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EVALUATING THE IMPACT OF MICROFINANCE INTERVENTION ON THE LIVING STANDARD OF WOMEN LIVING WITH HIV AND AIDS IN MUFINDI DISTRICT, IRINGA REGION-TANZANIA

A research project submitted to Van Hall Larenstein University of Applied sciences in partial fulfilment of the requirements for the degree of Master of Management of Development specialization Rural Development and HIV/AIDS

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Dedication

This piece of work is dedicated to my late mother Mwl. Neema Kisaka Mdahila. She was constant source of inspiration in my life and guided my steps towards the discovery of my strength. Although physically she is not here to give me strength and support, I always feel her existence that used to urge me to strive to reach better goal in life. Her love has made me what I am today.

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Abbreviations

ARV	Anti-retroviral Therapy
AIDS	Acquired Immunodeficiency Syndrome
CRS	Catholic Relief Services
CTC	Care and treatment clinic
GAM	Gender Analysis Matrix
HIV	Human Immunodeficiency Virus
IGAs	Income Generating Activities
ILO	International Labour Organization
MFIs	Microfinance Interventions
NACP	National AIDS Control Program
NGO	Non-government Organization
NBS	National Bureau of Statistics
PLHIV	People Living With HIV
SIDA	Canadian International Development Agency
SILC	Saving and Internal Landing Communities
SSA	Sub Saharan Africa
TACAIDS	Tanzania Commission for AIDS
TWLA	Tanzania Women Lawyers Association
UNAIDS	United Nations Agent for International Developments

Abstract

The living standard of women with HIV and AIDS, especially those residing in marginalized settings is considered to be poor. It is believed that, however, by providing this disadvantageous segment of the community with Microfinance Interventions (MFIs) would lead to an improved living standard.

The main goal of this study was to assess the impact of MFIs on how women access to saving, credits income, assets health and education improve the living standards using both in depth interview and observation. Excel and gender analysis matrix (GAM) methods were used to analysed data. Overall results showed that women within the microfinance programs had increased women scope on making decision, control, access of resources and services

The MFIs also enabled women to access basic resources like land and increased asset ownership. The micro financing activities reduced the power of patriarchy system, and hence gives women, especially those most disadvantaged; not married or widows, more voice on decision making and power to control over resources both at the household and community level.

It was also learnt that the intervention helped women to create network or groups, which assisted them to have common and strong way forward on issues at both household and community level. The interventions had higher impact on the not married headed than married households on issues regarding to decision making, control and access to resources and services.
The study also revealed that to some extent men still dominate hence hindering married women from decision making power, control and access to service and resources in both rural and urban areas. Finally, the MFIs had much contribution on access to basic services, reduced stigma, and increase livelihood options within the households. MFIs contributed on improving household's, income nutritional status, maintaining food security and empowering women through accessing legal ownership of asset(s) e.g. land, which is considered to be most valuable asset as collateral for acquiring credits from financial institution. This has been shown to increase the level of saving and income of the household by reducing the medical treatment costs due to the improved health status of the household members.

It was concluded that all social cultural practises and norms that in any form act as barriers to women, especially those living with HIV and AIDS, should be mitigated, if not absolutely overhauling, in order to freely utilizing savings, credits income assets health and education services provided within and outside MFIs. The study recommended more social studies to better explore on soft ways of mitigating dominance by husband over women, constant advocacies on human rights and basic needs to the communities are critical, involvement of local leaders during program implementation will further cement to the entire community to reduce stigma and wrong perception by non HIV segment has over HIV and AIDS segment, and finally, more MFIs opportunities should be availed to those who need, especially women living with HIV and AIDS in marginalized settings.

Chapter One Introduction and Background

1.1 Introduction

HIV/AIDS has the potential to create severe economic impacts in many African countries. It is different from other diseases because it strikes people in the most productive age groups 15-49, (NBS, 2008). In Tanzania, the HIV prevalence varies from one area to another depending on the social and economic dynamics of the region. HIV infection is spread by social and economic factors such as poverty, gender inequalities, lack of access to information and basic services (Nombo, 2007). In all the 30 regions of the United Republic of Tanzania, Iringa region is the most hit region recording the highest HIV prevalence of 15.7% (NBS, 2008). In the same report, it was shown that women were more affected than men (18.6% vs. 12.1 %). Apart from stigma most HIV/AIDS affected households revolve around illness, death, food insecurity, property grabbing, low income and poor access to health services, which impact much on the wellbeing of the households *(*Booysen *et al.,* 2003). The above factors increase the household's vulnerability, decrease the productive roles of the household and increase the income expenditure on health and food (Ngalula *et al.,* 2002). Time and resources lost during sickness and treatment negatively affect the livelihood and the living standards of people living with HIV/AIDS (Sigalla, 2009). Subsequently, the households become more vulnerable leading to poor access of health services resulted from inadequate money and other resources to meet medical associated expenses, transport, food, and other basic needs during the health seeking process. This situation has made most people living with HIV (PLHIV), especially women, to become poorer, extremely dependant and powerless, which in turn makes them more vulnerable both at an individual and community level. In addition, they do not have collaterals as a prerequisite requirement to access financial assistance from both informal and formal financial institutions for them to sustain their livelihoods (Pronky *et al.,* 2005).

HIV is not a gender neutral epidemic. It has been embedded with a lot of gender inequality, discrimination, and violation of human rights which exacerbates the constraints that men and women face in making a living in rural communities (Kabeer andTran*,* 2002). It has been realised that with the presence of HIV/AIDS, inequalities against women increases in situations where men want to exercise power in decision making, control over resources and services (Seeley, Bernett, 2004).This patrilineal system in Tanzania hinders women's ability to own and control household assets such as land, livestock and income (Seeley, Bernett, 2004).This makes women headed household more vulnerable, especially after the death of their spouse, because the majority loses their assets and income through grabbing mostly by husband relatives. This decreases their savings and ability to access credits from the official microfinance institutions. Health and education is the right and basic needs to every individual in the community but due to increased poverty most women headed households have poor access to basic services such as health and education. These factors increase ignorance, dependency and mortality (Appleton, 2000). Women living with HIV/AIDS are most vulnerable than men when they want to access credits from formal financial institution, because they have to find someone to take care of children and household activities while they travel to find the financial institution in urban areas. At the bank they always find male staff who are unapproachable (90% of staff are men) and not supportive to assist them properly (Leiken, 2012). Women in rural areas, usually require the smallest credits to run small business activities which aim at supporting their households (Imran *et al.,* 2002). However, lack of control of assets limits their eligibility for a credits and furthermore their low literacy skills make it difficult for them to properly manage paper work and or businesses. Lack of access to cash, savings facilities and

credits undermine women headed households economic security and enterprises (Seeley, Bernett, 2004)

Generally, lending practices in most microfinance interventions (MFIs) fail to involve most needy and vulnerable groups in the community who are more economically affected. Factors like poor living standard, low income, lack of decision making power, and poor access to basic needs and services made the usually fail to repay back the credits. This is because most of the MFIs are targeting on making profits, so it is risky to the latter to deal with above characteristic group of people.

1.2 Background

The United Republic of Tanzania is made up of Tanzania Mainland and Zanzibar Islands. It is the largest country in East Africa, with a total area of 945,000 sq. km compared to Kenya 582,582 sq. km, Uganda 236,040 sq. km, Rwanda 26,338 sq. km, and Burundi 27,830 sq. km (URT, 2005). The population distribution shows that, three quarters (77%) of the population reside in rural areas and few remaining (23%) reside in urban areas (URT, 2003). Tanzania has become among the most HIV affected countries in sub-Sahara Africa (SSA). Its HIV prevalence among 15-49 year old is 5.7 percent (NBS, 2008), with approximately 2 million people living with HIV (NACP, 2012). Of this group, women are more infected than men (6.6% vs. 4.6%). The epidemic is generalized and affects every group within the community.

"TUNAJALI" (a Swahili word to mean we care) program is being run by a non-profit, national NGO based in Dar es Salaam, Tanzania. It was established in 2006 and since its inception it has been actively involved in implementing health and capacity building programs in rural areas of Tanzania. TUNAJALI's main goal is to provide care and support services to PLHIV in their communities and households through promoting their access to health, nutrition, psychosocial, education, child protection, shelter, income generation activities, and life skills needs.

To mitigate the impacts of HIV/AIDS affected households in selected wards in Iringa region, TUNAJALI program introduced a local microfinance program in order to boost up income of the households with PLHIV in Mufindi district, in Iringa region. The program has been implemented as a pilot for the past three years; with the aim of providing microfinance supports and entrepreneurship skills to the HIV/AIDS affected households in order to enable them establish income generating activities (IGAs). In turn, the support would lead to an increased income flow and hence assist the household to cover health services, food and other household basic needs. Within pilot time period of intervention, enrolment of women in the microfinances programs has been 7.5 fold more than men (TUNAJALI, 2011). The pilot program was targeting both men and women but due to low uptake of men, the donor decided to support and involved more women. It is important to focus on women's programmes, because they were seen as more efficient savers and investors than men because they were the ones bearing the burden of HIV/AIDS in community (Cornwall, 2000). As a result of achievements over three years of program intervention, TUNAJALI wanted to scale up to other districts of Iringa region. It was expected that by October 2012, the program would expand and cover 32 other districts in the five regions of Iringa, Morogoro, Njombe, Singida, and Dodoma in URT.

1.3 Problem statement and justification

TUNAJALI microfinance program was introduced to support women living with HIV to access low interest credits and entrepreneurship skills so as to establish IGAs which might eventually improve income flow and support their own households in order to meet their basic needs like food, health care, transport, and education. After three years of piloting MFIs to women living with HIV and AIDS in Mufindi district, By December

2011, a total of 587 women from 6 wards accessed MFI services and entrepreneurship skills so as to earn extra income to support their households' basic needs. For better scale up and expected outcomes of the interventions TUNAJALI needs to explore more on how the MFIs has impacted on the income of women living with HIV and AIDS in Mufindi district, Iringa region, in Tanzania.

1.4 Problem owner "TUNAJALI" Program

1.5 Objective

To evaluate the contribution of microfinance interventions to the living standard of women living with HIV in Mufindi district, Iringa region, in Tanzania.

