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Integration of Microfinance Institutions and Health Programs in Northern Tanzania

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ABSTRACT

Integrating health-related services with microfinance programs have shown to improve health and income security. The steady expansion of Microfinance Institutions (MFIs) in Tanzania is evident, but there is inadequate information on their characteristics and integration with health programs.

We conducted cross-sectional study among 101 MFIs in Moshi, Tanzania to examine their characteristics and integration with health programs

All three categories of microfinance providers operated in the study area. Largest proportions were Village Community Banks (38.6%), Savings and Credit Cooperative Societies (34.6%) Formal banks represented the smallest proportions (17.5%). Financial-related services dominated, with none health education integration. Active borrowers were women, across all categories.

The study concludes that there are many MFIs, funding several activities, but none of the institutions has an integrated health education package. Diversification of products especially health-related interventions is recommended.

KEYWORDS Microfinance Institutions, Health programs

Introduction

Microfinance Institutions (MFIs) are increasingly recognized for their capacity to provide effective and sustainable programs to reduce poverty and associated vulnerabilities. (Leatherman, Metcalfe, Geissler, & Dunford, 2011). A single solution continues to be inadequate in confronting the prevalent problems of poverty, ill health and insufficient health systems worldwide. Microfinance institutions may be characterized based on number of factors including combined commercial and social goals, with the objective of reaching the poor and maintaining financial sustainability (Mori & Golesorkhi, 2013; Nashihin, 2014). Integrating health-related services with microfinance has been shown to improve health and income security. (Geissler & Leatherman, 2015; Leatherman et al., 2011) The steady increase of size and types of MFIs since their introduction in Tanzania is evident, but there is inadequate information on their characteristics and integration with health education.

Microcredit is one of the key products of microfinance services, which entail offering small loans to the poor, to help them grow a small-scale business or start a new one. Many institutions in Africa, Asia and Latin America have already been engaged in successfully offering services beyond microcredit. Services may include training in business management and financial management, health- and social-related services such as education, health care and financing (Leatherman & Dunford, 2010). A study in Ghana revealed that the microfinance industry globally has experienced a boom in innovations of new products combined with credit facilities (Issahaku, Dary, & Ustarz, 2013).

The Microfinance sector in Tanzania has faced rapid development including introduction of several new types of financial service providers and products. The development of the industry follows financial Sector Reforms of 1991-2003 and that of June 2006 (Piprek, Altvater, Fuglesang, Helgesson, & Mashauri, 2010). By the year 2000 the Tanzanian Government had already developed the National Microfinance Policy, along with the financial reforms initiated in 1991(URT, 2005).

Microfinance providers in Tanzania are grouped into three categories namely;. formal institutions which include commercial, cooperative and community banks,; semi-formal group which includes financial non-governmental organizations (NGOs), companies, and Savings and Credit Cooperative Societies (SACCOS). Another category is informal covering Village Community Banks (VICOBA and Village Savings and Loan Association (VSLAs). (FinScope, 2009)

Financial NGOs are pioneers of microcredit services in the country and estimated to be around 100 in the year 2009. The Rural Financial Survey Strategy (RFSS) of 2011 reported that financial companies engaged in microcredit services in the country were estimated to be more than sixty by the year

2009, while SACCOS have proliferated, and estimated to be 5,300 across the country (URT, 2011).

While microfinance has grown to become popular intervention in financing the poor in Tanzania, there is inadequate information regarding MFIs characteristics, which are considered pertinent to the uptake of the services by their clients. The characteristics and operational policies of the MFIs have been reported to influence delivery of microfinance programs by the institutions (Issahaku et al., 2013). A recent study in Tanzania revealed that the growth of microfinance industry in the country was steady; however, the pace of growth does not commensurate the uptake of the services by the poor (Kessy et al., 2015). A lack of awareness and understanding of characteristics of MFIs, guiding policies, products and services promoted by the MFIs in developing countries including Tanzania, appears to be a constraint (Piprek et al., 2010). Such information is important to guide policy intervention and practice in management of the Institutions, and promote uptake of microfinance services for the poor.

