`MAJOR THESIS PRESENTED TO THE CHAIR GROUP OF ECONOMICS OF CONSUMERS AND HOUSEHOLDS

# AN EXPLORATORY STUDY ON MICROFINANCE AND HEALTH
# A CASE OF VISIONFUND IN KOROGWE DISTRICT, TANZANIA

## MSC THESIS CONSUMERS STUDIES


WAGENINGEN UNIVERSITY AND RESEARCH CENTRE


NOVEMBER 6TH, 2014


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**REGISTRATION NUMBER**: 810611727120

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# AN EXPLORATORY STUDY ON MICROFINANCE AND HEALTH: THE CASE OF VISION FUND IN KOROGWE DISTRICT, TANZANIA.

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**THE MSC. MANAGEMENT, ECONOMICS AND CONSUMER STUDIES OF WAGENINGEN UNIVERSITY AND RESEARCH CENTRE**

**2014**

## DECLARATION

I, Ombeni Elly Sangiwa do hereby declare to the Senate of Wageningen University of Research, Netherlands, that the thesis presented here is my own original work and that it has not been submitted for a degree award to any other university.

## COPYRIGHT

## ACKNOWLEDGEMENTS

A work of this nature and magnitude cannot be completed single handedly without extensive moral and material support from different individuals and institutions. It is therefore impossible within such a limited space to make individual acknowledgement here, but I hereby thank you all that made this work possible. I am particularly indebted: First and foremost, I wish to express my heartfelt gratitude to the NUFFIC based in Netherlands, for financing this study; The Management of Wageningen University of Research; The Chair group of Economics of Consumers and Households particularly my supervisor Dr. Johan Van Ophem for his heartful guidance and directives in all stages to the accomplishment of this work. Sincere thanks go also to the second examiner Prof. Dr. Gerrit Antonides, study advisor Ms. Jamilla de Jong as well as Wageningen Tanzanian mates (WUR- Tanzania).

Special thanks go to my employer Arusha Region Secretary for giving permission that made my two years stay abroad possible. Also am greatly indebted to the Management of Vision Fund Tanzania, special thanks to Lear Msangula, branch Manager Vision Fund Tanga, Mr. Lucas Celestine branch Manager Vision Fund Korogwe and all staffs based in Korogwe and Tanga region, for their great full assistance that contributed to the success of this work. Special thanks again to Regional Administrative Secretaries (RAS) and District Administrative Secretary - Tanga and Korogwe of Tanga region for their permission to take study in the study area. I also indebted to thanks Miss Sikitu Musa and Miss Neema Kihiyo for their heart full help during the whole period of data collection.

Above all, I am deeply grateful and indebted to my relatives, sisters and brothers of Sangiwa family for their patient during the whole period of my absent for studies, their prayers has strengthened and blessed me so much. Finally, special thanks to all my friends.

## DEDICATION

This work is dedicated to my beloved parents, mother Late Mrs, Evelyne Elly Sangiwa and late farther Rev. Elly Paulo Sangiwa, whose, in this case, as in most others could always see the wood from the trees. To my beloved mother you passed away soon this september,2014 while taking last point to accomplish my studies, you have gone early all of you but am still keeping faith that spiritually we are together "*I love you so much and rest in peace Mama and Baba*''. To relatives, brothers and sisters for their eagerness support and indispensable prayers that contributed to the accomplishment of this work. May the Almighty God bless and reward them abundantly.

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## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| MFIs | Microfinance Institutions |
| MDGs | Millennium Development Goals |
| HIV/AIDS | Human Immune Virus/Acquired Immune Deficiency Syndrome |
| WHO | World Health Organization |
| REPOA | Research on Poverty Alleviation |
| USAID | United States of America |
| PEPFAR | Presidents' Emergency Plan for AIDS Relief |
| NBS | National Bureau of Statistics |
| CHF | Community Health Fund |
| NHIF | National Health Insurance Fund |
| LIC | Low Income Card |
| NHA | National Health Accounts |
| NGOs | Non-government Organizations |

## ABSTRACT

This study was conducted to examine the contribution of microfinance institutions (MFIs) in improving health services to women entrepreneurs in selected Wards of Korogwe District in Tanga Region, Tanzania. Data for the study were collected from a sample of 90 women entrepreneurs, 2 focus group discussions and key informants using structured questionnaire. Results showed that provision of health services loan related products by MFIs are not the demand of institutions' governing laws, guidelines and regulations. There was no such product related to health services access and made available to their prospective customers. Likewise, the findings revealed the existence of a need to consider provision of health loan related product to be on the list of other loan products offered by MFIs. The likely supporting reason is was to create opportunities for people to join health scheme including Community Health Fund (CHF). However, the major challenges identified in performing business were unfaithfulness of some customers, unreliable customers, inadequate capital for business operation, seasonality of business operation, and location of business enterprises. Based on the findings of this study, it was recommended that strategies should be put in place to prioritize and ensure proper operationalization, continuity and sustainability of MFIs in health services. The emphasis for this should be tailed in business management and operational skills to build up spirit in business and confidence to the principle of succession in doing business.

# CHAPTER ONE

# INTRODUCTION

## 1.1 Health Service Overview

Tanzania as a nation is facing many developmental challenges which affect sectors of her economy; health sector is inclusive. In overcoming these challenges, Tanzania is implementing National Strategy for Growth and Reduction of Poverty (MFEA, 2005). This strategy works to implement Millennium Development Goals (MDGs), which target to reduce diseases such as malaria related mortality, infant mortality, child mortality and maternal mortality by 2015. In this regard, provision of health services for all people in Tanzania irrespective of their differences in races has been a growing concern to the government and the private sector. However, there has been a high push towards huge investment in the health sector over years due to increase in population growth (NBS, 2012).

Nevertheless, there still exist limits to which government can singularly provide health services for all because of high population growth (approx. 44.9 million in 2012), low technology and inadequate funding from donors (NBS, 2012). The report from MFEA (2010) indicated that there is high amplitude of limitations to health services for all people in the country. In supporting microfinance institutions (MFIs) have been integrating health services in Tanzania to ensure better livelihood through improved health status of people. (Babajide, 2011) reported that MFIs are capable of integrating financial with health services by increasing knowledge that leads to behavioural changes.

Microfinance institutions have been widely acknowledged to be successful contributors to the alleviation of poverty and a valuable tool for achieving the MDGs (Saha ,2011). Saha (2011) reported further that there was high realization of poverty reduction by MFIs because of improved social welfare and health services. Poverty and ill health are intertwined and as such need to be addressed together. Since a vicious cycle of poverty and ill health affect the ability of MFIs clients to engage in productive activity, to repay loans taken from the bank, to build assets and to grow their businesses, which are the conditions necessary for pulling out of poverty. As

clients are unable to repay their loans and continue borrowing, MFIs sustainability can also be affected.

## 1.2 Background to the Research Problem

The accessibility of Tanzanian people to sustainable social services particularly health services is the great challenge currently facing the nation. Garg *et al.* (2008) urged that, people in developing countries, such as Tanzania, are behind in accessing sufficient health services than those in developed countries. However, within countries generally, the smallholders have less access to health services. Normand *et al.* (2013) reported that smallholders are always in risky or unhealthy conditions even if they are acquainted to jobs (Normand *et al.*, 2013).

In Sub-Saharan Africa, (Hargreaves *et al.,* 2007) the large part remains in the areas of the world which seemingly to be at the greatest risk of failing to meet any Millennium Development Goals targets. According to Hargreaves *et al.* (2007), the conditions of extreme deprivation are essential characteristics of the region and create "poverty traps" that limit access to proven interventions. Similar conditions also constrain potential gains in employment, income, food, shelter, and education, carrying dire immediate and longer-term health consequences. The interdependence of poverty, health, and development are mostly cross-sectorial which are experienced when are to be intervened and the feasible options remain unclear.

The MDGs adopted at the Millennium Summit of the United Nations in September 2000, is regarded the major solution to reduction in poverty and improvements in the health services (Ohri, 2004). Morduch *et al.* (2003) depicted that, MDGs stimulated the community development but improvement of the basic needs of the community remains a challenge. Reduction in hunger and poverty, elimination of HIV/AIDS and infectious diseases, are among the reported challenges. As a move towards implementation of MDGs health clusters, MFIs, however, documented success in poverty alleviation efforts. Morduch *et al.* (2003) evidenced that access to financial services enables smallholders to increase their subsistence needs, and reduce their vulnerability to daily life crises. The MFIs have been the driving engine of reducing poverty in diverse communities of the world. Ohri (2004) reported that there is an incentive to the recognition of the significant contribution of microfinance sector to poverty alleviation.

Sachs (2005) observed that despite the existence of many strategies taken to alleviate poverty, there is a need for the integration of several of them and not considering them individually.

Hargreaves *et al.* ( 2007) were impressed by the fact that microfinance provided diverse financial services for smallholders as credit, savings, insurance and money transfers. According to Leatherman *et al*.(2012), finance interventions coupled with other interventions such as training and healthcare are significant in poverty alleviation among smallholders. They also stretched that health requirements of any community is not a vertical approach but should focus on cross-sectorial approaches. Their observation was in fact to simultaneously increase potential achievement of economic and health welfare of the intended communities.

## 1.3 Statement of the Problem

Illness is the most social catastrophe to smallholders because deaths in the family take time off from work when sick and healthcare related expenses reduce earnings and savings capacity of the families. For microfinance clients, this situation is not exceptional thus illness remains often the main reason for failure to repay loans (Morduch *et al.,* 2003).

Women face high risks of health due to overwork and vulnerability to reproductive related problems. Likewise, the opportunities around mostly poor women do not guarantee their health protection (Ohri, 2004). Increasing investments in provision of microfinance services does not equivalent, the goal of direct availability of health services as a product in microfinance institutions. In this fact, (Saha, 2011) had a view that; provision of credit alone cannot mitigate poverty if a poor woman who generates income through microfinance does not have adequately made access to health care for herself and her family, since will still living in poverty associated with her poor health condition. Saha's observation focus directly on the genuine reason that, there is a greater significance in poverty reduction when microfinance programs are combined with increased access to basic social services such as health care than when the programs focus merely on credit alone; which seems to be a challenge to most of microfinance service providing institutions.

In many African countries; MFIs face a significant percentage of their clients infected with or at risk of HIV/AIDS. This situation ignoring clients' health not only negates the ultimate poverty

alleviation goal but also threatens the institution's viability, as increasing number of clients are becoming unable to pay back their loans(Ohri, 2004).

However as widely recommended on the importance of MFIs to consider health issues in their business operation; practicing of the same was not adequately reported on direct involvement of MFIs in addressing health related interventions. Mcpake and Normand, call for universal health and health care intervention, they recommended that all societies must make choices on how to allocate whatever resources available to the production and distribution of health services (Normand *et al.,* 2013).