1.6 Research question

1. What is the impact of the microfinance interventions on the living standard of women living with HIV in Mufindi district, Iringa region, in Tanzania?
- What is the impact of microfinance interventions on decision making and control of resources by women living with HIV in Mufindi district, Iringa region, in Tanzania?
- What is the impact of microfinance interventions on the access to resources of women living with HIV in Mufindi district, Iringa region, in Tanzania?
- What is the impact of microfinance interventions on accessing basic services of women living with HIV in Mufindi district, Iringa region, in Tanzania?

Chapter Two Literature Review

2.1 HIV/AIDS epidemic in Tanzania

Tanzania is one of the countries in SSA that has experienced high prevalence rates of HIV 5.7 per cent (NBS, 2008); from 7.1 per cent; (NBS, 2004). It has a generalised HIV/AIDS epidemic which is characterised by high infection levels among 'high risk groups' and widespread infection among the 'low risk' population (Barnett and Whiteside, 2006). Recent population-based HIV prevalence data shows that HIV prevalence ranges from 0.3% to 15.7% in Pemba Island and Iringa region, respectively (NBS, 2008). In general, there is a decline of the epidemic in some regions like Mbeya from 15.9% in 2004 to 9.2% in 2008. However, despite this decline of the epidemic in some regions, it has not been the same case when the epidemic is compared between female and male. The 2007-08 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) report showed that the HIV epidemic is higher (60%) among women compared to men (40%). The most age group at risk is 15-49, which portrays a negative impact on their productive and reproductive roles. This could be due to socio-cultural and economic factors which make women more susceptible to HIV infection than men in the county.

Subsequently, due to the epidemic there has been a rapid growth of the number of orphans in the communities. The UNAIDS (2010) estimated the number of orphans (aged 0-17 years) at 970,000 in Tanzania and orphans were indicated to have lost one or both parents. High morbidity and mortality of the productive age groups due to AIDS-related illnesses has immensely contributed to high demographic changes in household composition whereby there has been an increased number of orphans raised by relatives, neighbours and orphanage centres. Also, the epidemic has increased the number of orphan headed households and child labour in many households and communities (UNAIDS 2010).

2.2 HIV and women

Women are more affected by poverty and diseases than men; this made them to engage in harsh and laborious work at a low salary pay. Their school enrolment is low compared to men and as a result women do have limited skills. They are less empowered to make decisions and own resource (Aregawi, 2003). In Tanzania, women comprise more than 55% of the total population and they are much affected by HIV/AIDS compared to men ((NBS, 2008). The majority of Tanzanian women lives in rural area where culture, norms and tradition are still practised and this affect their control and access to services, such as health, education, credit and saving (Nombo, 2007, Sigalla, 2009). NBS survey (2007/8) shows that women comprised over 60% of people living with HIV in the country. Based on this, there are a large number of women who faced limitation on decision making, ownership of land, control over resources and access to services. The majority of women are affected by the low level and harsh conditions of the rural life (Aregawi, 2003).

The AIDS epidemic has caused adverse psychosocial and economic consequences leading to changes on household composition and structure, thus changed the capacity of the households to respond to their basic needs such as health and education. Studies show that women's economic situation has been improving, though there are still significant inequalities between women and men. There is proof that inequalities within the households and communities play an important role in increasing AIDS vulnerability (Nombo, 2007). Women, widows and elderly grandmothers, often bear the brunt of caring for PLHIV, while also being responsible for securing household food and income (Seeley, Bernett, 2004). Social economic and culture expectation of women within the

community increases their vulnerability and susceptibility to HIV/AIDS (Turmen, 2003). In addition, UNAIDS (2003) postulate that as the society's traditional care-givers, women carry the main psychosocial and physical burdens of AIDS care. Yet, they have the least power to make decision, control over and access to the resources they need to maintain their living standards. Widows lack knowledge and resources needed to sustain the production of cash crops which provides a vital source of income. In addition, they lack access to credit, a long-standing constraint, which has been exacerbated by the loss of their husbands who had a wider access to sources of financial support that benefited the whole family (Goldberg, 2003). The threat of violence affects women's power and ability to negotiate and decide on household income, saving, credits, and asset (Mayoux, 2006). The threat of violence may also affect women's access and use of health and other basic services (Turmen, 2003).

2.3 The importance of microfinance interventions

Microfinance has been defined as the extension of a small amount of collateral–free institutional credits, to jointly liable poor group members for their self-employment and income generation (Mayoux 2006), whereas the Canadian International Development Agency (CIDA) defines microfinance as "the provision of a broad range of financial services to poor, low income households and micro-enterprises usually lacking access to formal financial institutions. According to Goldberg, (2003), microfinance is a component of microfinance and is the extension of small credits to entrepreneurs, who are too poor to qualify for bank credits. However, it support the point that micro-credit enables very poor people to engage in self-employment projects that generate income, thus allowing them to improve living standard for themselves and their families Goldberg (2003). The study on microfinance done in Ethiopia by Doocy *et al.,* (2004) shows that microfinance has been explained as economic development tool whose target is to assist the poor to work their way out of poverty. In the same study, apart from credits it also covers a range of services which include health, education, saving, and life skills, to the clients, in light with their development objectives. A study by Hoque and Itohara (2009) reported that micro-credit is contributing to some extent in generating economic activities and participation in family decision making of the rural women.

Microfinance has been seen as a way forward in giving poor people in rural and urban areas access to financial services. Tanzania national microfinance policy (2000) indicated that the establishment of microfinance was to target low income segment of the society and to enable them to increase their income. The intervention is considered an effective way for supporting and empowering marginalized groups in communities through provision of small credits and entrepreneurship skills either to individuals or groups (Leach, 2002, Mayoux, 2006, Sigalla, 2009). According to Wilson (2003) microfinance focuses on expanding local economic activities and improving the standard of living of their clients by providing financial services needed to establish small businesses.

In Tanzania, women are less considered among the most vulnerable groups due to social economic and cultural factors prevailing in the society and they need more support than men in acquiring and accessing sustainable livelihoods (Nombo, 2007). Research indicates that gender inequalities in developing societies inhibit economic growth and development (Cheston and Kuhn, 2002). Currently, only 3% of women from different areas in Tanzania have access to microfinance services (Sigalla, 2009). Since 1980's, microfinance was promoted as an innovative way to target women whose work was identified to be largely invisible and less important within the community. This made the majority of the women to lack opportunities of being engaged in developmental programmes which aim at giving women access to credits and increase the income flow of their households (Ghodsee, 2003). Apart from credits other services are also provided

to empower women through providing them with legal advice and entrepreneurship skills. Microfinance programmes have widely and various impacts which can also increase women bargaining and decision making, ownership, control of resources and access to basic services (Mayoux, 2006). For most poor and vulnerable households in communities, informal microfinance have been used as popular means of improving their living standards by giving them opportunity to access resources and services at household and community level. In this study microfinance will be referred as financial services for poor and low-income clients offered by different types of service providers, it includes credit and saving (Mohammad and Mohammed, 2007).

2.3.1 Living standards

Living standards refers to the type of human activities which are in harmony with culture requirements and mostly look on social and economic goals of an individual (Kessy, 2008). Moreover, (Cvrlje and Coric, 2010) defines standard of living as the level of welfare available to individual or to the group of people. It refers to the influence by which people are able to satisfy their needs. It contains the physical circumstances in which people live, the goods and services they are able to consume and the resources they have access to, whereas Plunkett (2011), defines living standards as the kind of life that household or individual can afford to live and it is determined by resources and services that households or individual afford to access.

According to Mohammad and Mohammed (2007) resources, saving and income are main important elements of living standard of the poor people. MFIs are to provide small credits to the poor individual not only to improve their decision making power and access to services but also to control and mobilize household resources and saving Central Bank of Nigeria, (2005). Apart from above elements, other factors that contribute to human development are education and empowerment.

MFIs were established to fill the gap created by the formal financial sector by improving the socio-economic condition of the poor income generation as a potential solution to alleviate poverty in which standard of living is one of the indicators (Abiola *et al.,* 2011). Goldberg (2005) found that MFI promote living condition of poor people by offering supportive service to allow them in communities to access basic services, incomes, employment opportunities, consumption, building of assets and accumulating savings.

A study by Ghalib and Hailu (2008) on MFI to living standards concluded that apart from material and tangible assets that can be achieved through microfinance it also increase sense of ownership, commitment, confidence of women at household and community. Study conducted by Desta (2007) in Ethiopia showed that involving of women living with HIV/AIDS in household and community development activities helped to create and increase their access to basic services, resources and income. According to him women play important roles as producers of food, managers of natural resources, income earners, and caretakers of household food and nutrition security, giving them access to asset resources could increase families' welfare. Apart from that effective microfinance programs are major tools to increase women decision making power over her body and assets by reducing the high economic dependency. Ghalib and Hailu (2008) states that women accessing finance become more assertive, confident, and more visible and are better able to negotiate the public sphere and this because it increases their opportunity to secure better future for their sons and daughters.

Greener (2004) showed that the HIV/AIDS epidemic affects the living standards of the household and increases the vulnerability on the households of low income earners by increasing household expenditure and reduce ability to earn more income. In addition, a study done in India by Mahal *et al.,* (2005) indicated that households belonging to the

poor and less educated or unskilled groups, as well as female-headed households, face a proportionately greater economic burden due to AIDS. In SSA, HIV/AIDS tends to affect the rural poor individuals more heavily than other population segments, and this leads to increased gender-based differences in accessing services, ownership of resources, and decision making which impacted much on their living standards (UNAIDS, 2005).

According to ILO (2003) the living standards of female headed households is more affected with HIV/AIDS because of a doubling cost of medicines and treatment-related such as transport and other living needs. Moreover, most families spent less on other basic needs like food, shelter, and education in order to cope with rising costs for care, support and treatment. In some instances, they are also forced to sell assets and borrow cash money from friends and relatives. From local experiences sometime borrowing cash from friends is tied up with paying back primary or capital credits plus uncontrolled interest on top. Decision making on credit, credits purpose, and socio-economic activities, attendance and participation in women's association meetings and training, building self-esteem and confidence and trust/social capital and changes in social position.

In a study by Mohammad and Mohammed (2007) the main goal of microfinance is to spread the light to education throughout the community. Along with the health program it has great contribution toward building up a society free of poverty, inequalities, illiteracy and disease (Cheston and Kuhn, 2002). Therefore, in this research living standard will be measured through looking at the ability of women living with HIV/AIDS to make decision, control, and access to service and resources at household level. These three dimensions will be assessed by looking at saving, credits, income, assets and access to health and education.