The aim of this study was to examine characteristics of Microfinance Institutions and the possible integration of health promotion programs in microfinance services provision in Moshi, Tanzania

Methodology

Study design and site

This was a cross-sectional study conducted between October and December 2014. The study was conducted in Moshi Urban district which is situated in northern Tanzania. The district is one of the seven districts in the Kilimanjaro region. Based on the National census of 2010, Moshi Urban was estimated to have 33,910 households with a population of 200,000. Of these 80,000 (40%) live below poverty line, i.e. living below $ 1 a day. (TDHS, 2010)

Administratively the district is sub- divided into 15 wards, of which 5 are regarded as urban and 10 as peri-urban wards, and the study was conducted in all 15 wards. The peri-urban wards are considered to have high population density with limited access to formal financial institutions and guaranteed income, compared to urban wards.

Study population

This study included all Microfinance Institutions registered and operating in Moshi urban in the year 2014. The study excluded 6 semi-formal MFIs which did not consent to participate. The study included two sets of primary data base; the mapping data base of 101 MFIs and more detailed interviews with 40 MFI leaders.

Figure 1 shows schematic sampling

Sampling procedures

The list of MFIs operating in the study area was obtained from the leaders of respective umbrella organizations, and physical visits were made to the MFIs. One hundred and one MFIs consented to participate which included 7 Banks, 20 Financial companies, NGOs, and Government program, 35 Savings and Credit Cooperative Societies and 39 informal Village Community Banks.

Stratification was used to select 40 MFIs for more information, and stratification was based on the three MFI categories. In the formal sector all 7 institutions were selected. In the semi-formal sector 23 out of 55 MFIs were randomly selected. In the informal sector (VICOBA), 10 out of 39 were randomly selected.

Basically VICOBA has a multitude of small entities managed independently, but with common characteristics and modes of operations. Therefore response from one leader to another in the questions asked was consistent and the interviewer was not getting any new information. Saturation was used to determine the final number of respondents, due to this the interviewer stopped after the tenth respondents.

Data collection methods and tools

The focus of the study was to describe geographical coverage of MFIs, their products, operational policies and practices. Face to face interviews with open and closed questions were administered to the managers of all 101 institutions. The questionnaire covered information such as the name and type of the MFI, location, membership, terms and conditions for loan application, services offered by the MFIs, targeted clients etc.

In the subset interview database, a semi-structured questionnaire was used to collect more information about programs regarding socio-demographic and economic characteristics of the clients, type of services provided, interest and repayments, and sources of funding. Some quotes are included in the Results section for illustration.

Pilot-testing of the questionnaire was conducted in Hai district, a rural ward which was not part of the study sites. Changes were made in the questionnaire language to make some questions much elaborative and easier for the interviewee. The questionnaires were checked and corrected for consistency.

Data processing

Data processing analysis was conducted using a computerized database in the Statistical Package for Social Sciences Version 17 (SSPS Chicago). Before analysis the data were checked and corrected for consistency, and then the same software was used for data analysis. Descriptive statistics were summarized using frequency and proportions for categorical variables. To illustrate findings some citation are presented in the Result section.

Ethical clearance was granted by the Kilimanjaro Christian Medical University College. The MFI managers gave their written consent to participate in the study.

Results

Characteristics of the 101 MFIs

The results show that all three categories of microfinance providers operated in the study area, and they were widely distributed over the area.

Figure 2 shows distribution pattern of Microfinance Institutions.

The largest proportions of MFIs were VICOBA (38.6%) and SACCOS (34.6%). Commercial and cooperative banks had the smallest proportion of the microfinance service providers (17.5%). Most of the MFIs (80%) provide only financial-related services, and other products of social benefits such as health education, insurance, entrepreneurship skills and other related microfinance services were not included by most MFIs. Companies offered credit facility only, while other institutions offered both credit and savings. Only banks had formal regulatory authority, in contrast to the rest of the MFIs had no formal regulator of the business operations. A large proportion of VICOBA and SACCOS operate in semi-urban areas and extend more actively to rural settings, unlike banks and Companies.