Therefore, based on this background, this study was conducted with the intention of filling the identified knowledge gap by assessing the contribution of microfinance institutions (MFIs) in health care service provision and support to their clients who in this regards are women entrepreneurs in Korogwe. This will help to bring into light the position of MFIs in supporting health initiatives for sustainable life improvement which is an important component in poverty reduction.

## 1.4 Research Objectives

### 1.4.1 General Objectives

The general objective of the study was to examine the position of Microfinance Institutions (MFIs) in health care services support to their prospective clients. This was in particular for women entrepreneurs and hence to suggest strategies for supporting the provision of reliable and sustainable health services as other loan products offered.

### 1.4.2 Specific objectives

The study was guided by the following specific objectives including to:

i. Assess the extent to which microfinance institutions implement health services in the study area.
ii. Examine the needs of microfinance institutions in supporting health care services to their prospective clients.
iii. Analyse challenges encountered by women entrepreneurs in the management and operationalization of their entrepreneurial activities in the study area.
iv. Suggest strategies for supporting and promoting health services as other products offered by microfinance institutions in their business operation.

### 1.4.3 Research Questions

To effectuate research problems and the objectives required in carrying out an empirical analysis, and their results of which had to provide answers to the following questions:

i. Are the existing operations of the microfinance institutions addressing the short and long term health needs of their prospective clients?
ii. Is there a need for the microfinance service providing institution to incorporate loan services product that are directly addressing health services to their prospective clients?
iii. What are the existing challenges mostly faced by services providing microfinance institutions and their prospective clients in their businesses management and operations?

## 1.5 Significance of the Study

i. The findings of this study will contribute to the knowledge regarding to the participation of microfinance in supporting health services to signify their role in poverty reduction.

ii. The findings of this study will give a wide scope of understanding the potential challenges likely to occur when microfinance institutions are implementing health services to their clients as among the loan products.

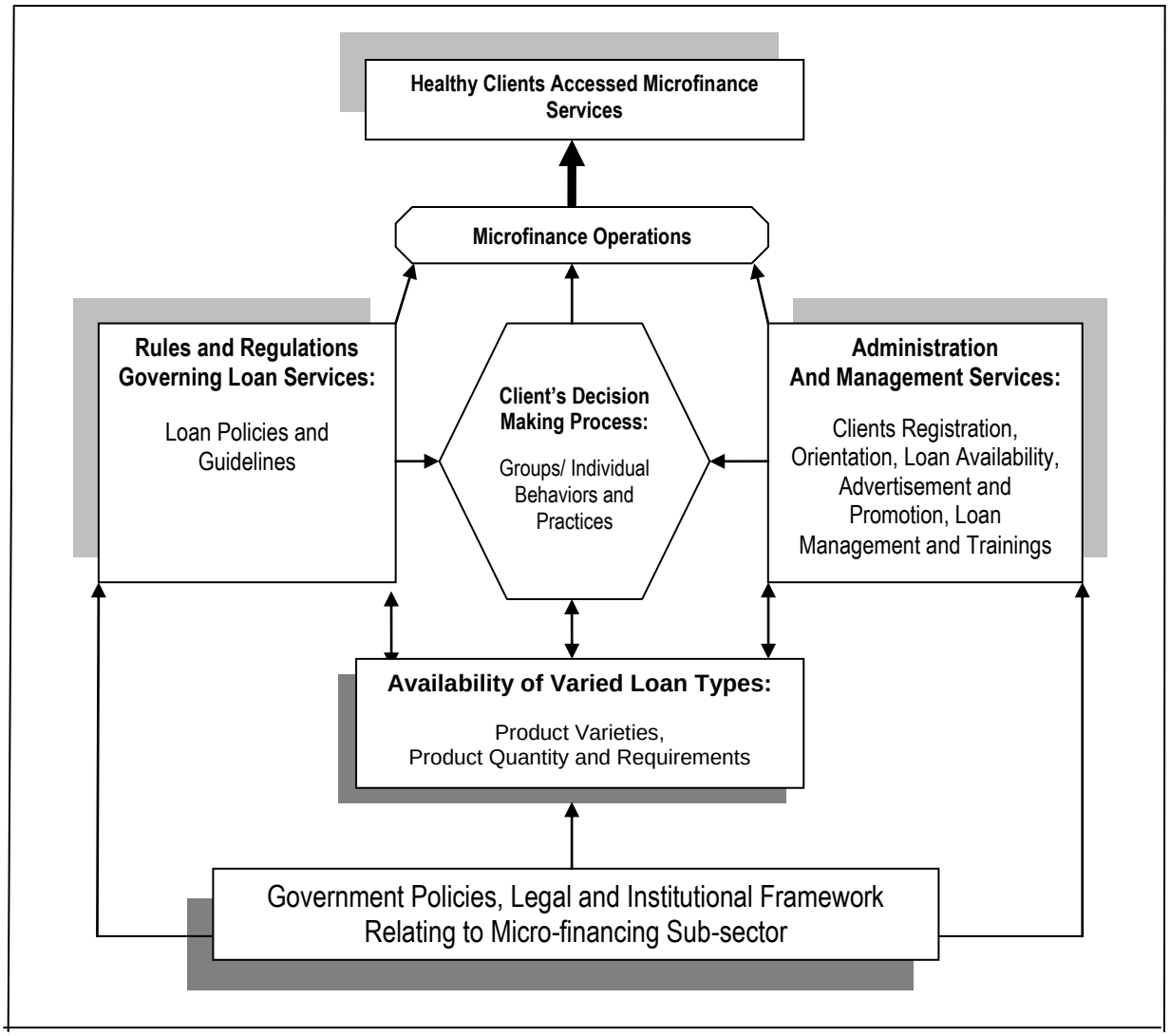
iii. The findings of this study will also reveal the impact of micro-credits on women's social and economic empowerment thereby becoming an important tool towards poverty reduction.

iv. Furthermore, the findings of this study will awake issues related to policy reconsideration to policy and decision makers, researchers, credit providers, and development supporters. This is likely to consider mostly on health services as an important aspect in loan services providing facilities hence supplementing to government efforts in poverty alleviation.

v. Foremost, the information generated from the findings of this study will be an important tool in setting gender specific programmes, and women empowerment as they play a significant role in the household and on overall country development.

## 1.6 The Conceptual Framework

Figure 1.6.1 presents the conceptual framework of the study but it is worth to note that healthy client(s) who access microfinance services determine greatly the smooth operation of MFIs.




**Source:** Author (2014)

**Figure 1.6.1. The conceptual framework for analysing the contribution of microfinance providing institutions to prospective clients' health improvement.**

However, microfinance operations are influenced by many interacting factors including regulations governing loan lending procedures and modalities in their operationalization. Similarly, the nature and type of administration and management styles practiced by the respective MFIs management have a great role in influencing individual lender(s) to decide the type and amount of loan to take including other services accessible to them (Fig. 1.6.1). However, (Morduch *et al*. 2003) observed that access to financial services by microfinance clients was the result of good performance of the management of the respective micro-crediting facilities. This indicates that micro-credit's services such as loan services have impact to increased opportunities for more investments which give an impetus to increased income generation by an improved health condition of the lending individuals. Leatherman *et al.* (2012) also observed that microfinance has mostly an indirect effect on health and this is because it is acquired through improvement of financial ability to access education and health care.

According to (Ohri , 2004), health services and their related attributes are the priorities to be invested in microfinance strategies because of their significances in all livelihoods. (Ohri, 2004) also insisted that poverty alleviation is only possible by including MFIs as a driving gear in provision of health services. On the other hand, the drawback to smooth running and/or viability of a MFIs remains threatened the increased health impairment and high number of clients becoming unable to refund for the loans. Therefore, based on the conceptual framework (Fig. 1.6.1), the assumption is that, micro-credit facilities offered have a significance role in the improvement of women health hence contributing to improved living standards at a household level.

The assumption drawn from Fig. 1.6.1 is that the operationalization of microfinance institutions has directly a big role in supporting entrepreneurial working groups that influences health improvement. However, the big challenge remains to be imbalances in direct provision of health services to people on needs in different perspectives. Ataguba *et al.* (2012) reported that the proportion of the population incurring catastrophic payments to health services is 1.52% in Tanzania. This is mostly linked to the household level, which sacrifices other basic needs in the favour of health services. Ataguba *et al*. (2012) reported that 0.37% of the population was subjected to increased level of poverty because of independent payments of health services

Tanzania as the government could not support. This observation indicates that loan provision might help people particularly women to get capital to invest in income generating activities, which ultimately facilitate payment of health services and increase sources of fund for family food adjustment.

In view of Fig. 1.6.1, the administration and management services have an important role on the achievement of the quality products and its sustainable management leading higher level of income generation. Garg *et al*. (2008) observed that the absolute levels of income and material deprivation influence people's risk of disease and ability to purchase health services. Furthermore, Morduch *et al*. (2003) reported that most smallholders use financial services for business investment in their micro-enterprises, health and education, to manage household needs while meeting the other cash needs.