2.3.2 Decision making and control of resources

According to Kebeer (2001) decision making and control of resources of the household is determined by the head of household. Women's ability to influence or make decisions that affect their lives and their future is considered to be one of the principal components of most microfinance. Besides, Noreen (2012) ascribes that microfinance interventions empower women living with HIV in order to make their own life choices. It generates the ability of women to self-decide and to secure desired changes and decision making power of their own life and resources at household and community level. Indicators for decision making and control of resources are the percentage of women who are using the income, savings, credits and assets as planned for by them. Ghalib (2007), states that giving credit to women can improve economic independence and reduce their risk points in the household, bringing about wider impacts at community level, which can change the gender norms and women's status in the family and society at large. Women can use their savings from credits to increase negotiating power in the household, increasing their voice in the decision-making processes of the households and community. This enables them to improve their living standards as they will have a say in what the money is used for at household.

Based on Pitt *et al., (*2006) microfinance interventions lead to women taking a greater role in household decision making, having greater access to financial and economic resources, having greater social networks, having greater bargaining power than their husbands, and having greater freedom of mobility and increase their spousal communication about family planning and nurturing issues. Mayoux (2009) states that microfinance services positively improve or influence women's decision making power and control of resources at household and community level, by increasing women's ability or decision over income resources. The microfinance intervention strengthens

women's economic and social autonomy and gives them means to different activities. Through these programs women living standards have been improved by escaping from abusive relationship, and in turn they are able to contribute economically to the household thus having control and making decisions over resources.

A study conducted in Kenya showed that most women who occupy low social status in the household are also negatively affected in making decision and control of resources which leads to highly dependency and poor living standards (Mwangi, 2005). Differences on household roles and responsibilities contribute to an increasing poverty among women living with HIV and reduce their rights and power to make decisions at household and community level (Gillespie *et al.,* 2005). Usually, culture and norms in Tanzania are still biased against women and limits their acquisition, decision, ownership and control over household resources. The situation has been worsened and fuelled with the existence of HIV/AIDS, where only 32 per cent of widows in Tanzania have been found to control and made decisions on income and assets after the death of their spouse (Maoulidi, 2007, FAO, 2008, Mayoux, 2009). This phenomenon is similar to findings in a study done in Iringa (Kessy, 2008), which shows that 75% of widows have the right to access assets but they are not allowed to control and make decisions without asking spouse relatives. Moreover, if women try to ask for legal ownership the assets the community and household members will identify her as a witch. Consequently, to this situation in most cases, affect the living standards of the household as the women have do not have the power to make decisions over resources. This in turn limits access to basic services like education and health due to low income.

According to CRS (2005), Mwangi (2009), and Mayoux (2004) it is evident that more than 50% of women who access microfinance services lack control and decision of the income this can hinder their effort to reduce poverty. This limits their chances of generating their own income and controlling their own resources and assets in the community. Credits and entrepreneurship skills increase women's participation, self-esteem and respect. This contributes to their decisions on expenditure and increases their ability to use credits profitably and control the credits and income at household level (Mayoux, 2009).

2.3.3 Access to basic services

IFAD (2008) define access to basic services as the ability of an individual or households to afford getting health, education, income, food, and shelter. According to UN-Habitant (2010) accesses to basic services are important because they add to human dignity and living standard. Moreover, it improves the potential of each person to engage in economic activities. In other words, access to income and employment generating opportunities is critically dependent on services; the lack of such services severely constrains productivity and, consequently earnings. Dimension of access to basic services can be evaluated by looking on how microfinance improves household ability to acquire, education and health services in Mufindi district. Primary education, primary health and income are some of basic needs which humans need to access in order to improve their living standards. Living standards are improved through access to education and health since education gives knowledge and good health gives them the strength to work and produce. Microfinance interventions have been shown to have a positive impact on the education of clients' children. Sigalla (2009), state that one of the first things that poor people do with income from microenterprise activities is to invest in their children's education. According to him levels of public expenditure on basic health and education services in many poor countries are insufficient to provide quality services which can fulfil their social protection potential. Thus, many poor individuals, household, and communities remain without access to basic services. Basic services are not

available and accessible equally worldwide. This in turn makes poor women to be more vulnerable, unable to enjoy equal and dignified lives and face great difficulties in improving their living standards. According to Greener (2008) having access to basic services is fundamental to improve the living standard of households and is also a fundamental right as indicated in international agreements on human right. Women are facing many types of barriers such as culture, income and collateral when trying to gain access to such essential services as primary education, health care and credits. HIV/AIDS affected households and communities end up in extreme poverty, high dependency, little income, big debts, and reduced access to services (Mushi *et al.,* 2003). This is because their ability to produce and save is affected by the diseases. Mayoux (2001) states that microfinance has much potential in communities by effects on poverty level of the household through accessing credits and making a significant contribution to increasing incomes of the poor and women. Moreover the intervention contributing to the smoothing out of income and expenditure thus allow the poor to handle with unpredictable shocks and emergencies like disease and death.

UNGASS (2008) indicated that increased costs arising from medical care for people living with HIV and related illnesses affect the household living standards through depleting household savings and assets. Microfinance interventions have given most vulnerable households and communities the ability to manage illness-related costs compared to other existing formal and informal support systems (Mayoux, 2001). Women in particular, are more susceptible to HIV compared to men because they have limited ability to access basic services and resources (UNAIDS, 2008, NBS, 2008). According to Leach (2002) microfinance interventions helped some women in rural areas to break vicious circle by increasing their decision to access basic services and resources.

2.3.4 Access to resources

In most African countries, rural women are the food producers, and carry the burdens of life. Africa's 100 million rural women grow almost 80 % of Africa's food, including food both for subsistence and markets (Mahmud, 2003). Rural women do almost 80% of the work to provide the proper transport and storage of Africa's food and still they are facing a lot of barriers in accessing and controlling of resources (Nombo, 2006). According to Mayoux (2004) women's access to resources such as income and assets can improve their ability to control and decide on household credits, savings which also affect household health sicking behaviours and contributes to improving their standards of living. According to Kessy, (2008) culture also contributes limits women's access to ownership of productive assets such as land within the household. Even when women have access to land, the general community members still do not accept and support them to have full access and control over the asset. Therefore, with such great obstacles, there is no incentive for women to invest in productive assets when they cannot hold control over them. The dimension of access to resources can be assessed by looking at assets and income utilized by household after accessing the credits. As per Kabeer (2001) increased access to resourcesll is regarded as an empowerment pathway to women and poor. According to him access to resources basically serves as a catalyst for empowerment or enabling condition under which empowerment is likely to occur. However, Mayoux (2000) notes gender and contextual constraints at all levels continue to obstruct women from accessing credit programs, increasing or controlling incomes or challenging subordination.

IFAD (2008) argued that access to credit is today acknowledged as a major constraint by most poor people in low-income countries, to improve their living standards and the achievement of other basic rights such as education and health. Microfinance have long

been associated with attempts aimed at providing poor persons with an opportunity for financial self-sufficiency and enhance women's ability to access income, input and output markets (Mayoux, 2001). Microfinance provides women with credits which are used to increase their opportunity to access and increase control over resources such as land, capital, equipment, education/training and health. Moreover, if women have access, control and decision making over the credits it will increase their living standards since they will be able to support their household's needs. According to Mayoux (2004) microfinance will support women in rural areas to abolish patrilineal system which makes women access land through their male relatives or their husband's sides and following the death of the husband, a woman loses rights to land.

2.4 Definition of concepts

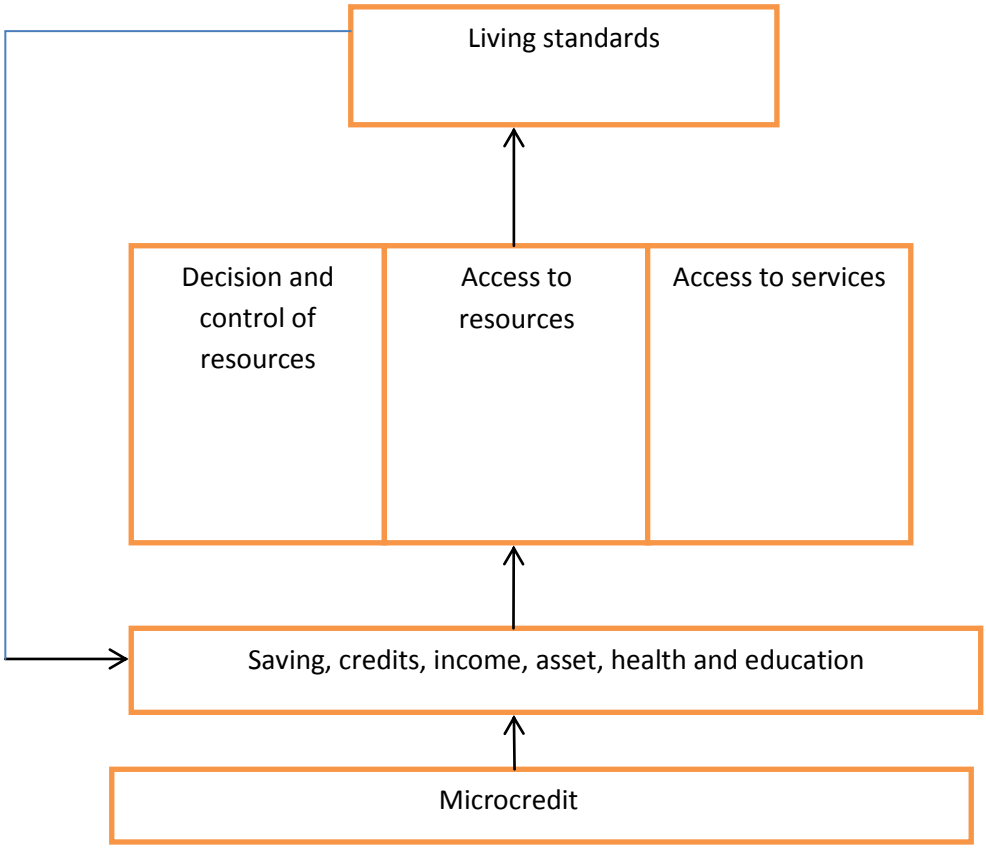
- **Microfinance**: is defined as financial services for poor and low-income clients offered by different types of service providers, it includes credit and saving (Mohammad and Mohammed 2007).
- **Household**: is defined as a group of individuals/people living together and usually economical interdependent (Foster 2002).
- **Living standard**: refers to the level of decision making power, control of resources and access to basic services of the households (Mohammad and Mohammed 2007).
- **Control of resources**: is operationally defined as the ability to exercise authoritative or domination over economic (e.g. land, house technology, livestock) and financial (money based) resources (Mayoux, 2006).
- **Decision-making power**: in this study is defined as ability of women to determine, plan, and implement over resources, saving and credits at household level (Mayoux, 2006).
- **Access to basic services**: is defined as the ability of household members to afford paying costs related to health or education services (Mohammad and Mohammed, 2007).
- **Access to resources**: is defined as the ability of household member to own and managed productive and financial assets (Mayoux, 2006).