Description of the subset data of 40 MFIs

The majority of the active borrowers were women across all categories (80%). Membership policies in the banks, companies and NGOs were open to the general public. Most of the SACCOS and VICOBA were restricted to specific group of clients. The unique characteristics regarding membership in SACCOS and VICOBA were that clients were founder members and owners of the institutions.

The minimum starting loan ranged from Tsh.50,000 – 250,000 ($25-$125) in VICOBA and SACCOS with the interest rates above 22% and repayment duration being within 24 months. In commercial banks and companies average starting loan was Tsh.1,000,000 (USD 500), with the lowest interest rate ranging from 18 to 22 % and repayment duration was up to 36 months. Physical assets were the main collateral for

accessing loans in the banks (100%) and companies (57%), while VICOBA and SACCOS used social collateral (100%) to access loans.

Across all MFIs equity, mobilized savings and deposits found to be the main source of funding for MFI operations (72.5%). More than three quarters (82.5%) of the MFIs funded both economic and social activities of the clients such as education, health services, housing etc. About 7/40 (17.0%) funded economic or direct income-related activities only.

Table 1 summarizes characteristics of selected MFIs

Perception of the leaders on the use of the loan by clients

The leaders were asked in an open-ended question what they thought the clients used the money for, and they made several comments. The responses reveal that women use their loans to finance direct income-generating projects as well as non-direct income-generating investment that ought to improve socio-economic outcomes of their families.

"…. they use their loan to establish or expand business, housing, education for children and food was most often mentioned. ".....they use loan for petty business like food venders, second hand clothes social services like health and education for their children.."

They were also asked if they regarded health education as a relevant topic to include in the services offered. They considered MFIs as an appropriate forum for health education, specifically addressing issues related to mother and child health, and communicable and non-communicable diseases.

".. MFI is appropriate for health education on HIV & AIDS, cancer, family planning and nutrition"

Discussion

This study revealed that all types of MFIs were represented, and that almost all were restricted to financial-related services. Health-related programs were seldom integrated though health education on nutrition, family planning, HIV/AIDS and cancer, although these topics were considered appropriate for the integration by the leaders. Interest rates in SACCOS and VICOBA were high compared to other MFIs, yet they were the most preferred by the poor clients. Banks and financial companies concentrated in urban wards, while SACCOS and VICOBA extended more to the peri-urban wards. Majority of active borrowers were women across all categories. Equity, mobilized savings and deposits found to be the main source of funding the MFIs operations.

It was confirmed that microfinance institutions could be classified into three categories; formal (banks), semi-formal (Companies, NGOs, SACCOS) and informal (VICOBA) categories. This kind of MFI classification seems to be common across Africa and Asia. In Kenya the institutions are classified into three different types; deposit-taking such as commercial banks, credit only non-deposit taking, and informal organizations (Kodongo & Kendi, 2013). In Indonesia Microfinance players are categorized into three; Institutional microfinance (banks, state – owned, Village Credit facilities, Savings and Credit Associations), program microfinance (microfinance system building, poverty alleviation programs, NGO microcredit programs and Crisis-related funds) and the Individual Microcredit (Money lenders, Traders, Shopkeepers, Family members) (Nashihin, 2014)

The results revealed that a large proportion of MFIs operating in the study area were SACCOS and VICOBA, which extended services more to peri-urban areas. This observation suggests that their business model of operation like social collateral through group-based lending, favoring poor clients. This statement is supported by a study conducted in Kenya that group lending attracts more clients because of low delinquency levels and social collateral (Kodongo & Kendi, 2013).This is also consistent with the market-failure hypothesis, which predicts that MFIs fulfill a need that commercial banks fail to fulfill (Vanroose & Espallier, 2013).

Minimum starting loans ranged considerably where SACCOS and VICOBA issued the smallest starting loans compared to Companies, NGOs and Banks. The condition for accessing such loans was social collateral or group-based lending systems, unlike physical asset collateral used by other MFIs to access loans. The findings suggest increased financial options for small-scale entrepreneurs to access capital in Tanzania to start-up or improve their business due to increased MFI providers. However, a recent study in the country concluded that the drastic growth of MFIs in Tanzania does not match uptake of the services by the poor. (Kessy et al., 2015).