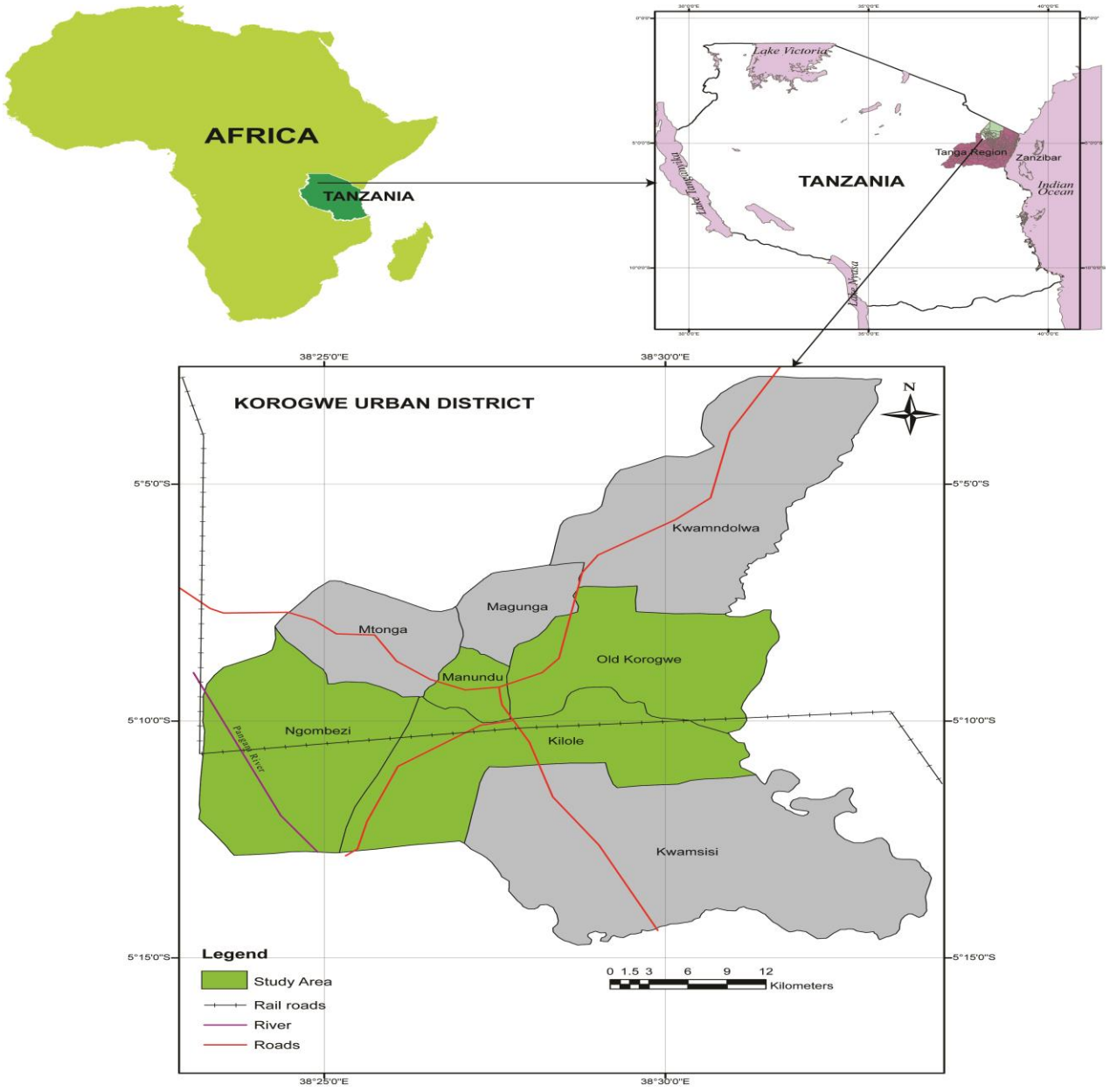
The presentation in Fig. 1.6.1 also indicates that the decision of whether to cling to individual or group loan remains so particular to the individual client(s). This reveals that most of the decision is vested in group based loan types rather than individual. Moreover, government policies, legal and institutional frameworks related to micro-financing sub-sector have a vital role on stimulating and promoting microfinance institutions policy towards health services (Fig. 1.6.1). This indicates that the existing government policies, legal and institutional framework provide an enabling environment for MFIs. This is based on the operation in the broader context of having very sound administration and management strategies, rules and regulation governing loan services. These services also embrace availability of varied loan types, reasonable and viable loan products and far most cherishing availability of decision making environment among prospective clients.

## 1.7 The Study Area

This study was conducted in Korogwe District, Tanga Region, Tanzania. The main focus Wards in the study area were Kilole, Ngombezi, Manundu and Old Korogwe (Fig. 1.7.1). Several factors were considered in reaching the decision to choose Korogwe District as an area for the execution of this study. The factor considered was accessibility of the respondents that perform entrepreneurial activities. These surveyed wards are found in the good networking infrastructure from within and outside the Korogwe District.

According to NBS (2012), Tanzanian population stood at 44.9 million with its growth rate of 2.7% per annum. In addition, the population density is estimated to be 51 persons per square kilometre with high variation across regions (United republic of Tanzania (URT) 2006, United republic of Tanzania (URT) 2014). The majority of population 77% lives in rural areas where farming is the main economic activities (United republic of Tanzania (URT) 2006). The current population of Korogwe District is 242,038 whereby the number of females is 123,494 and males are 118,544 (United republic of Tanzania (URT) 2014). Korogwe township council experiences a growing influx of movement of people, availability of social services, communication and networking infrastructures, road networks infrastructure system. These characteristics necessitated the rapid growth of financial operating institutions including Banks, quick money transfer facilities such as tiGO-pesa, Airtel-Money and M-Pesa. The town is also located along the main tarmac road of Tanga and Dar es Salaam – Arusha.

**THE MAP OF TANZANIA SHOWS THE STUDY AREA**




**Source:** Author, (2014)

**Figure 1.7.1. Map of Tanzania showing the study area.**

# CHAPTER TWO

# THEORETICAL ORIENTATION

## 2.1 Overview

This Chapter reviews existing literatures on issues related to the study. Special attention is directed on reviewing key concepts of microfinance and health issues. However, the chapter is divided into four main sections. The second section presents an overview of health status in Tanzania whereas section three provides literature on the concept of catastrophic payment in health care, followed by concept of microfinance in section four and fifth section presents overview of microfinance in health care. Finally, the chapter concludes with study expectations.

## 2.2 Health Status in Tanzania

The World Health Organization defined health as state of complete physical, mental and social well-being of a person and not merely the absence of disease or infirmity (WHO, 1948). Life expectancy at birth is one of the measures of the quality of life in a country. It is also an indicator of the return on investment in human capital and the overall socio-economic development of a country and is considered to be a good general indicator of the health status of the population REPOA, (2011).

Ministry of health, (2007) shows that in 2004 life expectancy at birth was 46 years in Tanzania and this was lower than the average in Sub-Saharan Africa of 49 years and other low income countries which is 53 years. The report further describes that, Tanzania's fertility rate is as high as 4.9%, and this, is equivalent to that of other low income countries but lower than that of Sub-Saharan Africa which is 5.2%.

Regarding to child mortality, (Adam, 2005) defined child mortality as the chance of dying between the age of 0 and 1 per 1000 births. Mortality is distributed bimodal with high probabilities of dying in the first years of life (in particular at birth and immediate afterwards) and gradually increases chances of dying after the age of 30 years. The author regarded high mortality among infants and children under age of five as one of the important characteristics of

the general state of health in developing countries. Adam (2005) further writes the mortality rate for children under age of five was 95 per 1000 births in developing countries. Adam (2005) also reported that from the year 1995 to 2000 the probability of mortality was found to be 81 for children of age between 0-1 years and 129 deaths per 1000 between 0-5 years, and it was accompanied by the life expectancy of 44 years (Szirmai Adam 2005).

The Human Development Report (URT, 2014), shows that the currents statistics for life expectancy of Tanzania has increased to 58.9 years. This is an indication that the government of Tanzania works in its level to ensure the provision of health by increasing its expenditure on health to almost 13% of its total expenditure(USAID, 2007). Despites, this struggle in effective resource allocation to health issues, still experiencing challenges which need donors support to increase its financial ability to invest on health.

According to USAID report, (USAID, 2007), Tanzania's is experiencing high HIV prevalence rate of 6.5% in the 15-49 age group (compared with a Sub-Saharan Africa average of 5.9% and 9 out of 10 people at risk for malaria. The report added that, the country received approximately $130 million in FY 2006 from the President's Emergency Plan for AIDS Relief (PEPFAR) and approximately $27 million for FY 2007 from the President's Malaria Initiative (PMI), and despite country commitment and donor assistance, the health status of the Tanzanian population remains one of the poorest in the region and in need of further efforts (USAID, 2007).

According to REPOA, (2011), malaria prevention, diagnosis and treatment increase with increase in the use of insecticide-treatment mosquito nets. Moreover, the country increased its efforts to address new-born deaths, which are inextricably linked to maternal healthcare, in order to ensure, the continued rapid reduction in child mortality to meet the Millennium Development Goals for child survival (REPOA, 2011).

## 2.3 Health Care Implementation in Tanzania

Health care implementation refers to the general measures taken towards prevention, treatment, and control of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions. Regards health care implementation; the

government of Tanzania plays a greater role in health services provision of which in the case of private organizations plays just one-third of all health services (MOHSW, 2003).

According to World Health Report (2007), Tanzania is still highly dependent on donor funding and its total expenditure on health and it has been stable at 4% of GDP between 1999 and 2003. The external funding accounted for a quarter (22%) of Tanzania's total health spending has been steadily increasing since 2002. In the same period, however, the external funding was less than one fifth (ranged between 16% and 18%) of total health spending for Sub-Saharan African countries and other low-income countries (USAID, 2007).

The World Health Report (2007) emphasized universal coverage in health systems through focusing on universal coverage of health care. The report further argued on declaration of the World Health Assembly for member states to aim for affordable universal coverage and health accessibility for all citizens on the basis of equity and solidarity. In 1999, the Ministry of Health of Tanzania approved the National Health Insurance Fund Act, which establishes a compulsory social health insurance scheme for formal sector employees. This fund currently covers 3% of the population. However, Community Health Funds (CHF) established in 2001, bring community-based insurance to 48 districts, mostly in rural areas. Churches, informal sector groups, cooperatives, and mutual health organizations run micro insurance schemes for those employed in the informal sector. Although in fulfilling this goal, the private health insurance is limited, but available for those who choose to pay (USAID, 2007).

In the past decade, Tanzania has introduced mandatory health-insurance schemes for formal-sector employees, offering comprehensive health-care benefits to their members, the largest being the National Health Insurance Fund covering civil servants. However, the National Social Security Fund (for private formal-sector employees) has also introduced a Social Health Insurance Benefit (Ataguba *et al*., 2012). Moreover, despite the introduction of various funds for helping in health challenges; the Tanzania's government in 2003 spent almost 13% of its total expenditures on health, a higher percentage than other countries in Sub-Saharan Africa and in the low income group (9.0% and 8.7%, respectively).

Borghi et al,(2013), writes, in Tanzania there is two largest health insurance schemes, National Health Insurance Fund (NHIF), which is a compulsory scheme offering comprehensive benefits to the formal sector, and the Community Health Fund (CHF), which is a voluntary scheme for the informal sector in rural areas where it offers limited benefits in public lower level facilities (Borghi *et al*., 2013). However, authors pointed that, apart from having these health schemes as a government health intervention strategies, its improvement remain fragmented and the coverage still low. Along the same lines, more than half (55%) of total health spending is public, which is close to the average 50% in Sub-Saharan Africa and more than the average 46% in other low-income countries (USAID, 2007) .

## 2.4 Catastrophic Payments in Health Care

Catastrophic health expenditure is defined in relation to the households' capacity to pay (World Health Organization, 2007). It has been considered as a health spending when a household reduces its basic expenses over a certain period of time in order to cope with the medical bills of one or more of its members. In the views by WHO; health expenditure is called 'catastrophic' whenever it is greater than or equal to 40% of the capacity to pay. However, catastrophic payments is described as the expenditure exceeding 40 percent of effective income(Evans et al. 2003).