2.5 Indicators for the concepts

Table 1: Indicators for the three different concepts

Type of variable	Indicator
Decision making and control of resources	Ability of women to make decision over saving, credit, income, assets, health and education in the household
Access to resources	Women ability to access saving, credits, income, assets, health and education in the household.
Access to services	How access to services impact on saving, income, assets, health and education on women households

2.6 Conceptual framework



In this framework virtuous spirals model from Mayoux (2006) will be adopted to analyse the impact of microfinance on the households of women living with HIV/AIDS in Mufindi district. Microfinance intervention is used to improve the living standards of women living with HIV/AIDS by increasing their opportunities to savings, credits, income, assets, and access to health and education. This model will be used to assess how microfinance has an impact on decision, control, access to services and resources of HIV/AIDS affected households. The model will also make it clear how these factors can contribute on improving the living standards of HIV/AIDS affected households.

Chapter Three Methodology

3.1 Study area

Iringa region is located in the Southern Highlands of the United Republic of Tanzania (Figure 1 below) and is amongst five major grain basket regions with the total of six districts namely Iringa, Kilolo, Ludewa, Makete, Mufindi and Njombe. According to the 2002 Population and Housing Census, total population for the region was 1,490,892 with the current HIV prevalence of 16% (18.6% and 12.1% for female and male, respectively), the highest in Tanzania. Mufindi district is the only district selected to implement this intervention due to higher number of PLHIV second to Makete district. This situation in the district contributes to poor living standards of most households. In addition, the geographical location of Mufindi district requires PLHIV to travel long distances to access care and treatment services. Most of the students/pupils from HIV affected households drop out from school due to lack of school fees and other education costs like uniforms and stationeries. TUNAJALI was spending significant amount of financial resources to support PLHIV to enable them access to care and treatment in clinical services, and affected orphans to access education in the district. Microfinance intervention has been implemented in six wards namely Ifwagi, Mninga, Mtwango, Igowole, Kasanga, and the Luhunga in Mufindi district. Data for this research was collected from only four wards namely Ifwagi, Mninga, Mtwango and Igowole because of the following reasons;

- The four wards are the pioneer of MFIs. Ifwagi and Mtwango represent rural, whereas Igowole and Mninga represent urban setting.
- The area has high numbers of MFIs groups with large saving in the bank compared to other.
- There are no other MFIs introduced by other organizations in study wards so it is possible to evaluate the impact of TUNAJALI microfinance intervention.

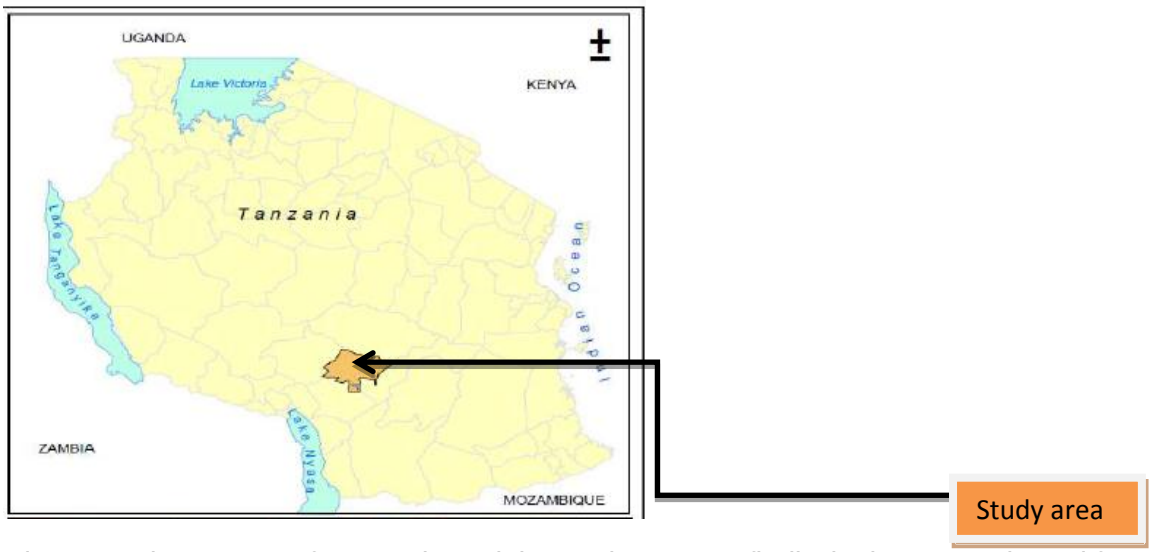


Figure 1: Shows map of Tanzania and the study area-Mufindi District. Map adopted from ENATA report 2008.

3.2 Research design

This research utilized a qualitative approach using both desk study and field work data collection. The households for this study encompasses women living with HIV/AIDS who have been engaged in microfinance activities for more than three years and live in one of the four selected wards in Mufindi district. Selected women aged between 30 and 45 and had enough experience in microfinance activities. Eight out of 480 (1.7%) households with microfinance intervention were purposively selected to participate in the study. The case study assisted a researcher to use different techniques like observing, probing, and crosschecking to get in depth information from the household members. Data was collected from different clusters (Table 2); all participants were systematically selected under each group to represent intended household.

Table 2: Different clusters from which respondents were selected

Type of household	Location		Total
	Urban	Rural	
Not married*	2	2	4
Married	2	2	4
Total	4	4	8

*Not married (includes, divorced, and widow and separated)

3.3 Data collection

Data collection for this study was conducted from 23rd of July to 7th of August 2012 using both in-depth interviews and direct observations. The researcher spent three days in each selected household. The first day was for making an appointment with the household members. One hour was spent every day with each household to make these appointments. The second day was allocated for an in depth interview and observation which was done at their homes. The interviews were conducted in Swahili which is the local language and later translated into English. Time for this process, which also included discussions, was 5-6 hrs. Observations were done to further verify the information gathered through the in-depth interviews in order to understand the impact of microfinance on the living standards of women living with HIV/AIDS. Data or information on household credits, saving, assets, income, access to health and education were collected as indicated in appendix 1.To have accurate data, verification between two data sources (observation and interview) was done at every household; observation was done to verify the availability of the assets (Appendix 2). Appendix 2 was developed using extensive literature review. The last day was used by the researcher to share data collected with the head of the households.

3.4 Data analysis

Before the data was analysed, the researcher translated all interviews and observations from Swahili to English. Data was clustered into married and not married households in both urban and rural areas (Table 2), and summarized in order to understand the underlying impact of microfinance intervention on respondents. Data was analysed using both gender analysis matrix (GAM) and excel. The data was used to compare single and married women in urban and rural areas. The main result was to generate information on women's use of MFIs to improve their living standards through increased decision making, control of resources and access to services. These were influenced by the

women's access to savings, credits, assets, income, health and education at household level.

3.5 Ethical issues

In any research study ethical issues are important to be observed, especially when the topic involves human subjects such as exploring individual income and HIV related matters. All study participants were provided with ample time in order to understand why they have been selected to participate in this study. Researcher took time to explain the usefulness of the research and what is expected from her. Finally, they were asked if they voluntarily agree to participate in the study before signing an informed consent form, and further authenticated by a witness. The information collected from the participants will be protected, and used only for the purposes of this study.

3.6 Limitation of the study

The study encountered several limitations; language barrier in rural areas was experienced. In Ifwagi and Mtwango wards majority of people speaks the vernacular language which is Hehe and Kinga. This made some of the respondents to be more comfortable expressing with Swahili but when they wanted to show the importance or emphasis on an issue they mixed it with their vernacular language. It is always difficult to maintain the original meaning of words or concepts when asking for a back translation as language tends to correspond to its respective culture. To combat this problem, the researcher had to ask more clarification about the meaning of those words from study participants.

Chapter Four Research Findings

4.1. Respondents characteristics

The average age for all study participants ranged between 34-41 years. Two women from the rural areas who were not married and had lost their husbands due to AIDS were interviewed. Another two from the urban areas, one separated and one who had not ever married at all were also interviewed. From both rural and urban areas two married women were also interviewed. The characteristics of the households were as shown below.

Table 3: Composition of household members by age, marital status and geographical location

Urban					Rural			
	Adults 18-59	Adult >60	children	Household size	Adults 18-59	Adult >60	children	Household size
Not married	3	1	6	10	4	2	8	14
Married	2	1	5	8	2	1	6	8
Total	5	2	11	18	6	3	14	22

In rural areas women from married households were working as housewives while their husbands worked as temporary workers in the nearby tea company. It was also noted that not married women households interviewed were not formally employed, and depended only on agriculture and IGAs. On the other hand, not married women in urban areas were not employed but were engaged in IGAs. In addition to the IGA one not married woman was temporarily working as a maid in a nearby hostel. All married women the urban areas were not working but doing their IGAs. In addition, their husband's worked as a guide and another as a driver in a road construction company. All family members in the rural and urban settings who were away from their homes due to different reasons such as education (boarding school) and treatment (seeking health services) and were still depending on the head of the household, were counted too.

Women were supposed to pay back the credits with an interest rate of 5% for each credit. These credits were basically supposed to support them in establishing a small business like a tree nursery, wells (water-bore holes), selling fruits, vegetables, both second hand and new clothes, food, snacks, soft drinks, alcohol (locally brewed), sun flower oil, charcoal and firewood. In all four wards, farming and trading were the main economic activities of the households. In rural areas married and not married households interviewed declared to have accessed credits and used it for agricultural activities such as buying fertilizers and hiring labour when needed. While in urban areas the not married households declared that sometimes they accessed credits in order to build and renovate their houses. To the contrary, married women in urban areas stated that they were forced by their husbands to take credits and instead of investing the loan accordingly they gave the money back to their husband to support their business or cover personal debts to their friends.

