37.
- Desai, S. and Jain, D. (1994), "Maternal employment and changes in family dynamics: the social context of women's work in rural south India", *Population and Development Review*, Vol. 20 No. 1, pp. 115-36.
- Dmytraczenko, T., Escalante, C.S., Capra, S.K., Abramson, W.B., Saravia, V.A., Aitken, I., Holley, J. and Aparicio, E.M. (1998), "Evaluación del seguro nacional de maternidad y niñez en Bolivia", Informe Técnico 22, Partnerships for Health Reform Project, Abt. Associates Inc, Bethesda, MD.
- Elo, I.T. (1992), "Utilisation of maternal healthcare services in Peru: the role of women's education", *Health Transition Review*, Vol. 2 No. 1, pp. 49-69.

- Fosu, G.B. (1994), "Childhood morbidity and health services utilisation: cross-national comparisons of user-related factors from DHS data", *Social Science and Medicine*, Vol. 38, pp. 1209-20.
- Gage, A.J. (2007), "Barriers to the utilisation of maternal healthcare in rural Mali", *Social Science and Medicine*, Vol. 65 No. 8, pp. 1666-8.
- Goetz, A.M. and Gupta, R.S. (1996), "Who takes the credit? Gender, power, and control over loan use in rural credit programmes in Bangladesh", *World Development*, Vol. 24 No. 1, pp. 45-63.
- Hashemi, S., Schuler, S.R. and Riley, A.P. (1996), "Rural credit programmes and women's employment in Bangladesh", *World Development*, Vol. 24 No. 4, pp. 635-53.
- Hidayat, B., Thabrany, H., Dong, H. and Sauerborn, R. (2004), "The effects of mandatory health insurance on equity in access to outpatient care in Indonesia", *Health Policy and Planning*, Vol. 19, pp. 322-35.
- House of Commons (2008), *International Development Committee Maternal Health Fifth Report of Session 2007-08, Volume I*, House of Commons, The Stationery Office, London.
- Hulme, D. and Mosley, P. (1996), *Finance Against Poverty, Volumes I and II*, Routledge, London/New York, NY.
- Huntington, D. (2004), "Health sector reforms and maternal care programmes, background paper", Global Forum for Health Research, Mexico City, November 16-20.
- Khandker, S.R. (1998), *Fighting Poverty with Microcredit: Experience in Bangladesh*, Oxford University Press, New York, NY.
- Khandker, S.R. (2005), "Micro-finance and poverty: evidence using panel data from Bangladesh", *World Bank Economic Review*, Vol. 19, pp. 263-86.
- Ledgerwood, J. (1999), *Sustainable Banking with the Poor, Micro-finance Handbook, An Institutional and Financial Perspective*, The World Bank, Washington, DC, July.
- Levin, A., Dmytraczenko, T., McEuen, M., Ssengooba, F., Mangani, R. and Van Dyck, G. (2003), "Costs of maternal healthcare services in three anglophone African countries", *International Journal of Health Planning Management*, Vol. 18, pp. 3-22.
- McKinnon, R. (1973), *Money and Capital in Economic Development*, The Brookings Institution, Washington, DC.
- Mayoux, L. (1995), *From Vicious to Virtuous Circles? Gender and Micro-Enterprise Development*, United Nations Research Institute for Social Development, Geneva.
- Mayoux, L. (1998), "Women's empowerment and micro-finance programmes: approaches, evidence and ways forward", Open University Development Policy and Practice Working Paper No. 41, Open University, Milton Keynes.
- Mekonnen, Y. and Mekonnen, A. (2003), "Factors influencing the use of maternal healthcare services in Ethiopia", *Journal of Health, Population and Nutrition*, Vol. 21 No. 4, pp. 374-82.
- MkNelly, B. and Dunford, C. (1996), "Are credit and savings services effective against hunger and malnutrition? A literature review and analysis", Research Paper No. 1, Freedom from Hunger, Davis, CA.
- MkNelly, B. and Dunford, C. (1998), *Impact of Credit with Education on Mothers and Their Young Children's Nutrition: Lower Pra Rural Bank Credit with Education Programme in Ghana*, Freedom from Hunger, Davis, CA.
- MkNelly, B. and Dunford, C. (1999), *Impact of Credit with Education on Mothers and Their Young Children's Nutrition: CRECER Credit with Education Programme in Bolivia*, Freedom from Hunger, Davis, CA.

- Nanda, P. (2002), "Gender dimensions of user fees: implications for women's utilisation of healthcare", *Reproductive Health Matters*, Vol. 10 No. 20, pp. 127-34.
- Navaneetham, K. and Dharmalingam, A. (2002), "Utilisation of maternal healthcare services in Southern India", *Social Science and Medicine*, Vol. 55, pp. 1849-69.
- Obermeyer, C.M. (1991), "Maternal healthcare utilisation in Jordan: a study patterns and determinants", *Studies in Family Planning*, Vol. 22 No. 3, pp. 177-87.
- Obermeyer, C.M. (1993), "Maternal healthcare and women's status: a comparison of Morocco and Tunisia", *Studies in Family Planning*, Vol. 24 No. 6, pp. 354-65.
- Panjaitan-Drioadisuryo, D., Rosintan, M. and Cloud, K. (1999), "Gender, self-employment and microcredit programmes: an Indonesian case study", *Quarterly Review of Economics and Finance*, Vol. 39, pp. 769-79.
- Pebley, A.R., Goldman, N. and Rodriguez, G. (1996), "Prenatal and delivery care and childhood immunisation in Guatemala: do family and community matter?", *Demography*, Vol. 33 No. 2, pp. 231-47.
- Pitt, M.M., Khandker, S.R., Chowdhury, O.H. and Millimet, D. (2003), "Credit programmes for the poor and the health status of children in rural Bangladesh", *International Economic Review*, Vol. 44 No. 1, pp. 87-118.
- Raghupathy, S. (1996), "Education and the use of maternal healthcare in Thailand", *Social Science and Medicine*, Vol. 43 No. 4, pp. 459-71.
- Roberts, M.J., Hsiao, W., Berman, P. and Reich, M.R. (2004), *Getting Health Reform Right: A Guide to Improving Performance and Equity*, Oxford University Press, New York, NY.
- Rogaly, B. (1996), "Micro-finance evangelism, destitute women and the hard selling of a Newanti-poverty formula", *Development in Practice*, Vol. 6 No. 2, pp. 100-12.
- Shaw, E. (1973), *Financial Deepening in Economic Development*, Oxford University Press, New York, NY.
- Tangcharoensathien, V., Tantivess, S., Teerawattananon, Y., Auamkul, N. and Jongudomsuk, P. (2002), "Universal coverage and its impact on reproductive health services in Thailand", *Reproductive Health Matters*, Vol. 10 No. 20, pp. 59-69.
- Udry, C. (1990), "Credit markets in northern Nigeria: credit as insurance in rural economy", *World Bank Economic Review*, Vol. 4 No. 3, pp. 251-69.
- WHO (1992), *ICD-10. International Statistical Classification of Diseases and Related Health Problems*, World Health Organisation, Geneva.
- WHO (2007), *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*, WHO, Geneva.

Further reading

WHO (2000), *World Health Report 2000, Health Systems: Improving Performance*, World Health Organisation, Geneva.

Corresponding author

Gordon Abekah-Nkrumah can be contacted at: ankrumah@ug.edu.gh

To purchase reprints of this article please e-mail: reprints@emeraldinsight.com
Or visit our web site for further details: www.emeraldinsight.com/reprints