A study conducted in Thailand on equity in health-care payments, revealed that, uninsured people and those covered by the low-income card (LIC) scheme faced high out of pocket payments (4.6% and 6.1% of their income respectively), whereas Civil Servant Medical Benefit Scheme and Social Security Scheme members spent only 1.7% and 0.6%, respectively, of their income on health. The study further revealed that, households using inpatient services, especially private and public hospitals outside the respondent's home province, had a higher incidence of catastrophic expenditure and impoverishment from health payments ( Viroj *et al*., 2007).

In the views of Peter et al; the poorer the country, the larger the amount of total health spending that is out of pocket. According to these authors, the average spending is more than 60% of the mean spending on health care in low-income countries accounts out-of-pocket payments,

compared with about 20% in high-income countries. Out-of-pocket payments for health care are usually the most inequitable type of financing because they tend to hit the poor the hardest by being a barrier to health care or by denying individuals financial protection from catastrophic illness (Garg *et al*., 2008).

Furthermore, ( Ataguba *et al*. 2012), in their study on equity in financing and use of health care in Ghana, South Africa and Tanzania, find that, in Tanzania the proportion of the population incurring catastrophic payments to health care is 1.52%, Ghana 2.43% and 0.09% in South Africa. The report was further showing that, this catastrophic payment affects poor households in particular Tanzania, where 137 000 people which is equal to 0·37% of the population was pushed into poverty through catastrophic payments.

According to (Ataguba *et al*. 2012), the low level of coverage by insurance schemes, out-of-pocket payments remain a major share of health-care funding in Tanzania. In comparison to health spending and GDP, the study revealed that, Tanzania has a per-person GDP of $1358, and total health-care expenditure is 5·1% of GDP; of which household out-of-pocket expenditures in Tanzania constitute four fifths (81%) of private health expenditures, similar to other countries in Sub-Saharan Africa and in the low-income group (81% and 85%, respectively). According to Tanzania's 2000 National Health Accounts (NHA), households contribute almost half (47%) of total health expenditures; almost three quarters (72%) of out-of-pocket expenditures in health were spent on services from public providers where 13% and 15% were spent on services from private for profit and not-for-profit providers, respectively (USAID, 2007).

World Health Organization, explains that, other countries, such as Zambia, households face not only geographical health services accessibility but also financial barriers to health service use because they are confronted with excessive fees and other large out-of-pocket payments (World Health Organization 2007). The study on health policy and planning by Perkins *et al*. (2009) revealed that, out-of-pocket medical costs for normal delivery increased at all types of facilities in Tanzania (Perkins *et al*., 2009). Moreover, out-of-pocket payments for delivery are a barrier to the use of health facilities.

## 2.5 The Concept of Microfinance.

Microfinance concept has been defined differently by different people. In view of (Babajide, 2011), microfinance is a full range of financial oriented services that low income people use to earn credits, saving and money. Microfinance institutions have the role of providing financial services to the poorer sections of the population such as provisions of small loans to entrepreneurs to initiate their small enterprises The primary objective of microfinance programs is poverty alleviation, operating under the assumption that certain groups in the population lack access to reliable financial resources and/or services that could enable them to improve their own and their families' living standards (Wolfensohn ,2000). However, the most common type of intervention is probably microcredit, in which organizations offer very small loans to a borrower, usually a woman, to help her grow her small-scale business or start a new one.

In regard to this, microfinance involves the provision of small loans to the poorest socioeconomic strata for the purpose of improving earning capacity and standard of living. It gives awareness to the origin of concept as was invented in 1976, in Bangladesh with the establishment of Mohamed Yunus' Grameen Bank. However, he recognised that lack of credit was the major obstacle preventing development of the poor, who had been largely excluded from formal banking institutions. Microfinance is emerging as a highly promising tool in the fight against poverty (Galenson, 2012).

## 2.6 Microfinance in Health and Health care

Microfinance, the provision of small loans to groups of people for the purpose of investing in self-employment programs, has proved to be an effective and powerful tool for poverty reduction and improved welfare of the people (Saha, 2011). In addition, MFIs are capable of contributing to health improvement by increasing knowledge that leads to behavioural changes, and by enhancing access to health services through addressing financial, geographic and other barriers (Leatherman *et al.*, 2012).

Moreover, small loans that have been used for income generation are potential for reducing poverty and social benefits including better health. It also help individuals cope with unemployment caused by illness and forestall their need to sell off valuable assets (Hargreaves *et*

*al*., 2007). For instance, by the end of 2005, more than 3000 MFIs were providing services to 113 million clients, 84% of whom were women (Hargreaves *et al*., 2007).

Microfinance institutions (MFIs) as well as non-government organizations (NGOs) with a strong microfinance component, are increasingly recognized for their capacity to provide effective and sustainable programs to reduce poverty and associated vulnerabilities such as food insecurity among the world's poorest people (Leatherman *et al.*, 2012).

A freedom from hunger report, identified four areas of microfinance health related services and these four broad categories are; health education, health finance, linkages to health provider and access to health products (Crookston *et al*., 2009). These four categories of variables, account for most of the health related services provided by Microfinance Institutions. Microfinance institutions have adopted a strategy of offering health-related programs, including health-related education (including nutrition and sanitation), health care financing (such as health loans or savings accounts), training community health workers, direct delivery of clinical services, and health micro insurance services (Leatherman *et al.*, 2012).

Studies conducted by Metcalfe *et al.* (2012) on microfinance services providers' show that health education contributes positively to health care. However, the component of health education alone, usually delivered during the routine microfinance group meetings improves knowledge that leads to behavioural change(Leatherman et al, 2012). These behaviours are associated with positive health outcomes that are critically important for improving the health status of the poor and for achieving the Millennium Development Goals in areas such as maternal and child health.

Moreover, MFIs can effectively contribute to community and national malaria initiatives by increasing knowledge of malaria prevention and treatment, leading to the use of increased insecticide treated net ownership and the use of it by vulnerable members of the household (children under the age of five and pregnant women) (Crookston et al, 2009). In respect to Uganda, 32% of women receiving education about HIV/AIDS prevention through their microcredit groups tried at least one HIV/AIDS prevention practice, compared to 18% of non-clients (Gaile et al, 2001).

However, studies on credit with education carried by CRECER in Bolivia on implemented nutritional education alongside microfinance showed that, participants of the microfinance purchased more foods in bulk and were more likely than residents in control communities to have spent money on medical costs (MkNelly Barbara and Christopher, 1999). In addition, in Ghana CRECER implemented microfinance alongside malaria awareness education. In view of CRECER, the products by MFIs was not the provision of medication and treated nets but rather the provision of related malaria control education and awareness raising to their targeted population that is clients (MkNelly Barbara and Christopher, 1999).

In the views of Gilson *et al.* (2007), proposed microfinance as one-way of providing some financial protection against illness because through microfinance, clients can increase their savings and their number of income sources (Gilson *et al.*, 2007). In Indonesia, microfinance was shown to play an important role in helping families cope with the costs of medical care and loss of income caused by major health shocks (Levine *et al*., 2009). In Mali, microfinance clients showed increased household ability to deal with periods of crisis and economic difficulty, and established clients were less likely than incoming clients to report periods of acute food insecurity (Dunford and Denman, 2001).

Empowerment has an important influence on the demand and use of health services by women and adoption of positive health-related behaviour changes. (Bentley ME and Griffiths, 2003) showed that greater self-confidence was linked to breastfeeding, introducing weaning foods, and making changes in health practice.

## 2.7 Conclusions

Increasing empowerment of women through microfinance programs is believed to have a positive influence on health of those who are involved in micro finance programmes, particularly in terms of promoting good health-seeking behaviour. Therefore, it is the question of this research finding, that, the established facts will help to clear this doubt, that the participation of microfinance in supports health care services contribute to women health condition improvement.

## 2.8 Study Expectations

To come up with compliance of objectives, the following study expectations were developed:

1. Client's membership to Community Health Fund (CHF) is positively related to education, age and marital status.

2. Views on necessity of incorporating health related loan products is negative related to health cost paid direct for accessing health services.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1 Overview

Chapter Three describes the methodological aspects of this study. The remaining portion of this Chapter is divided into six main sections. The second section presents data needs and sources. This is followed by sampling procedures, data collection instruments and operationalization of field work in five sections. Section six explains data processing and analysis.

## 3.2 Data Needs and Sources

Data for the study were obtained from primary sources during a field survey carried out between January 2014 and 5$^{th}$ March 2014. Mostly, data related to characteristics of respondents and performed entrepreneurial activities were collected by single visit interview (cross-sectional survey) to target sample respondents and key informants (focus groups such as manager, government officials) in order to achieve the objectives of the study.

## 3.3 Sampling

A purposive sampling technique was used in selection of the surveyed wards. The criteria employed were the accessibility of the area, easily networking and communication to the prospective respondents. In order to obtain sample population, the first stage, involved was to listing wards/areas that Vision Fund is operating together with respective groups. Random selection approaches of the respective individual respondents (Table 3.3.1) were applied including physically visited during data gathering exercise.

However, selection of administrative areas (wards and surveyed areas) was done during the first week of research work for the purpose of providing enough time to get prepared for the research work.

Groups involved in the discussion were purposefully selected, based on the criteria that, they have been benefitted from MFIs services for more than a year, and these groups were eleven (11) (Table 3.3.1). In Manundu Ward, four (4) groups were selected where three (3) groups each had 10 members and one (1) had 13 members. In Kilole Ward, four (4) groups were selected where

each had 6 members. In Old Korogwe Ward, two (2) groups were selected where each had 6 members and one (1) group from Mgombezi Ward had 11 members. However, other groups were selected from Manundu Ward because many members who benefitted from MFIs services are from this ward compared to others.

**Table 3.3.2. Sample respondents by wards and groups for (FGDs)**

| S/N | Wards | Groups | Sample | Percent (%) |
|---|---|---|---|---|
| 1 | Manundu | (4) | 43 | 47.78 |
| 2 | Kilole | (4) | 24 | 26.67 |
| 3 | Old Korogwe | (2) | 12 | 13.33 |
| 4 | Mgombezi | (1) | 11 | 12.22 |
| | **Total** | **11** | **90** | **100** |

**Source**: Author (2014)

### 3.4 Data Collection Instruments

Structured questionnaires were used as tools for data collection from prospective respondents. The structured questionnaires were constructed to capture both qualitative and quantitative data, and all questionnaires were open questions. The first type of questionnaire (Appendix 1) was designed to capture information related to clients who access credit or loan services. The questionnaire was made up of six (6) main parts in which the first part was designed to obtain background information on characteristics of respondents, the second was intended to obtain loan services and perform entrepreneurial activities, the third aimed at gathering data related to health improvement, fourth part is the need of integration of health product, fifth part is social services and the last part was designed to obtain information on challenges faced by entrepreneurs in performing their activities.