In both the rural and urban areas, both married and not married women were allowed to take credit ranging from $ 5 to $ 100 depending on member's repayment ability and needs.
One of the respondents from not married household narrated that *"There are no special criteria on who can take the credits. The main qualification for a credit is that the woman must be a member of the group and has managed to buy shares for a certain period of time. The share is 500 Tsh ($ 0.32). Members can buy a maximum of five shares per week. Another criteria for accessing credits was that the woman who was taking the credits should establish an IGA like selling food, cloth, making boreholes or any other business which would help her to repay the credits to the group within the specified time period"*
(Credits of $180 for local beer and selling water)

4.2 Impact of microfinance program on women's decision making and control of resources

In depth interviews with all eight women in Mufindi district revealed different understanding on decision making between married and not married women in rural and urban areas. During discussions not married women in rural areas stated that they had more decision and control of their own savings than married women. On the other side, married women from rural areas explained that they could make decisions on their savings but they first had to discuss it with their husband. According to them, their husbands had the final say in the house so they had to be informed about everything. Women also stated that regardless of owning money their husbands would not allow them to give out money without their approval. Social practices and beliefs about household members roles assumed within the community significantly affected household decision-making process. On the other side women from urban areas showed that they had power and ability to make decisions over their savings and income. Not married women stated that they had the ability to make their own decisions even before the intervention but lack of income limited their ability to make decisions. The MFIs therefore, made it possible for them to generate an income. On the other side married women from urban declared that the intervention had helped them find better ways to improve their living standards. Their ability to own assets, make decisions and access to basic services had also improved. Married women in both rural and urban areas declared that, if married one could not make any decisions on their own, this also applied to all savings within the household.

When my husband died, I used to inform brother in –laws about anything and they were making all major decisions for me and my children. Since I joined the program, I have been the head of my household and my children don't do anything without consulting me and asking my permission. (Respondent accessed credit of $ 200 for nursery tree, snacks, and selling water)

Saving

All the women interviewed agreed that MFIs had to a large extent improved their decision making, confidence and saving ability at household and community level. From rural to urban the level of saving differed from married to not married households as indicated in table 4. In rural areas not married women had higher average saving of $ 20 than married women; $ 11 per month. The same difference was revealed in urban areas where the average for not married was $ 35 against $ 23 saving per month in married or what. The four not married households in both rural and urban areas declared that they could decide by themselves on how to use and save their money without any

interference from children or relatives. These not married women had power over resources in their households because they were the head of the house. The two married women from the urban area declared that their ability to manage savings had been improved due to the fact that they had a source of income. With their IGAs they managed to get some savings, but still their ability to make decisions over their savings was medium. The two women declared that $ 1 is the highest amount they could make decision over without informing their husbands. The two married women in rural areas declared that their husbands were the ones who knew how to save and deposit the money because they had bank accounts in town. One married women from the rural area declared that sometimes when her husband had his own money; like during harvesting seasons (June to December), she could keep savings but during the cultivating seasons (January to May) it was the husband who wanted to manage their money because at that time they did not have tea leaves or wheat to sale. All married women in urban and rural areas declared that if they got more profits in their business they could not show it or inform their husbands but only inform them about the same amount they were supposed to save (known to their husband beforehand). The extra saving they got from their business could not be shared with their husbands

"The 5000 Tsh ($ 3) can be a very little amount but it means a lot to me. I can buy soap and send it to my mother in the village"
A married 37 year old woman of Mninga ward (Accessed credit of $200 for maize mills and selling sunflower)

Table 4: Average amount of credits accessed

Household type	Urban			Rural		
	No of credits for 3 years	Average amount of credits in 3 years	Saving per month	No of credits for 3 years	Average amount of credits in 3 years	Saving per month
Not married	6	240	35	4	190	20
Married	4	195	23	3	135	11
Married	5	218	29	3.5	163	15

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Credits

All not married women from the urban area agreed that they had full control and decision on the resources in their household because no one was supporting their households for food, shelter or anything. So, they always made their own decisions. According to them, before joining the program they used to ask for money from neighbours and friends. So, their decision on the amount of credits to take was determined by those who had money, but with the MFI program they could make their own decision on the amount of credits they wanted and how to use that amount.

"After the death of my husband, my brother in-law chased me out of the house, I became property less. SILC members supported me to start my life afresh so no one could ask me about my credits apart from my group members"
(Accessed $ 250 credit, for maize mills and selling of second hand clothes)

When asked about how microfinance affected their control and decision making over the credits, the two married women from the rural area declared that at the beginning it was difficult. According to them, their husbands wanted to have the final say on what amount

women could take and the husbands wanted to take all the credit and to use it for other activities. One woman from the rural area declared that her husband forced her to take a credit of $ 20 and instead used that credit to marry another wife. In urban areas married women explained that they had to report the challenges they were facing from their husbands on controlling the credit. The group leaders had to discuss and sensitize the husbands, where necessary. As a result now the women had more control and power than before meaning that they just informed their husbands about the credits. As the women now have access to credit through MFIs, the husbands assisted women with purchasing products, record keeping and saving the money in their bank account. The two not married women from the urban area also agreed that to have control over the credits gave them full control and they could decide what to do with the credit. Thus, they took their credits and used it to support their households.

Income

Rural and urban women declared that the intervention really affected their decision on using and contributing to the household income. In rural areas not married women said that the amount of income they got from their day to day activities had been improved and this increased their ability to decide how to use it in supporting their households.

One not married women from the rural area stated that *"Nowadays because I am selling water and I have a tree nursery. I can use my own income to pay food and other household associated costs."*

Married women from the rural area responded that before enrolling into the MFIs groups, they had nothing to contribute to the household. It was the husbands who made decisions on how to use the income because they were the breadwinner for the households. With the MFI intervention they got the opportunity to earn some income and they could decide to buy food and other household groceries without consulting or asking their husbands. This had more implication on their roles at the household because they could also comment on matters relating to income like buying food, clothes or medicine. The same findings were noted in urban areas where not married women declared that because of an increase in income, the women had increased their ability to solve household problems which needed money and increased their support to other family members outside their households. On the other side married women declared that having an income increased their decision making power because they tended to contribute more than the husbands. The income generated from IGAs positively affected their involvement in decision making and control of the household and community resources. This also increased women involvement in development activities as two women (not married and married) were selected to be members of the village development committee in Mninga and Igowole wards.

"We always made decisions about our lives with my husband. Both of us thought and discussed about how we could improve our lives and we agreed that SILC was our solution as you have seen our lives changed, and now even the neighbours respect us"
(Accessed credit of $ 150 for vegetable, selling fruits, firewood, and soft drinks)

Asset

In rural areas not married women declared that before joining the MFI program they did not get an opportunity to own asset(s) at household level. With the credits and income from IGAs they, managed to buy land and build their own houses within the village. According to them the savings were used to pay for the labour power and buy building material like bricks, thatch and asbestos. One respondent from not married headed household declared that, she was staying with her brother in the same village but after

getting the credit she managed to start her own business of selling clothes, food and sunflower oil in town and managed to buy her own plot and build a small house. She was now staying with her children and other relatives. She also managed to buy a radio and bicycle, which simplifies their movement and eases access to health or education services.

In rural areas a different phenomenon was observed with married women. All of them agreed to have added some assets and that they had managed to buy productive and non-productive assets for the household like chicken, pigs, pots, clothes, mobile phone, bed, table and chairs, land and renovate their houses. With regards to their assets, married women declared that they could decide on what to do without informing their husbands. Moreover, women declared that due to culture and norms some assets like land and houses were not allowed to be owned by women so it was the husbands who had the right to own those assets. In urban areas the not married women also showed that they had the ability to own productive and non-productive assets like land, household utensils, a house and bicycle. According to the findings the assets could be used in the future as collateral and helped increase respect within the communities because value within the community changed and people regarded them as important. For the married women the results were similar to what had been seen in married women in rural areas. One married woman from the urban area declared land as always inherited by men because it was the father who bought land for the son or inherited from his parents

Health

The data showed that all households interviewed in both the rural and urban areas had improved their health condition. During the visits in rural areas no member of the household was chronically ill for the past three month. Apart from improving their health status two respondents from the not married households in rural areas managed to pay costs (transport and accommodation cost) for other household members to test for their HIV status at the district hospital. Moreover in rural areas, the married women said that because of the distance and high transport costs they had managed to test only 3 children. Married women in rural households indicated that they did not depend on their husband or relatives to pay for their medical cost any more due to the fact that they could use their own money. The amount of money they saved every month was enough to pay for medical costs. According to them the TUNAJALI program used to give them money for transport but they had stopped taking fare from the program and instead paid their own fare to the hospital. So, they could decide where and when they could access health services but they only informed their husband on their plans in advance.

In Urban settings the not married women declared that, the intervention helped them to access health services and improve their health status. According to them they could manage to buy, mosquitoes nets for all household members, and provide medicine when needed. Women also declared that they had also managed to improve the quality of their food by affording to add cooking oil or nuts. The urban married women also described that it was easy to access family planning services because they could buy their own pills from medical store without informing their husbands. It was also revealed that the intervention helped to reduce the number of drop outs from care and treatment services because every month they managed to attend the clinic schedule and afford transport and accommodation costs when needed.

Education

The study found out that both married and not married women in rural areas worked together and did tailoring, gardening or other IGAs as a group, as well as teaching each

other how to prepare different kinds of food, nurture their children and overcoming stigma. As a result it had offered opportunities for those who were more experienced to impart life skills to those who were new to the group. For the married household in the rural area the teachings also entailed how to involve and influence their husbands to make well informed decision. Both married and not married in the rural and urban areas stated that they valued education and made sure their children were accessing education. Subsequently, this made every woman work harder in order to pay education costs for their children. It was observed that most young children of both sexes were attending schools. In one household interviewed the family decided to move from Luhunga to Igowole in order to get advantage of quality education for their children.