The majority of the active borrowers from the selected MFIs were women; this finding is consistent with other studies which show that typical microfinance clientele in many parts of the world have been poor female entrepreneurs (Leach & Sitaram, 2010). By December 2010, there were 3652 MFIs reported to be reaching approximately 200 million clients worldwide. Sixty-seven percent of those reached by MFIs were the poorest clients when they took their first loan, and of these 82.3% were women (Maes & Reed, 2012). Women are predominant clients of MFIs globally because they experience higher levels of poverty (as compared to men) and are also marginalized in social and economic opportunities (Kim et al., 2007).

Interest rates were relatively low in the banks and financial companies as compared to SACCOS and VICCOBA. According to the MIX Market database, the annual median lending interest rate charged by MFIs during the period 2005 – 2010 ranged between 27.9% and 30.40%. Hudon and Ashta, 2013). In Tanzanian context the SACCOS and VICOBA provided highest interest, yet had majority of the clients. There are several explanations to that effect including high administrative cost due to small and short-term loans provided by the institutions. Administrative cost for handling small loans of short-term is relatively higher than that of banks that handle huge loans for a longer term. (Armendariz and Moduch, 2010). On the other side, it is also important to note that the members are the founders and owners of the institutions. Paying high interest rate therefore is part of their profit or increases their savings at the end of the business cycle.

In line with previous study by Haruna, equity, mobilized savings and deposits were found to be the main source of funding the MFIs operations (Issahaku et al., 2013). Equity is an important source at the commencement, and mobilized savings and deposits implies a low cost of financing the MFIs and financial sustainability due to limited dependency on donor support and bank loans. On the other hand, whereas MFIs depend much on the savings and deposits as main source of financing their activities, this dependency might result in a limited loan portfolio and limit access of the size and number of beneficiaries. Strategies for multiple and more reliable sources of funding like savings, deposits and equity need to be enhanced for the MFIs to reach more poor clients with a sustainable financing scheme.

Health-related programs were not found in most of the MFIs. This omission may be considered as an underutilized potential based on the fact the poor are at risk multiple health problems, including lower health care access and worse outcomes with higher rates of maternal and child mortality (World Health Organization, 2012). The findings concur with other studies which concluded that, microfinance sector offers an underutilized opportunity for delivery of health- related services to many hard-to-reach populations (Leatherman et al., 2011)ill health and insufficient health system capacity worldwide. The poor need access to an integrated set of financial and health services to have income security and better health. Over 3500 microfinance institutions (MFIs. Tanzania, like other developing countries, experiences worse health outcomes of maternal and child health, and other diseases attributed to poverty such as malnutrition and cholera. Non-communicable

diseases like breast and cervical cancer, and diabetes mellitus are also increasing at alarming rates. Appreciating the role of integrating health programs and microfinance services, several countries in Africa, Asia and Latin America have already started to capitalize in this opportunity (Bassani et al., 2013; Geissler & Leatherman, 2015; Tarozzi & Johnson, 2013). Furthermore it has been argued that to make microfinance a more effective means of poverty reduction, other services such as training, technological support, education and health-related strategies should be included within microfinance *(Nawaz, 2010)*. Integration of microfinance with health-related programs in Tanzania could help reduce the burden of poverty and diseases and at the same time extend the services much closer to the needy.

This study is limited in some aspects. First, the study is cross-sectional in design and therefore precludes the ability to make causal inference about the results. A second limitation of the study is that, the MFIs studied in Tanzania may not representative of similar institutions in other settings due to differences in cultural context, growth trend of MFIs etc which differ across countries. Another limitation is that the study addressed financial matters and some questions were sensitive; hence respondents might have been skeptical.

Conclusion and Recommendations

The are many MFIs funding several activities but none of the institutions has an integrated health education package. The lack of health programs integrated in the rapid expansion of microfinance services is a potential opportunity that needs to be fully utilized for social and economic transformation. The performance of SACCOS and VICCOBA seems to have effectively intervened with accessibility barriers affecting the poor such as interest rates, collateral and geographical proximity. Innovations to diversify products need to be considered to accommodate a much wider range of microfinance programs including health-related interventions. A comprehensive study in the country is important to establish trends, and strategies required for MFIs to reach a wider scope of the poorest population.