The second type of questionnaire (Appendix 2) was designed for manager of microfinance providing services. It is also made up of two main parts. The first part was intended to obtain general information of manager, and the second was designed to capture information related to loan services provided. The third type of questionnaire (Appendix 3) was designed for focus group discussion. In this respect, a list of guiding questions was designed and used during focus

group discussion and this was made purposely to gather the qualitative information. Direct observation technique was also employed to evaluate the status of the surveyed sample respondents as well as physically assess type of entrepreneurial activities performed. It was also used to evaluate differences in physical settlements and status, health conditions and environmental context of the surveyed sample respondents.

## 3.5 Operationalization of the Fieldwork

The field work was conducted from 17th January to 5th March 2014. The operationalization of the work involved questionnaires interviews and discussions with key informants including government officials. The 90 interviews and 2 group discussions were carried out by the researcher. Prior to the day of starting interviews, the researcher visited 4 wards, district council offices to inform the relevant authorities about the purpose of the study. Individual household heads and/or functional heads were interviewed in their homes or business places. Appointments were made at least one day before the interview date. The objectives of the study were explained to each respondent prior to interviews in order to create good understanding between interviewers and interviewees. Respondents were interviewed once and their responses were recorded immediately.

To overcome language barrier, the interviews was conducted in Kiswahili after the researcher had interpreted the questionnaires' language (English) to fit the need of prospective clients. Both English and Kiswahili languages were used to managers and government officials. Besides questionnaires, informal discussions guided by checklists were held with government officials and focus group discussion. Two assistant persons were involved during data gathering since time was limited to accomplish all things at once.

## 3.6 Data Processing and Analysis

### 3.6.1 Data processing

Data was coded and entered into the Statistical Package for Social Sciences (SPSS) for windows versions 20 cleaned by running frequencies of individual variables and later analysed.

### 3.6.2 Data analysis

A substantial part of the analysis was based on descriptive statistics such as frequencies and some cross-tabulations as well as logistic regression. These statistics were used to assess respondents' characteristics, assessing the extent of microfinance institutions implementation of health care service, examining the needs of microfinance institutions in supporting health care services, analysing challenges encountered by microfinance providing services and women entrepreneurs in the management and operationalization of their entrepreneurial activities as well as checking for relations among variables. Logistic regression analysis was used to assess the relationship between ages, education, and marital status to community Health Fund.

# CHAPTER FOUR

# RESULTS

## 4.1 Introduction

This chapter present results of the carried out research study on contribution of Microfinance Institutions in improving health and health care to women entrepreneurs. However, this chapter description is divided into three main sections. The first section presents findings of the focus groups discussions; the second section presents managers' responses; and the third section presents findings of the surveyed sample respondents. However, section three is further divided into two sub-sections. The first sub-section presents characteristics of the surveyed sample respondents; where information on duration in accessing loan services, loan types provided, preference and reason for loan selection, performed activities, accrued benefits and employment is presented in sub-section two. Major findings namely microfinance institution health support (health service support status and impact of MFIs operations), MFIs operation and need to health support (necessity on incorporating health related loan product, reasons for payment of health services, membership to health insurance funds) and finally challenges and its effect on loan repayment, business operation as well as options in handling health issues are presented in sub-section three.

## 4.2 Focus Group Discussion

The focus group discussion (FGD) is a semi-structured data gathering method in which purposively selected set of participants gather to discuss issues and concerns based on a list of key themes drawn up by the researcher/facilitator (Loice, 2013). In view of this research, key themes discussed during FGs are described as; incorporation of health related loan products such as health insurance, health education, and earned tangible benefits. Improvement in loan services provision, and skills development with a focus on business and entrepreneurship skills have been discussed.

In facilitating discussion of these thematic areas, the selection of FGs participants was done after establishing a list of individuals who access loan services at Vision Fund Korogwe. The researcher had used the list to communicate to individual client(s) requesting them to participate in the FGDs which was scheduled one week later. However, it was finally done after 21 individuals had agreed to appear for the discussion. Arrangement towards conduction of FGDs was performed after participants were being grouped in two groups; where one group had 10 and other 11 participants. Each group was assigned its own schedule for discussion and thereafter each group members was invited to appear for the focus group discussion. However, the results of their group discussions collected during field survey in each respective research thematic area is presented as follows.

### 4.2.1 Incorporation of health related loan products

The concept of incorporating health related loan products was firstly introduced among FG participants. The purpose was to create a common understanding to the concept before starting the discussion. However, the understanding drawn among participants on the concept of health related product was learned to be any practices of MFIs done with the intention of offering monetary services in the form of loan or health insurances to increase their direct access to health and medical services. Moreover, discussion of this thematic area resulted in the following groups' views:

> ''Utoaji mikopo huongeza/kusaidia upatikanaji wa huduma za afya hivyo kuwafanya walio wengi kupenda kujiunga na huduma hizi'' its translation ''incorporating health related loan products will increase improvement in health services accessibility thus, promote many individuals feel willingly to join the microfinance services...''. This particular group observation was supported by the view of one participant from Manundu Ward, who said that;

> *''kama utakuwepo utaratibu huo wa kuingiza suala la huduma za afya kama vile elimu ya afya, bima za afya kwa sisi ambao hatuna njia nyingine ya matibabu zitatunufaisha sana, tutakuwa kama wenzetu wanaofanyakazi serikalini'' Translation ''It will be worth paying if health related services/products (such as health education, health insurance services) are incorporated because some of us we don't have any means of being insured, therefore if*

*introduced we will be like government employees who are directly insured through their monthly pay/salary''.*

However, many participants showed similar feelings commenting to MFIs that, although it is in their capacity through their regulation to decide whether to incorporate the health services or not but it will be good and wise decision if MFIs consider health issue in their services like health insurances or health education. The related groups' observation is to see one day everybody in the community is insured, the thing which will help to reduced health cost related challenges.

In supporting this view, another participant from Ngombezi had this to say;

*"usituone hapa baba huwa tunaomba Mungu tusiumwe kwani hua ukiumwa au hata mtoto akiumwa unawaza rejesho tu lakini kama wataweka vitu kama hizo bima za afya zitasaidia sana" Translation, " don't see us here, we always pray to God that's we don't fall sick because when you get sick or your child get sick you will double think on repayment and attending the sick one, but if we get health insurance it will be helpful''.*

This view showed that health service is a challenge which touched every participant in the group discussion. In their support, all participants have shown their concern and wishes if health related services such as health insurances be part of MFIs services.

The question of handling lives hardship was also emerged during these groups' discussions; the view was that, availability of insured health services by MFIs will at least reduce direct costs that one will incur for health services; hence being able to meet other family needs. In the sense that the income and profit gained /generated from the entrepreneurship, can be used to manage other family needs instead of being used to cover other costs like health cost which is currently paid direct through their pockets. Paying direct from the pocket reduce ones cash holding hence reduce his/her capacity to meet households needs and requirements.

In supporting this view, one participant from Manundu Ward said that;

*''kwa kweli gharama za huduma za afya zinaongezeka siku hadi siku na hivyo kuchangia kuleta ugumu wa maisha kwani mtu ukiwa mgonjwa huna mbadala zaidi ya kulipia gharama za*

*huduma za afya'' its translation ''health costs increases daily that's fuel into life hardship as once one is sick would not have any option from these escalating costs but rather to pay for.*

In this view, the learnt observation is that; provision of health related loan product like health insurance by MFIs will have a direct consequence to reduction of health costs and increase capacity of the family to meet other needs and obligations.

Additionally, it was revealed during focus group discussions that; few participants have joined the health scheme (CHF), and in explaining this, one participant from Manundu Ward explained that;

*''people sometimes are being mobilized to CHF but failed to join because of its subsequently benefits. In giving this view more support, a participant from Old Korogwe ward had this to say; ''si kwamba wakati mwingine hatupendi kujiunga na mifuko ya afya ya jamii lakini ukweli ni kwamba faida zake nichache na matibabu yake ni kwa magonjwa madogo tu hivyo ukipatwa na ugonjwa mkumbwa haina kazi wala haikusaidii katika rufaa kwenye hospitali kubwa hivyo unakuwa mvivu kujiunga hata kama unahamasishwa''. Translation ''we are not dislike to join CHF, the thing so hated is the limited in services provision to small health cases and issues become so challenging when you get referral cases, you will be required to meet health costs at the referral facilities, thing which discourage us to join CHF''.*

Another participant from Kilole Ward said that;

*''huu mfuko hausaidii sana pamoja na kwamba serikali inania nzuri ya kutusaidia lakini isingeweka mpaka kwenye huduma kama kweli inalenga kutusaidia watu wa chini ambao maisha yetu ni magumu na mara nyingi wanaume wetu maisha yao na vipato vyao ni vidogo'''*.(translation)*''CHF is not helpful bearing the government good intention to support us (poor people); yet the challenge remains in insuring us freely access to health services provision; ''remember our husbands income is small, thus limiting health service affordability*".

Furthermore, it was observed that, women members related their husbands' income and ability to afford health cost as majority joined MFIs to help their husbands in rising family income to afford various family needs includes health issues. They claimed that, husbands' income is small as compared to daily family responsibilities. Therefore, the

challenge is that apart from being initiated to support the cost sharing but still is limited in insuring health cost for poor people even at the referral health facilities.

In supporting this view; a participant who is a retired community development officer from Old Korogwe Ward said that;

*''hakuna asiye jua ya kwamba kwasasa maisha ni magumu ni vema wajasiriamali wajiunge na mifuko ambayo inatoa zao la afya kama bima kwani hivi sasa mfuko kama huu wa afya ya jamii ni wa kisiasa sana'' Translation ''everybody knows that life is so challenging nowadays; is better for entrepreneurs to join MFIs that offers health related loan products like insurances because the said CHF is seems to be none effective in helping people especially poor individuals''*

Majority participants shows a similar feelings; commenting that life is so challenging CHF has to change the way it offers services because most of its beneficiaries are poor people.

All in all, during focus group discussions majority participants appreciated and acknowledged the good intention/plan of the government for initiated CHF, the challenge is limited services provided to people, hence making health issue a challenge and their general observation is to see MFIs initiate or includes health related service as part of their products. However, they insisted on reformation of CHF or checking on its performance for improved health services provision.