In Urban areas single women had accessed secondary education and this helped them to perform better with their IGAs. The level of the credits and even the type of IGAs made them get more savings as indicated in table 4. The married women in the urban areas described that it was difficult for them to make some decision at household because they were not educated. Women declared that they consulted their husband before accessing credit so they could help them with keeping the financial statement in order. The two married women did not want their children to go through the same problem of being uneducated. In order to make sure women were involved in decision making they started to involve their daughters in some of the decision-making processes at household level and taking them to schools.

4.3 Effects of microfinance program on women access to resources

Saving

All participants from the rural and urban areas had the same ability to negotiate with other MFI group members when they wanted to get credit. Not married women in the rural households agreed that the criterion to access credit was the same for everyone and they were not very difficult to adhere. According to them each group set their own agenda, rules and regulations, which fit every member of the group. The community resource person (in charge of the microfinance program at ward level) always visited the groups after every two weeks and provides technical support and advices. They agreed that MFIs had a positive effect on access to resources from the household level to the community. During the study rural married women who were interviewed in the rural areas described that since they started to get credits, they had managed to save from their business which helped them pay for man labour in their fields. Besides, they used their saving to buy fertilizers, which in turn gave them more money after selling their produce to the business men from town. The large saving they had from selling maize was used to pay for school fees, treatment costs and other household basic needs.

In Urban areas not married and married women also explained that MFIs increased their ability to produce through making their own income from IGAs which contributed to the households expenditures. The saving they generated every month helped them to buy food and increased the capital for their business. The not married women had declared that they had started with the saving ranging from $ 10-15 in 2009/2010 but now their access had increased their savings up to an average of $ 25-35 per month.

Credit

In the four wards visited (Ifwagi, Mninga, Mtwango and Igowole) MFIs program was perceived as a program which helped most vulnerable households with their economic problems while, empowering them to access money for themselves. In the rural areas both women despite their marital status declared that the program had helped them to access household resources like land, income and businesses which helped them to

afford to cover their costs of living. They also described that the program made them stand on their own feet and reduced their social and economic dependence on friends, husband, children and other relatives. In addition, women in rural areas stated that their level of trust within the community had improved because they could ask for credit from other people in the village with the assurance of repayment.

All not married and married women from the urban areas explained that the IGAs they had, helped them to create more financial and social networks which enabled them to access credit from other entrepreneurs within the area. The credits that women from the urban area got helped them to contribute to their households welfare and reduced their dependency on other relatives or husbands in meeting children expenses. One not married women from Ifwagi wad declared that her brother used to send money for food and rent, but now she had her own house and managed to pay for medical cost and food. Moreover, women reported that they thought that their relatives used to regard them as a burden but that had changed since they now had the potential to contribute towards their household and community development activities.

Income

All women from the urban and rural households explained on how the program reduced their dependency to their husband or relatives. In rural areas not married women stated that the income from the MFIs had given them the ability to make purchases and increased household expenditures on food, health and education which were previously low. The study found that access to income played an important role in changing a previous limited financial ability by giving them an opportunity to have their own IGAs. The widows felt that MFIs helped them to continue being respected by the in-laws because of reduced dependence especially for children‘s support. Married women from the rural area declared that the savings they got from MFIs increased their ability to purchase households need than before when their husbands provided everything for the household.

The not married women from the urban area declared that the quality of the kitchen they were using had improved. They managed to use their savings from the IGA to build an improved stove, which did not require them to use much firewood. The improved stoves had little smoke so they were free from chest and eye diseases. The quality of the food had also improved and become more nutritious as they managed to add nuts and cooking oil due to increased income. Furthermore, married women from the urban area declared that even the number of meals within their household had improved from one meal to three meals per day. On the other hand, households in the rural and urban setting explained that even during the hunger period (January to march) they managed to get all three meals per day.

Assets

From the households interviewed it was revealed that assets (both productive and non-productive) were very important, especially in households with chronically ill persons. In the rural areas not married women, stated that the culture, norms and traditions were that once a man got married, he was provided with assets like land or cattle as a sign of authority over his household. Conversely, women were not given those assets because they would get married and in turn used their husbands land. If you were divorced or became a widow you were not allowed to inherit that land or cattle because it had to be returned to the husband’s clan. With the MFIs the ability of women to own land has been improved and all women interviewed had access to their own land, houses and other productive asset as indicated in table 5.From the findings it was revealed that married women from rural were heavily involved in agriculture and looking after their children but

they did not own or have full control over those resources. They were excluded from the ownership of land and its products.

Not married women in the urban area explained that access to income allowed them own assets like land, radio, mattress and no one could grab them. The intervention helped them to gain certain value and respect within the community by giving them ownership to land. In married households in urban areas the findings were similar with women in rural areas. During the interviews with women within the not married households both women explained that, saving helped them to buy and own assets as indicated in table 5.

Table 5: Type of assets within women households

Asset	**Type of assets**	**Urban**				**Rural**			
		Not married	Not married	Married	Married	Not married	Not married	Married	Married
Productive Asset	-								
Land/farms		+	+	-	+	+	+	+	+
Animal plough		-	-	-	-	+	-	+	-
Wheel barrow		-		-	-	+	+	-	-
Hoes		+	+	+	+	+	+	+	+
Animal	Goats	+	+	-	-	-	-	+	-
	Duck	+	+	-	-	+	-	+	-
	Cattle	-	-	+	-	+	-	+	+
	Chicken	+	+	+	+	+	+	+	+
	Pigs	+	+	-	+	+	+	-	+
Non productive									
Bicycle		+	+	-	+	+	+	+	+
House									
	Brick house with asbestos	+	-	-	-	-	+	-	-
	Mud hut with grass thatch roof	-	-	-	-	-	-	-	+
	Mud hut with asbestos	-	+	-	-	+	-	-	-
	Brick house with grass thatch roof	-	-	-	-	-	-	+	-
	Cement plastering	-	+	-	-	+	+	-	-
	Electricity/solar	+	-	-	-	-	+	-	-
Household utensils									
	Table	+	+	+	+	-	+	+	-
	Chairs	+	+	+	+	+	+	+	-
	Bed/mattress	+	-	+	+	+	+	+	+
	Plates/pots	+	+	+	+	+	+	+	+
	Radio	+	-	+	+	+	-	+	+
	Mobile phone	+	+	-	+	+	+	-	-

Key: + indicates that households use the strategy, - indicates that households do not use the strategy

Health

All women in the rural and urban settings declared that they were able to access health services with more ease than before. Not married women in the rural areas declared that the MFIs had managed to link them with the private hospitals and they could get treatment at a lower cost than before using community health fund (CHF). In addition, they often accessed health information by inviting health or community workers to teach them about certain topics. Now, access to the health facilities was easy as they used bicycles to the facilities to get treatment (often times for opportunistic infections related to HIV and AIDS). Moreover, they also managed to pay for bus fare when they travelled to the district hospital from primary HIV and AIDS care and treatment services. Likewise, married women in rural declared that the intervention had helped them to access health services by joining the community health fund (CHF) program, which made them access health services at the subsidized costs. This was possible because they no longer sold households assets like chicken or hired pieces of land for them to get money.

Similarly, both non-married and married women in urban area had used their savings to cover their medical costs. In the urban areas not married women declared that they used their savings to pay for their medical costs at the private health facilities if they had an emergency. They also got information about reproductive health, positive prevention strategies, stigma and nutritional issues. Accessing health had been easy due to the provisional of a CHF card which allowed five members of a household to use for one year at the cost of $ 3. The burden of illness had gone down as it was possible for members to access health services with or without cash in their pockets. Access to family planning services had also improved because access without asking for money from their husband. As a result, household financial stability had highly improved because they did not incur any extra cost when they were sick.

Education

As a result of MFIs, not married women households in the rural area indicated that the interventions helped them to pay fees and enrol children who had previously dropped from school. All households interviewed in the rural and urban areas had children who were in primary and secondary school or vocational training. Furthermore, not married women from the rural areas declared that the TUNAJALI program had significantly supported their children through provision of school uniforms and paid half of the school fees. Parents were supposed to cover half of the cost for examination fees and renovation of the school building. Cost sharing was not possible before the MFI program as women or parents were not able to contribute to school fees, instead they had to ask for assistance from their relatives and neighbours. Likewise, married women in rural explained that MFIs enabled them generate income, and enabled them cover the other half of the cost, which was not covered by the program. Before the intervention, that situation was a prohibiting factor for children to access education due to the fact that their husbands income were not enough to cover for all household running costs including paying for the school fees.

On the other hand, women in the urban area explained that access to credits had positively contributed not only to the quality of their children's lives but also to themselves as house wives. Not married women from the urban areas explained that the entrepreneurship skills they got from the trainings had helped them to create more income through assessing the market before accessing the credits. As a result it had enabled them to invest in more productive IGAs such as running milling machines, and selling clothes which gave them more profits than selling vegetables which were available in every household. According to them maize was the staple food in the area but due to drought experienced in the past season maize production had dropped. The findings were similar to what was revealed by married women in the urban areas who

showed that they benefited from the credits and their roles had changed from being bread recipients to the breadwinners. Women declared that the entrepreneurship skills had assisted them to get more market avenue to sell their products as a result of improved packaging and costumer care.

"The savings I made were not much, but I can afford to pay for my children's education and pay for my medical bills. There is no need for me to consult my in in-laws for assistance anymore." (Accessed credit of $ 230 for clothes, charcoal and selling sunflower oil)

4.4 Effects of microfinance program on women access to basic services

Saving

During data collection women from the rural and urban areas stated that their ability to save and invest had been improved. Women declared that before the intervention they depended on agriculture for everything. In this case it was impossible for them to get more income or access capital to start the IGAs because the agriculture production was only for food consumption. The findings from the not married women in the rural area showed that access to credits had boosted the household ability to invest in IGAs. All women had more than two IGA activities which had increased the employment opportunity to other household members and amount of the income earned.

Likewise, married women in the rural setting declared that the MFIs increased their ability to invest for their future and sometimes withstand emergency without depleting other assets such as chickens, phone, radio and land. Subsequently, this scenario had freed more time for the household members to spend more time on income generating activities and get more profits than previously.