Fig 2: Schematic presentation of the Sampling

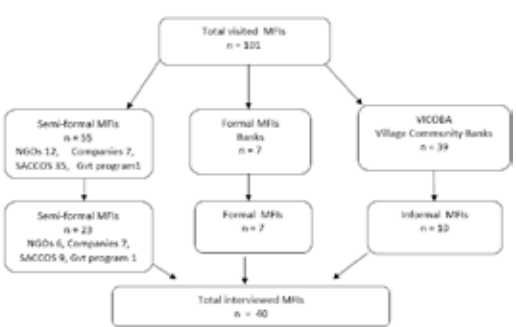

Figure 2:

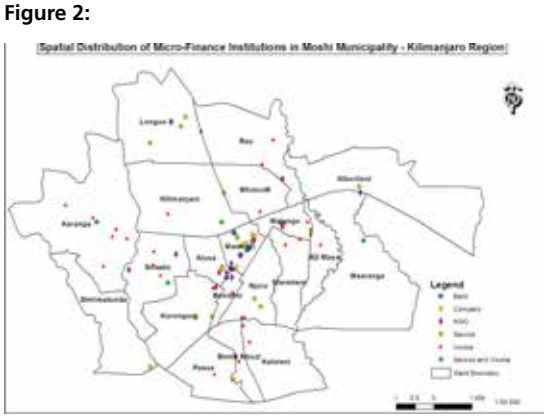

Table 1: Characteristics of 40 Financial Institutions providing Microfinance services in Moshi Municipality n = 40

	Formal formal MFIs			Semi-		Informal MFI
	Banks =7 n (%)	Companies= 7 n=(%)	NGOs= 6 n(%)	SACCOS = 9 n(%)	GVt program=1 n(%)	VICOBA = 10 n(%)
Main Collateral required						
Physical collateral (Physical assets/ facilities)	7 (100)	0	0		0	0
Social collateral (group members or employer)	0	3 (43)	2(33.9)	9(100)	1 (100)	10 (100)
Both physical and social collateral	0	4 (57)	2(33.3)	0	0	0
NA	0	0	2(33.3)	0	0	0
Services provided						
Financial related services	7 (100)	6 (85.7)	3 (50)	8(88.9)	1(100)	7(70)
Both financial and non financial related services	0	1(14.3)	3(50)	1(11.1)	0	3(30)
Savings requirement						
Yes	7(100)	5(71.4)	3 (50)	9(100)	0	10(100)
No	0	2 (28.6)	3(50)	0	1(100)	0
Interest rate						
≤ 10 %	0	1(14.3)	5 (83.3)	0	1(100)	0
10-18%	2(28.6)	0	0	8(88.9)	0	2(20)
>18%	5(71.4)	6(85.7)	1(16.7)	1(11.1)	0	8(80)
Loan processing duration						
One day	0	0	0	0	0	10 (100)
Within one week	2(28.6)	6(85.7)	6 (100)	5(55.6)	0	0
More than one week	5(71.4)	1(14.3)	0	4(44.4)	1(100)	0
Repayment duration						
Within one year	2(28.6)	4(57.1)	5(83.3)	4(44.4)	1(100)	10(100)
More than one year	5(71.4)	3(42.9)	1(16.7)	5(55.6)	0	0
Active borrowers						
Men	0	1(14.5)	0	0	0	0
Women	6(85.7)	4(57.1)	5(83.3)	8(88.9)	1(100)	8(80)
Both	1(14.3)	2(28.6)	1(16.7)	1(11.1)	0	2(20)
Employment status of the targeted clients						
Formal only	1(14.3)	1(14.3)	0	4(44.4)	0	0
Informal only	0	0	2(33.3)	4(44.4)	1(100)	7(70)
Both formal and Informal	6(85.7)	6(85.7)	4(66.7)	1(11.1)	0	3(30)

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