### 4.2.2 Earned tangible benefits

In discussing this thematic area, group members were asked to mention tangible benefits that the studied MFI has contributed. This was done with the intention to examine the extent to which microfinance services have contributed to this aspect. However, learning from the group discussions were as follows:

*''faida tulizopata ni kuweza kusomesha watoto; kuweza kupanua mtaji/wigo wa biashara zetu, kuboresha makazi/nyumba zetu na kuweza kuajiri watu katika shughuli zetu za kilimo'' Its translation ''we have increased our capacity to pay for school fees of our children, procured home facilities, increased our capital for our business, renovated our settlements, performed agriculture farming (hiring of labor for land cultivation, planting, wedding and harvesting), and far most, some of us were able to construct new houses.*

In supporting this view, a participant group from Kilole Ward said that;

*''nazishukuru sana taasisi hizi jamani za mikopo kwani ingekuwa hazipo sijui ingekuwaje binafsi nimejenga kibanda kwa kwekeza faida yangu'' Translation'' I highly appreciate the presence of this MFI if would not existed, I do not know the situation I could have been today; myself I have managed to build my small house because of their loan facilities''.*

Moreover, group participants extended their appreciation by acknowledging that; MFIs has improved their lives in their families. For example, one participant from Ngombezi ward has this to say,

*''Sisi katika kikundi chetu wote ni wajane kasoro mmoja lakini tangu tumeanza mikopo maisha yameboreka na tunasomesha watoto hii yote ni shauri ya mikopo hii''. Translation' ''in our group all are widow women except one but since we joined MFIs our lives have improved tremendously and we are supporting our school going children''.*

Indeed, all participants seemed to have gone the similar experience on MFIs performance when showing that MFIs services have a positive influence on their lives. Mostly, the group participants were commented that, due to life hardship it was difficult to find someone in our communities lending you money and in some circumstances even you're nearer friends or relatives my fail to support your request. Therefore, MFIs in particular has offset this challenge that, today we're capable of meeting these challenges. .

### 4.2.3 Microcredit service improvement

Improved services by MFIs influence efficiency in work performance. In examine this, groups members were asked to describe how effective was the microfinance service offered to them, and in Old Korogwe Ward, a focus group discussion participants explained that,

*''kanuni na utaratibu wa mikopo na urejeshaji wake zimeendelea kuboreshwa ... angalizo ni kuona uwezekano wa kupunguza asilimia ya mikopo kuwa chini ya iliyopo sasa''. Its translation: ''rule and regulations governing issues of credit facilities and payment were reviewed regularly for improvement ... however, observation was to at least to go down to the current charged interest rate for each loan taken''.*

In supporting this observation, many participants explained that, "*pamoja na uboreshwaji huo ni vema kwa sasa hata riba ikapungua kidogo sio mbaya kwani itasaidia kwa kiasi chake kwa hii ya sasa ya 3% kwa mwezi kwa muda wa miezi sita ni kama 18% kwa kikundi bado ni kubwa na inategemea kama na biashara imelipa kama haijalipa bado inaweza kuwa shida katika kurejesha*". Translation, *it's true there are some improvements on services provisions but despite such improvement interest rate of 3% charged monthly for each taken loan which is 18% for a period of six months is huge interest rate for an individual to manage, because not always our business are doing well; there are ups and downs. Therefore recommendation was made those MFIs to see the possibility of reducing this rate*''.

However, it was observed from the discussion that services delivery has generally improved and one participant from Kilole ward had insisted that;

> *''ninaona kwasasa kama wameanza kujitahidi kuboresha huduma zao za mikopo kulinganisha na hapo mwanzo na kiukweli inatia matumaini na tunahamasika kama wajasiriamali'' Translation'' I see MFIs have currently started to improve their services compare to previous period; it is a new hope for entrepreneurs''*

Furthermore, it was learned from group discussion that (quoted from participants) ''*ujengaji uwezo katika mambo ya ujasiliamali ni vyema uwepo kwani mafunzo yatolewayo tu kuhusu usimamiaji mikopo na urejeshaji wake hayatoshi na utaratibu huu haumjengi mkopaji kufanya biashara yake kijasiliamali''*. Its translation ''*let there be regular entrepreneurship skills development trainings than merely insisting on loan management (expenditure and repayment), these trainings do not impart entrepreneurial management skills in business operation*. In supporting this view, one participant from Mgombezi Ward said that;

> *''Jamani tunaeleweshwa vizuri kwa sasa kusema ukweli lakini elimu iongezwe zaidi kadiri iwezekanavyo tuvuke hapa tulipo maana tusipoelimishwa mara kwa mara tutajisahau katika kuendesha biashara zetu, na elimu isiwe hii tu hata ya afya ikiwezekana iongezwe kwani sisi ni wakina mama'' Translation'' in reality, we have been educated more on issues of loan management and administration (mechanism to avoid loan defaults), but it is more worth this education package to consider health issues whenever necessary be provided''*

In that regard, majority participants responded positively by saying, health education is another important aspect, that MFIs should consider in their services. Majority were on the view that, incorporating this kind of education will help in widen up their understanding on health issues (hygiene and environmental issues). The question of meeting regularly was learnt that, group members were not used to meet regularly but through MFIs, they automatically have been granted an opportunity to meet and discuss pertinent issues of their health.

### 4.2.4 Skills development

Business skills development is another thematic area and of importance which is given consideration in micro-financing operations. This is because, the prosperity and sustainability in loan rendering business is determined by good management skills and practices to those who receive loan services. The acquired skills (managerial tools) influences loan repayment since a client who benefitted from the loan is confident in her business performance. In assessing practice of this aspect, members were asked to describe types of skill development packages they have been offered and responded as follows;

> *''tumekuwa tukipewa mafunzo yaliyolenga utumiaji na urejeshaji mikopo ... ujengaji uwezo kwenye mbinu mbalimbali za ujasiliamali katika biashara haujafanyika jambo tunaloona ni changamoto kwetu''.(Its translation): ''skill development training had focus on loan management ... there is a need that these trainings concentrate also in the area of entrepreneurial capacity building kind of training, this is a challenging area we face''.*

This observation support the reality that management of entrepreneurship activities in today's' world of business requires individuals who are well equipped with business skills which build them to be more competitive in the markets. Addition to the point, one participant from Kilole Ward who said that;

> *''tukiwezeshwa jamani kwa kupewa mafunzo vizuri tutajiamini na tutafanya vizuri katika biashara zetu kwa ujumla'' If we well empowered through good entrepreneurship trainings, we can do confidently in our business management''*

### 4.2.5 Conclusions

In view of all discussions in all thematic areas, all FGDs have emphasized mainly on: the need to incorporate health related loan products since will increase improvement in health services, as would promote many individuals feel willingly to join the microfinance services and foremost get directly insured, and lives hardship will be eased in the sense that availability of insured health services will reduce the direct costs that one is incurring (thus more directly costs payment be reduced) hence being in a position to meet rising family needs and other obligations.

Additionally, it was learnt that; is not like group member do not like to join CHF, issue is failure in provision of the anticipated health services at the lower level of health facilities and it was learnt further that, issues become so challenging when health cases advanced to the referral health facilities. However, the learning is that, majority appreciate the government intention but yet is challenged with limited provision of health services to its people. In giving more strength, observation was made that, life is so challenging; the best way is for entrepreneurs to join MFIs if sought to offer health related loan products like insurances because community health fund (CHF) is not effective in helping people. This observation however, was reported during the survey, where majority respondents reported to have paid health costs apart from being CHF members. Their concern is still that, being a member in CHF does not guarantee them free health costs payment during accessing health services (Table 4.6.2.5.1) in any health facilities located or available within and outside their localities.

In discussing tangible benefits it was learned however, that increased capacity to payment of school fees was seen to be one of potential benefits. Other benefits are procurement of home facilities, increased business capital, renovated settlements, performed agriculture farming (hiring of labour for land cultivation, planting, wedding and harvesting), and some managed to construct new houses.

In the question of improvement in micro-credit services, rule and regulations governing issues of credit facilities and payment were reviewed for improvement, however, observation was made that the currently charged interest rate to at least go down but otherwise loan services improvement was seen to be a new hope for entrepreneurs. In this thematic area of discussion, it was learnt however that, regular entrepreneurship skills development is highly required since it

will impart entrepreneurial skills and experience in business operations. Another area of emphasis was provision of health education whenever seemed necessary to do so; all in all this practice will increase confidence in business management administration.

**Figure 4.3.4.1: Loan borrowers in one of training sessions in Manundu.**

## 4.3 Managers' Responses

### 4.3.1 Microfinance operation experience

The study revealed that, Vision Fund (formally named SEDA) has been in microfinance operation for not less than 16 years. Therefore, this is a good duration in assessing the performance of the institution.

### 4.3.2 Loan types and assessment criteria

In a discussion with the Vision Fund manager, with a focus to assess the work of the Vision Fund in microfinance service provision, it was learned that four products; namely Kitita product, Premium product, Jiendeleze product and lastly Biashara product are provided, where each product is limited in term of loan amount that, a client can sought to acquire.

Kitita and Premium products were both classified as individual loan and each loan funds disbursed to clients has a limit. For instance, Kitita product loan amount ranges from Tshs.1million to Tshs.10 million, while Premium product has a loan amount above Tshs.10.1 million. A group loan category is classified into two products namely Jiendeleze and Biashara. Each loan category differs in terms of group member as well as amount of loan disbursed to them. Jiendeleze product has membership ranging of 3 to 5 members and the loan amount disbursed to them is ranging from Tshs.500,000/= to Tshs.5 million, the Biashara product comprised 6 to 25 members and the loan amount disbursed to them is ranging from Tshs. 50,000/= to Tshs. 5 million. Mostly, loan preferred by women is Biashara where each group member has access to loan ranging from Tshs. 50,000 to 400,000 in the first loan cycle.

During an intensive interview with the Vision Fund Manager on eligibility of their client(s) the following criteria were identified: A clients should have a running business aging at least 6 months; a client should age between 18 to 65 years; should be a Tanzanian; should have legal businesses which conform to the set regulations; should be well known by his/her local leaders; and lastly but not least should be ready to guarantee all members in a group for the case of group loan.

**Figure 4.3.2.1. Women in group repaying their loan as observed in Kilole.**

### 4.3.3 Challenges in business operation and observation on provision of health related loan product

In business, operation challenges are unavoidable where their occurrence may positively or negatively influence the institutional performance which is also subject to control measures which are subject to be taken regularly by the institution in question. During an intensive interview with the Vision Fund Manager, two predominant challenges were identified which were described as: existence of un-faithfully clients and failure to pay back their loans. The question here was learnt to some clients give wrong information as were supposed to do so, other may fall short to the set regulations, rules and procedures on loan reimbursement requirements.