Not married and married women in urban area disclosed that their participation in MFIs had strengthened social ties amongst themselves as members of MFIs and also within the community members. Through the social networks created they could take the products from wholesale shops in the areas and sell them for a higher price within the community and pay the wholesale later. Moreover, savings had given women more ability to contribute and be involved in social gatherings and developmental activities within the community. The IGAs had created an environment where all groups' shared necessary information on market and health related issues, and linked them with the wholesale outlets to learn more experience on business related issues

Credits

Women in rural areas declared that their ability to engage in economic activities had been improved after accessing loans. Not married households in the rural areas explained that the capital they got from MFIs had helped them to get an opportunity of owning IGAs like selling local beer, firewood, soft drinks, and drilling boreholes and selling water. Similarly, married women households in rural area claimed that their ability to invest had improved since they joined a group. Before joining the MFIs the women stayed at home and waited for their husbands to provide everything. This limited them from asking or arguing about income or assets. Women's roles had improved due to access to credits which also increased the ability of the household to engage in IGA activities within the area. Their freedom of mobility from one place to another to access market had also been increased. The same result was found in urban areas were credits empowered both married and not married women to get capital to start up IGAs which increased their ability to get saving and more income for their households.

Assets

Respondents in the study areas were asked to explain how the intervention helped them to access legal services for ownership of the basic resources like land and houses. Not married women in the rural areas explained that they had legal village ownership of their land. In addition, with the assistance from TAWLA (Tanzania women lawyers Association) which supports women to get legal rights in the communities they managed to get title deeds for their land from the district. On the other hand married women in the rural areas got title deeds with their husband's name because only men had the right to own land within the community. Due to legal ownership of assets women could make decisions on how their assets would be inherited when they passed away.

In the urban areas, married women explained that even though they contributed for the household income and savings their culture, norms and traditions made men legal owners of the assets. Man's legal ownership of resources made women have boundaries on accessing and utilizing assets like land and houses. One married woman declared that her husband allowed her to process legal ownership of the houses allocated in the village because she had contributed for the construction of the house.

Health

In the rural and urban areas women explained how the interventions affected their access to information and the health status of the household members.

From rural areas results showed that not married and married women had more access to health information. Accessing information health education is not a problem as it is provided within the MFIs meetings. So by being a member, women had access to basic information about prevention, nutrition, reproductive health, and positive living, how to overcome stigma, HIV and other issues that were happening in the country through media and experience sharing.

In urban areas both not married and married women explained how the intervention had helped them to get more information which was being provided during their monthly group meetings. Radios allowed women to be up to date on issues relating to reproductive health for youth, vaccine, personal hygiene, HIV/AIDS prevention strategies and positive living. For both married and not married households in rural areas women declared that the health status of their house holds members had improved because of this information. The health education which they got helped them to improve their sanitation and quality of cooked food.

Education

All the women in the four wards greatly valued education for their children. In rural areas both not married and married women had access to financial education which improved their knowledge on money management, saving and planning. These also improved the ability to access loan and invest in more profitable ways. In rural areas it was observed that most young children were attending primary and secondary schools, and some were reported to be in vocational training colleges.

In the urban areas not married households had a higher level of education compared to married households. The average education for the not married was secondary level while the average for married was primary education. Although all children were going to school the average of children who were in vocation and secondary school was higher among the single women. All women interviewed anticipated that their living standard would be much better in the future as a result of literacy of their children. They also believed that the patrilineal system would eventually be abolished and both men and women would have equal access to resources and services within the communities.

Table 6: Level of Decision making, control and access to resources and services

	Married household			Not married household	
		Urban	Rural	Urban	Rural
Decision making	Saving	Medium	Low	High	High
	Credit	Medium	Low	High	High
	Income	Medium	Medium	High	High
	Assets	Medium	Medium	High	High
	Health	High	High	High	High
	Education	Medium	Low	Medium	Medium
Access to resources	Saving	Medium	Medium	High	High
	Credit	High	High	High	High
	Income	High	High	High	High
	Assets	Medium	Medium	High	High
	Health	High	High	High	High
	Education	High	High	Medium	Medium
Access to Services	Saving	Medium	Medium	High	High
	Credit	High	High	High	High
	Income	Medium	Medium	High	High
	Assets	Medium	Medium	High	High
	Health	Medium	Medium	High	High
	Education	Medium	Medium	Medium	Medium

Results from study showed that not married women had higher level of decision making, control and access to services than married households

Chapter Five Discussion and Analysis

5.1. Impact of microfinance intervention on women living with HIV/AIDS households

Sigala (2009) stated that microfinance intervention promoted women whose works were not identified to be largely tangible or of great value. Before accessing credit married and not married women who were involved in the agriculture field were not appreciated and recognized within their households and communities. This was simply due to the fact that produce from the farms by women was not enough to support household members and increased household vulnerability by lacking ability to cover education costs for their children and pay for medical costs. With the MFIs the household vulnerability had been reduced and household ability to cover for food, education and treatment cost had increased.

Microfinance interventions increased the ability of women living with HIV/AIDS households to respond to HIV/AIDS related shocks like stigma, morbidity and mortality. This in turn, reduced susceptibility and vulnerability of household members. These results corresponded with the study done by Pronky et al (2005) who discovered that microfinance programs had the potential to stabilize the economic situation of vulnerable individuals and households and thereby reduced behaviours that were associated with poverty and increased the risks of HIV infection. This study showed that MFIs in Mufindi district had contributed in improving the living standards of women living with HIV/AIDS by giving them an opportunity to access credits with an interest rate of 5%.The credit was used as capital to empower women in the households and increase their livelihood options apart from agriculture. In rural and urban areas both married and not married women managed to access to credits from their local MFI groups. These women established different IGAs which gave them an opportunity to do small businesses like selling local beer water, snacks, clothes, food and trees to generate some income to support the household. IFAD (2008) and Goldberg (2005) explained that credits accessed by women could help poor groups in society who could not access credits from financial institutions like banks in order to get self-employment and run some income generating activates. In rural and urban not married households some women who lost their assets after the death of their husband were helped by the intervention to get credit and start some income generating activates which assisted them to not only get income but also to own and control their own assets like land, house and other household utensils.

As described by Goldberg (2005), credits and entrepreneurship were important driving factors on improving the living standards of women and gave women skills on how to improve business as a proxy indicator to improving living standards in the household. Entrepreneurship skills and having credit increased competence and innovative skills before starting their small business. In this study both married and not married women received skills which helped them to evaluate the market needs before they started investing their money. One not married woman decided to ask for credit and started business of selling maize meals because the drought affected the maize production which was the main food. This made her get savings of $ 25 every month as the profit. This showed that entrepreneurships skills increased the ability of women to assess before investing their credit in to the business.

In addition, skills that women got from MFIs were seen to have an impact on other household members like children and relatives who always supported the women to do their business. These ensured constant flow of income to support the household when

the women were sick or had died. Results in this study revealed that women who had access to credits reduced dependence and increased their dignity to relatives, husbands and the community. These findings were in line with the study done by Mohammad and Mohamed (2007) that resources and income were the main important elements of living standards of the poor that helped women to increase their sense of ownership and power within households and the community at large.

From this study it was seen that savings and income contributed to rural and urban married women whose bargaining power within the household over ownership of assets and income had increased. This finding is in line with the study done by Mayoux (2006) and Mohammad and Mohamed (2007) which showed that the MFI had improved women's decision making, ownership of resources and access to services within the household and community by removing their barriers to access credit and increase their savings.

In this study it was revealed that lower level of illiteracy among women from rural and urban areas acted as a challenge in the utilization of MFI services. Lower level of literacy among women in rural and urban as previously explained by Fletschner and Kenney (2011) affected women's ability to process information and women's exposure to different opportunities. In rural areas education affected married women's ability to access credit and invest in more profitable IGAs compared to not married women in urban areas. On the other hand, married women households showed continuity in depending on their husbands for record keeping and this consequently limited them from networking and accessing other opportunities in the community. In this way married woman seemed to be denied from full participation in IGAs, hence continuing to be heavily dependent on their husbands' not only socially but also for economical related matters.

5.2 Impact of microfinance on women decision making and control of resources.

Contributing financial resources to the households or communities contributed to the greater legitimacy and value to women's views and gave them more entitlements than they would. Generally married and not married households interviewed from rural and urban showed that credits and saving had helped them to improve their day to day lives by giving them more power within the households and facilities to owned asset(s). Assets like land increased self-esteem within women by improving women's social status within the community despite their HIV/AIDS status. This finding is in line with UN-Habitant (2010) who stated that access to basic services were important because they added to human dignity and living standard to improve the potential of each person to engage in economic activities.

This study showed decision making and control of resources at the household was still affected with the presence of strong culture practices and norms within the household. As it have been explained by Kebede, (2011) and Kessy (2008) that the ability of married women to have self-decision making and control over saving, credits income and assets, health and education was low compared to the not married households. This in turn, affected the ability of married women to earn more savings compared to single headed households due to the fact that what married women accessed less credits compared to single women in both rural and urban settings.

The study also find out credits that women accessed from their groups gave them ability to decide on what type of IGA could be established in their households. Furthermore, findings from the study showed that single headed household have more power on making their own decision on what they want to do with their income, saving and credits

in both rural and urban settings. In married households, findings showed that married women still consulted their husbands before making any decision of taking loan and they also had limits on the amount of money to make decision with. This affected saving and access to credits of the married women due to the fact that if the husband was not at home some decision at household had to wait for him to come back. The social status of the married women within the household was still low although they contributed on the households' income. Mwangi, (2009) states that women who had low social status in the households are negatively affected on making decisions and control over households resources. This limits women ability of married women to make their self-decisions over resources for better living standard improvement of their households. This argument was in agreement with Tayub (2008) who described that giving credits to women could improve economic dependency, and reduced vulnerability and susceptibility of the household members. In this study women access to microcredits interventions reduced their vulnerability by having quick access loans with low interest rate. In turn, this reduced their dependency to their husband, hence improved their access to health, education and improved their ownership to assets. Both married and not married women had managed to increased their produces and non-productive assets after accessing the credits. The ownership of the assets increases respect and dignity of women within the household because it gave them with an opportunity to contribute to the households expenditures.

Based on Pitt et al., (2006) microcredit interventions led to women taking a greater role in household decision making by giving greater access to financial and economic resources, having greater social networks, having greater bargaining power than their husbands. Findings from this study revealed that due to skills and experiences sharing during the monthly meetings, married women had increased their bargaining power over their husbands and managed had legal ownerships of some assets like house and land from the husband. This study also found that not married households in both rural and urban settings had full control and decision over resources and made self-decision of their households without any interference from relatives. Access to income reduced, not married household vulnerability and susceptibility and increased their ability to owned assets such as land. In turn, this made them have full control and decisions over household's assets and resources. Eventually, women increased their social network from within and to other organizations outside their network. The social capital that women created increased access to other services like legal, communities apart from getting land title deed, health information and education on various topics including but not limited to life survival skills.

The study revealed that the ability of all women households to access basic health services had improved. Women used their savings to pay for their medical related cost, and in turn the health status of the family members had greatly improved. As a result this reduced the healthcare cost, subsequently increased household saving because the profits that women got from the IGAs could be saved and invested in other IGAs, and not covering medical treatment as before. The improved health status in turn allows women and other household members to supervise IGA network, utilize the available opportunities in the community and spend much of time in production activities.

5.3 Access and control over resources

All interviewed households showed that access to credit and savings had helped them to improve their day to day living by giving them more power within the household and motivated them to have their own asset(s). All respondents declared that before joining the MFI program they did not get an opportunity to own asset(s) like land, bicycle and house at household level.

This study found that not married women from the rural area felt the program had positive effects for them to access resources within households and communities. Through networking they managed to have legal ownership of their land. Access to credit empowered women living with HIV/AIDS to decide and look for other alternatives to ensure food availability in the household and constant supply of labour in their farms. This helped households increase their income (cash monetary) through selling of crops. Moreover, the savings that households got had helped other members to access services like education and health which improved the living standards of their households. The results showed a high relationship between being educated and deciding on access to credits and the type of IGA selected. This finding was in support of the concepts by Mayoux (2004) who stated that the income that women got helped to improve their ability to decide on the access to income and savings, which in turn affected their health seeking behaviours.

Both rural and urban households showed that credits and saving helped them to improve their day to day living by giving them confidence and motivating them to have their own asset(s). All of them declared that before joining the MFI program they did not get an opportunity to own their own asset(s) at household level. It was also disclosed that the ownership of productive and non-productive asset(s) among women households had increased. Table 5 showed that all not married women managed to buy and own land within the community. In the study areas land was always regarded as an important and valuable asset with the community. As a result ownership of land by women increased their dignity, value and respect within the community. This in turn, enabled them to mitigate if not abolish the patrilineal system because it was perceived as women acquiring same status as men within the community. This finding was in agreement with a report by FAO (2008); that culture and norms limited women's access to some of the asset(s) and control over resources.

Uniquely, this study found that assets owned by not married women were of top quality as opposed to those of married women households. The fact was that married women despite having financial power had fears of buying quality asset(s) as they already knew that once the husband passed away all the items or asset(s) will be eventually grabbed by the husbands' relatives. Conversely, the not married women did not have fears instead they bought quality asset(s) as they knew from scratch that all the items would belong to them and or her child or children. The MFIs have helped women, especially widows, to start their lives afresh and developed confidence in their decision making and the control of resources. This was exemplified by the fact that three women who participated in this study were illiterate and did not get access to education at all, three were semi illiterate with primary school education and two had access to secondary school education. Despite the different education backgrounds all of them valued education to the extent of using part of their incomes to pay for school fees for their children.

Generally, it was found that the MFIs had double effects on women, especially widows living with HIV/AIDS. Firstly, it empowered them in decision making by reducing their dependency on relatives. Secondly the intervention gave them confidence to own and increase their roles and dignity at the household and community at large. Ownership of land, income, saving or any other asset had a reciprocal relationship with the control of ownership as well as decision making in general.

Kabeer (2001) observed that increased access to resources was regarded as an empowerment pathway to women and the poor. Access to resources basically served as a catalyst for empowerment or enabling conditions under which empowerment was likely to occur. Findings from this study showed that TUNAJALI MFIs had potentially improved

access to resources among women from rural and urban areas. Much effect was observed in not married headed households both in rural and urban where their level of accessing credits was higher than the married household. In this study, not married woman from urban had accessed the highest amount of credits ($ 250) than married woman ($ 200). The patrilineal system within the four wards continued to influence the process of accessing credits whereby by women had to consult their husbands' before accessing credits and this in turn demotivated women. As a result this made the improvement of their living standards invisible when compared to the not married households.

5.4 Access of basic services

Access to basic services was among the advantages that women managed to benefits within their three years of membership in MFIs. As was described by UN-HABITANT (2010), the access to basic services was important and added human dignity and improved the living standard. Access to health, education, food, shelter and legal services had also improved roles and the value of women in the household. With a good health status of household members' continuity of day to day IGAs activities was enabled hence generating income for the household. Households were not spending more income for treatment costs conversely this increased their ability to save profits generated from their IGAs. The income obtained by women after joining the microfinance programs gave them power thus contributing to the welfare of their household rather than being recipients of income from their husbands and relatives. Instead from what they got they could pay for school fees and medical related cost as stated by one respondent.

"*I always make decisions about our lives with my husband. Both of us always think and discuss how we can improve our lives, and we agreed that SILC would be our solution. As you have seen our lives have changed and now even the neighbours respect us".*

Lower level of literacy among women in rural and urban as previously explained by Fletschner and Kenney (2011) affected women's ability to process information and women's exposure to different opportunities. The same findings were revealed during data collection where two women from rural areas failed to access part time jobs within a local NGO due to lack of education. Moreover, women who did not get an opportunity to go to school, failed to keep IGA records properly. As a result this made them fail to understand how much they were earning and spending per month. To overcome these challenges women used their credits and savings from microfinance interventions to support their children in having better health and acquiring better education.

From this study was further revealed that households had increased their access to health information through listening to different programs using their radios and through exchanging information with other members. All women in rural and urban areas responded that apart from accessing credit, networking and sharing of experiences had motivated them to be in the groups. This assisted members to access market opportunities and other opportunities that emerged in their community

Chapter Six Conclusions and recommendations

6.1 Conclusions

In order to understand living standards three different dimensions were evaluated. These were decision making and control of resources and access to resources and services. This evaluation was done in order to assess the impact of MFIs on three different dimensions governing the living standards of women living with HIV and AIDS. From the findings was clearly observed that women within the microfinance programs had increased their scope on making decision and control over resources as a result of increased household income and asset contributions. The MFIs also enabled women to access basic resources like land and asset ownership. The micro financing activities turned the patriarchy system upside down giving women, especially those most disadvantaged; not married or widows, a stronger voice in decision making and power to control resources both at the household and community level. This was justified by most of the widows by revealing how they were deprived of and had their ownership rights grabbed by their in laws after the deaths of their husbands. Instead, by joining the micro financing firms, they were not only able to buy their own land but also to build houses and support other households needs such as accessing basic services namely education and health services. It was also learnt that the intervention helped women to create networks or groups which assisted them to have common issues which were also a way forward at both household and community level.

The interventions had a higher impact on the not married than married households on issues regarding decision making, control and access to resources and services. The study also revealed that to some extent men still dominated hence hindering married women from having decision making powers, control and access to service and resources in both the rural and urban areas.

Furthermore, the MFIs had contributed on access to basic services and resources within the households by improving household's nutritional status, maintaining food security and empowering women through access of legal ownership of asset(s) e.g. land, which was considered to be the most valuable asset as it could be used as collateral for acquiring credits from financial institution. This showed an increase in the level of saving and income of the household by reducing the medical treatment costs due to the improved health status of the household members.

Based on study findings it was concluded that all social cultural practises and norms that acted as barriers to women, especially those living with HIV and AIDS, should be mitigated, if not absolutely overhauled in order to utilize the drivers of living standards. By doing this more women would be enabled to freely access the drivers of living standards backed up by MFIs.

6.2 Recommendations to TUNAJALI

Based on the conclusions of this study the following recommendations were made to the TUNAJALI program; the problem owner and implementer of MFIs in the study areas:

- Involvement of the husbands in the MFI activities which will help reduce the male domination over savings and assets by getting more knowledge about MFIs and more access of his own savings and assets and assist their wives with record keeping.
- TUNAJALI should involve local leaders during the trainings of new groups. This will help in assisting women to access their rights to their own savings and assets within the communities.
- TUNAJALI should form a partnership with TWLA (Tanzania Women Lawyers Association) on advocating women rights to help reduce some of the culture and practises which hinder women's access to services of legal ownership of the assets as they already have members in every district that can support women
- More MFI leaders should be trained to support women who can read and write so that they improve on their record keeping and balancing of their financial statements.

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Appendix 1: Checklist matrix for household

Socio demographic Characteristics of the households …... Household composition …….. Age ……. Sex……..

No	Type of variable	Saving	Credit	Income	Asset	Health	Education
1	**Decision making and control of resources**	Women Self-decision on saving.	Control and decision over credits	Decision on how to contribute on the household income	Decision and control over land, building.	Access to ARV and CTC services	Education on entrepreneurships skills
					decision and control over household after the death of spouse	Decision on family planning	
2	**Access to resources**	Access to produce and saving	Increase women collateral	Impact on household dependency	Women access to income	Household health seeking behaviour	ability of household to afford education cost
			Access to fund for income generating activities	Impact on household expenditure			
			Increase women financial self sufficiency	Women access to income	Household productive and non- productive assets.		
			Increase access of capital to women				
3	**Access to basic service**	Increase household ability to invest and save		Ability of household to engage in economic activities	Increase legal ownership on basic resources	Access to health information	Household access and acquiring education
						Health status of the household members	Education level of household members

Appendix 2: Observation Checklist

Asset	**Type of assets**	**Yes**	**No**	**Remarks**
Productive Asset	-	-	-	-
Land				
Animal plough	-	-	-	-
Wheel barrow	-	-	-	-
Hoes	-	-	-	-
Bicycle	-	-	-	-
Animal	Goats	-	-	-
-	sheep	-	-	-
-	cattle	-	-	-
-	chicken	-	-	-
Non productive	-	-	-	-
House	-	-	-	-
-	Brick house with asbestos	-	-	-
-	Mud hut with grass thatch roof	-	-	-
-	Mud hut with asbestos	-	-	-
-	Brick house with thatch roof	-	-	-
-	Cement plastering	-	-	-
-	Electricity	-	-	-
Household utensils	-	-	-	-
-	Table	-	-	-
-	Chairs	-	-	-
-	Bed/mattress	-	-	-
-	Plates/pots	-	-	-
	Radio			
	Mobile phone			