On the question of policy emphasis on issues of provision of health related (any practices of MFIs done with the intention of availing monetary services in the form of loan to increase direct

access to health and medical services) loan product it was observed to be not on the priorities of the institution. However, there was some observation that it will be of significance if health related products being considered; the challenge is how this policy initiative will be practiced by micro-financing service providing institutions like Vision Fund.

### 4.3.4 Clients' skill development and its contribution

In view of skills development it was learnt that, the capacity building trainings conducted were mainly focused on issues of loan management. These trainings were facilitated in every loan cycle (refers to period of completion of the first loan to the subsequent loan). Apart from skills development, other packages offered were described as provision of good customer care services; technological (use of well IT networked facilities) improvement; clients serviced by dedicated and committed staffs and provision of loan types which match the clients' expectations.

Besides the above learning; the Manager was requested to respond on the issue that, if the country policy happens to direct MFIs to administer health loan (any practices of MFIs done with the intention of availing monetary services in the form of loan to increase direct access to health and medical services) related products; the observation was that; provision of quality health services would be challenging, since the existing health infrastructures and facilities is still limited and likewise, supporting implementation of this policy requirement by MFIs will not favor their modalities hence remain to be a new challenge.

## 4.4 Characteristics of Sample Respondents (Survey responses)

This section of the analysis entails major sub-units of discussion namely; age groups of the surveyed sample respondent(s), roles in their families, level of their education, marital status as well as members that constitute the household. In order, to have an in-depth analysis of each respective unit, description of results is presented in Table 4.4.1.

**Table 4.4.1. Background information of respondents**

| S/N | Unit of Enquiry | Responses (percentage) |
|---|---|---|
| 1 | **Respondents age groups** | |
| | 21 – 30 | 24(26.7) |
| | 31 – 40 | 35(38.9) |
| | 41 – 50 | 23(25.6) |
| | 51 – 60 | 8(8.9) |
| | **Total** | **90(100)** |
| 2 | **Roles** | |
| | House Wife | 59(65.6) |
| | Head of Household | 28(31.1) |
| | None of the above | 3(3.3) |
| | **Total** | **90(100)** |
| 3 | **Education Levels** | |
| | Primary education | 60(66.7) |
| | Secondary education | 29(32.2) |
| | College education | 1(1.1) |
| | **Total** | **90(100)** |
| 4 | **Marital Status** | |
| | Single | 22(24.4) |
| | Married | 59(65.6) |
| | Divorced | 3(3.3) |
| | Widow | 5(5.6) |
| | Separated | 1(1.1) |
| | **Total** | **90(100)** |

***Note:*** *Figures in the bracket represent percentage of respondents*

On the age of respondents, the study found that most of the respondents (39%) fall within the age group of 31 – 40 years old followed by the age group of 21 – 30 which account 27%. The age groups between 41 – 50 years old account for 26% while a small proportion (9%) of sample respondents was above 51 years.

The role of respondents was examined during the survey. However, the study revealed that, the housewife role was performed by the majority women who accounted 66 percent, followed by 31 percent who reported to be head of the households.

The study sought to establish different education level performed by respondents. The findings showed that, majority of respondents (67%) were less educated and completed primary education followed by small proportion of respondents (32%) who had attained secondary education (Table 4.4.1).

During the survey, respondents were asked to state their marital status as shown in Table 4.4.1: In respect of their marital status, the study revealed that most of respondents (66%) were married, 24% single and 6 percent widowed. In addition, the results reveals that a small proportion of the surveyed respondents (3%) were divorced.

The results presented in Tables 4.4.2.1 show the composition of family members of the respondents. The observed numbers 1, 2, 3, 4, 5 and 6 represent the composition of family members forming the household, whereby A indicates number of female family members per age group and B indicating male family members per age group. Generally, number 1 has featured the overall leading response followed by number 2 which emerged second in all age group categories.

**Table 4.4.2.1. Family members' composition**

| Number of dependents | Response per age group | | | | |
|---|---|---|---|---|---|
| | **0 -5** | **6 - 10** | **11 - 15** | **16 – 20** | **21 above** |
| **A: Number of female family members per age group** | | | | | |
| 1 | 15 (16.7) | 27(30) | 18(20) | 26(28.9) | 10(11.1) |
| 2 | - | 5(5.6) | 2(2.2) | | 8(8.9 |
| 3 | - | 1(1.1) | 1(1.1) | 2(2.2) | 4(4.4) |
| 4 | - | - | 1(1.1) | - | 1(1.1) |
| 5 | - | - | - | - | 1(1.1) |
| **B: Number of male family members per age group** | | | | | |
| 1 | 19(21.1) | 11(12.2) | 15(16.7) | 15(16.7) | 16(17.8) |
| 2 | 1(1.1) | 2(2.2) | 3(3.3) | 6(6.7) | 5(5.6) |
| 3 | - | - | 1(1.1) | - | - |
| 4 | - | - | - | - | 1(1.1) |
| 6 | - | - | - | - | 1(1.1) |

***Note:*** *Figure in the bracket represents percentage response per age group which computed out of 90 surveyed sample respondents.*

## 4.5 General Findings

### 4.5.1 Duration spent in accessing loan services

Any economic performance is significantly evidenced by time spent in performing that particular economic activity. In view of the current research, the interest in finding out time spent by sample respondents in accessing loan services was crucial as it help to examine the specific duration inclined to individual(s) respondents from the time when started accessing MFI's services. However, the maximum duration in loan accessibility was observed to be 12 years, whereby 85.6 percent of the respondents had spent 3-6 years, 8.9% spent 7–9 years (Table 4.5.1.1).

**Table 4.5.1.1. Time experienced in loan service accessibility**

| Duration in accessing loan services (Years) | Respondents | Respondents by percentage |
|---|---|---|
| 3 – 6 | 77 | 85.6 |
| 7 – 9 | 8 | 8.9 |
| 10 -12 | 5 | 5.6 |
| **Total** | **90** | **100** |

### 4.5.2 Types of loan offered by MFI and preference for selection of loan types

Women entrepreneurs who accessing loan services were asked to indicate their preference in selection of loan product types and the apparent decision to do so. The study interest was to get to know the insight of MFIs' position in issues of loan product categories made accessible to their prospective clients and the decision making criteria. The response of the respective respondents is shown in Table 4.5.2.1. However, the study revealed that, the most preferred types of loans was individual and group loan services and majority (91.1%) were opted group loan category compared to 8.9% who opted for individual loan category.

**Table 4.5.2.1. Types of Loan products**

| Response | Respondents | Percentage |
|---|---|---|
| Individual | 8 | 8.9 |
| Group | 82 | 91.1 |
| **Total** | **90** | **100** |

Similarly, women entrepreneurs were also asked to indicate reasons that supported their decision in loan service selection. It was revealed however, that; reasons influencing their choice to loan services were two (Table 4.5.2.2) described as easy accessibility of loan which accounted 67.8 percent followed by easy mobilization of group members. The reality that is reflecting these reasons is that, groups stand a collateral position to most of individuals who are seeking loan services. An individual loan type requires a lot as described in part of the discussion with the manager.

**Table .4.5.2.2. Reasons for choosing loan service**

| S/N | Reasons | Respondents | Percentage |
|---|---|---|---|
| 1 | Easily to access loan in a group | 61 | 67.8 |
| 2 | Group members are easily mobilized | 29 | 32.2 |
| | **Total** | **90** | **100** |

### 4.5.3 Entrepreneurial activities performed

In examining varied entrepreneurial activities performed; during the survey respondents were requested to mention activities they have implemented. Table 4.5.3.1 presents list of entrepreneurial activities performed by the respective sample surveyed respondents. However, the performed activities were food vending, goods selling 'retail shop', farm products selling, tailoring mart, women hair dressing saloon, glossaries/beverages selling, charcoal selling, and readymade cloth/second hand cloth selling. In a list of performed activities, selling of farm products was a leading activity which accounted 28.9%, followed food vending by 21.1%, and goods selling 'retail shopping' by 18.9%. However, women saloon services or hair dressing was number four in the list.

**Table 4.5.3.1. Entrepreneurial activities performed by the Clients**

| S/N | List of Entrepreneurial Activities | Respondents | Percentage |
|---|---|---|---|
| 1 | Food vending | 19 | 21.1 |
| 2 | Goods selling 'Retail Shop' | 17 | 18.9 |
| 3 | Farm products selling | 26 | 28.9 |
| 4 | Tailoring mart | 5 | 5.6 |
| 5 | Women saloon services | 9 | 10.0 |
| 6 | Glossaries/beverages selling | 5 | 5.6 |
| 7 | Charcoal selling | 3 | 3.3 |
| 8 | Readymade cloth/second hand cloth selling | 6 | 6.7 |
| | **Total** | **90** | **100.0** |

**Figure 4.5.3.1. An entrepreneurial woman as it was observed during field survey in Manundu.**

### 4.5.4 Accrued benefits

The accrued benefits shown in Table 4.5.4.1 reflecting the results of the performed entrepreneurial activities presented in Table 4.5.3.1. However, a list of accrued benefits include: business expansion, building of family house, sending children to better schools, payment of house rents, buying plots of land, buying cattle for farming and home facilities. Along these benefits, business expansion was accounted 30% followed by sending children to better schools (25.6%). Other mentioned accrued benefits were: building a family houses (14.4%) and buying a plot of land (11.1%). It was learned however, that; health benefit was indirectly acquired as member of the family fall sick or meet health challenges as the accrued profit is being used to buy medications or health services.

**Table 4.5.4.1. Benefits Accrued by women entrepreneurs**

| S/N | Benefits Accrued | Respondents | Percentage |
|---|---|---|---|
| 1 | Business expansion | 27 | 30.0 |
| 2 | Enabled building a house | 13 | 14.4 |
| 3 | Sending children to better schools | 23 | 25.6 |
| 4 | Enable to pay rent | 8 | 8.9 |
| 5 | Buying plots of land | 10 | 11.1 |
| 6 | Buying cattle's for farming | 1 | 1.1 |
| 7 | Buying home facilities | 8 | 8.9 |
| | **Total** | **90** | **100.0** |

## 4.6 Major Findings

### 4.6.1 Microfinance institutions and health service support

#### 4.6.1.1 Provision of health related loan products.

The successful support in health services by microfinance providing institutions is the result of the laws and guidelines put in place, this is in line with the observation made during the interviewing session with the manager. However, in view of this, the surveyed respondents were requested to show whether the operations of microfinance service providing institution consider provision of health related products or consider it as one among the lists of loan products that are made accessible to them as loan seeking individuals or rather prospective customers. It was revealed that, no provision of such loan product related to health services.

The learning was (Table 4.6.1.1) that 95 percent of surveyed respondents reported neither the institutional policies nor its usual operationalization practices works on the direction and grounds of offering opportunities for accessing health loan related product.

**Table 4.6.1.1. Provision of health loan related product**

| S/N | Reasons | Respondents | Percent |
|---|---|---|---|
| 1 | No health loan related product is being offered | 86 | 95 |
| 2 | Do not know if health related product is being offered | 4 | 5 |
| | **Total** | **90** | **100.0** |

**Note**: Health related product was learned or understood to be any practices of MFIs done with the intention of offering monetary services in the form of loan or insurances to increase direct access to health and medical services or any form of extension to enhance the health of the clients.

#### 4.6.1.2 Microfinance institutional impact to health improvement

The MFIs appeared to contribute to clients' health welfare, and from the contextual evidence of this research study, the physical benefits reported in Table 4.5.4.1 and the financial gained by individual respondents were being used and hence plays a significant position in health improvement. To concur with this result, the studies by (Leatherman *et al*., 2012), supported this finding that, MFIs are capable of contributing to health improvement by removing financial

barriers which may limiting access to health services. For example, if you have to pay for a prescription cost such as medicine, treatment and transport fee to health facilities you may not be able to afford this could be a problem.

In supporting this, majority of about 97.8 percent of the respondents had shown the importance of MFIs in household health improvement compare to 2.2% who responded that, MFIs do not contribute anything (Table 4.6.1.2). Additionally, section 4.5.4, the accrued benefits has a direct contribution to the health improvements. Nevertheless, respondents were responded further that, loan services are helpful in affording health related costs to them and their family members.

**Table 4.6.1.2. The Microfinance institutions in health improvement**

| S/N | Views on MFIs importance in health improvement | Respondents | Percent |
|---|---|---|---|
| 1 | Plays a significant role on household's health improvement | 88 | 97.8 |
| 2 | Do not play a significant role in family health improvement | 2 | 2.2 |
| | **Total** | **90** | **100.0** |

### 4.6.2 Microfinance institutional operations and needs to health support

#### 4.6.2.1 Necessity of incorporating health related loan products

All respondents were asked to show their respond on whether or otherwise of MFIs to consider provision of health related loan products in their microcredit financing schemes. However, 95.6% of the surveyed were positively responded that, would be more worth if health related product would be considered as other loan products (Table 4.6.2.1.1).

**Table 4.6.2.1.1. Necessity of incorporating health related loan products**

| S/N | Reasons | Respondents | Percent |
|---|---|---|---|
| 1 | It is important loan health related product to be considered | 86 | 95.6 |
| 2 | It is not important loan health related product to be considered | 4 | 4.4 |
| | **Total** | **90** | **100.0** |

**Note**: Health related product was learned or understood to be any practices of MFIs done with the intention of offering monetary services in the form of loan or insurances to increase direct access to health and medical services.

In supporting the above finding respondents were asked to give reason on their views on the necessity of the health product to be considered in micro-financing scheme, and the results show that 64.4% of the respondents were supportive in time of emergency against 35.6% of the minority interviewed.

**Table 4.6.2.1.2. Necessity of accessing health related loan products**

| S/N | Reasons | Respondents | Percent |
|---|---|---|---|
| 1 | It will be supportive in time of occurrence of health emergence issues. | 58 | 64.4 |
| 2 | It will be helpful in contributing to health scheme such as CHF | 32 | 35.6 |
| | **Total** | **90** | **100.0** |

In cementing these findings; all surveyed respondents were asked to give out views on none accessibility of health loan related products. Two reasons were observed as presented in Table 4.6.2.1.3 as there those who said that do not have idea (46.7%) on microfinance provision of health loan related product, and those (53.3%) who responded to be the question of MFIs policy and regulation requirement.

**Table 4.6.2.1.3. Views on, why MFIs do not make health loan related products accessible to clients**

| S/N | Views of Respondents | Respondents | Percent |
|---|---|---|---|
| 1. | Do not have idea on microfinance provision of health loan related product | 42 | 46.7 |
| 2. | It might be the microfinance policy and regulation requirement that provide a room for such product not to be accessed to clients. | 48 | 53.3 |
| | **Total** | **90** | **100.0** |

**Note**: Health related product was learned or understood to be any practices of MFIs done with the intention of offering monetary services in the form of loan or insurances to increase direct access to health and medical services or any form of extension to enhance the health of the clients.

**Figure 4.6.2.1.1. Group meeting as it was observed in Ngombezi.**

### 4.6.2.2 Institution for accessing health services

In the context of the study area, health service providing institutions were categorized in two; the public and private facilities. It is in this context, respondents were asked to indicate health facilities that they have mostly visited. The interest was to know which health facility is mostly visited and the reason accompanying their decisions (Table 4.6.2.2.1).

**Table 4.6.2.2.1. Health Facilities**

| S/N | Health Facilities | Response | Percent |
|---|---|---|---|
| 1 | Public hospital | 60 | 66.7 |
| 2 | Private hospital | 12 | 13.3 |
| 3 | Public dispensary | 7 | 7.8 |
| 4 | Public health centre | 4 | 4.4 |
| 5 | Both public and Private hospital | 7 | 7.8 |
| | **Total** | **90** | **100.0** |

However, public health facilities were accounted 66.7% compared to 13.3% of private health facilities.

Furthermore, the study was sought to investigate reasons that accompany their decision, by asking all respondents. The result in Table 4.6.2.2.2 presents five (5) major reasons which influenced decision to choose either of the two health facilities. The identified reasons were; low costs/affordability, availability of medications, good medical attendance, accessibility of health services, and accepting of health insurance card. However; low cost or affordability (50%) and availability of medications (28.9%) are the leading reasons in the public health facilities.

**Table 4.6.2.2.2. Reasons for using public and private health facilities**

| S/N | Reasons | Frequency | Percent |
|---|---|---|---|
| **A** | **Public Health Facilities** | | |
| 1 | Low cost/affordability | 45 | 50.0 |
| 2 | Availability of medications/Good services provision | 26 | 28.9 |
| 3 | Good medical attendance/good treatment | 3 | 3.3 |
| 4 | Accessibility of health services | 6 | 6.7 |
| 5 | None of the above | 10 | 11.1 |
| | **Total** | **90** | **100.0** |
| **B** | **Private Health Facilities** | | |
| 1 | Accepting insurance card | 1 | 1.1 |
| 2 | Availability of medications/Good services provision | 8 | 8.9 |
| 3 | Good medical attendance/Good treatment | 10 | 11.1 |
| 4 | Accessibility of health services | 1 | 1.1 |
| 5 | None of the above | 70 | 77.8 |
| | **Total** | **90** | **100.0** |

In the case of private health facilities (Table 4.6.2.2.2) major reasons are availability of medication (8.9%) and good medical attendance (11%).

### 4.6.2.3 Reasons for payment for health services in public and private health facilities

In view of subsection 4.6.2.2, interest was drawn to examine reasons complementing payment for health facilities. However, referring findings in section 4.6.1.1 that no health related loan products is being made accessible to the surveyed women entrepreneurs; it is an indication that, people use to access health services through normal procedures.

However, the sample surveyed respondents were asked to indicate reasons that have driven their decisions either to pay for health facilities or not. Table 4.6.2.3.1 and Table 4.6.2.3.2 present list of reasons towards the decision for payment made in both of health facilities.

In the case of public and private health facilities, four reasons were identified as: good service provision and treatment, low costs and affordability, accessibility of health services, and accepting insurance card. Low costs/affordability in public health facilities was reported by most of respondent (48.9%) and therefore learnt to be a pushing factor for the payment of health services. In addition, provision of good services in the public health facilities were also mentioned to be a reason for paying for health facilities (31.1%) followed by far by the reason accessibility which accounted for 6.7%.

**Table 4.6.2.3.1. Driving factors to public health facilities service payment**

| S/N | Description | Respondents | Percent |
|---|---|---|---|
| 1 | Good services provision and treatment | 28 | 31.1 |
| 2 | Low cost/affordability | 44 | 48.9 |
| 3 | Accessibility of services | 6 | 6.7 |
| 4 | None of the above | 12 | 13.3 |
| | **Total** | **90** | **100.0** |

The view on health services payment in private health facilities as reported by respondent were presented in Table 4.6.2.3.2. Among the listed factor; good treatment and services provided in the private health facilities were reported by most of respondents (17.8%) who opted for this type of health facility. Accepting of insurance cards and accessibility of the health services were both accounted 1.1%.

**Table 4.6.2.3.2. Driving factors to Private health facilities service payment**

| S/N | Description | Respondents | Percent |
|---|---|---|---|
| 1 | Accepting Insurance card | 1 | 1.1 |
| 2 | Good treatment and service provided | 16 | 17.8 |
| 3 | Accessibility of services | 1 | 1.1 |
| 4 | I don't know | 72 | 80.0 |
| | **Total** | **90** | **100.0** |

### 4.6.2.4 Membership to health insurance funds

In attempting to the membership status of the surveyed respondents to the health insurance funds; respondents were asked to state their membership status to the two Health Schemes namely; National Health Insurance Funds and Community Health Funds (Table 4.6.2.4.1). Findings revealed that; respondents are between NHIF and CHF (33.33% in NHIF and 11.11% in CHF) while 67.67% of surveyed respondents are not member to National Health Insurance Fund (NHIF) compared to 88.89% of respondents not member to the Community Health Fund (CHF). Moreover, an interesting observation is that 80% and 94.4% of the families of the surveyed respondents are neither members of NHIF nor CHF.

**Table 4.6.2.4.1. Health Funds Membership**

| S/N | Description | Respondents in NHIF membership | | Respondents in CHF membership | |
|---|---|---|---|---|---|
| | | **Response** | **Percent** | **Response** | **Percent** |
| 1 | Yes | 30 | 33.33 | 10 | 11.11 |
| 2 | No | 60 | 67.67 | 80 | 88.89 |
| | **Total** | **90** | **100.0** | **90** | **100.0** |
| | | **Household members in NHIF** | | **Household members in CHF** | |
| 1 | Yes | 18 | 20.0 | 5 | 5.6 |
| 2 | No | 72 | 80.0 | 85 | 94.4 |
| | **Total** | **90** | **100.0** | **90** | **100** |

### 4.6.2.5 Obliges of NHIF and CHF members to cash payment/out of pocket payment for health services

The sample respondents were asked to show whether being member in NHIF or CHF guarantee them free health costs payment during accessing health services. The result in Table 4.6.2.5.1 showed that, 21% reported to pay cash for health facilities while being member of NHIF compared to 100% who have reported to pay for their health facilities while being member to CHF

**Table 4.6.2.5.1. Cash payment in health services**

| S/N | Description | Response | Percent |
|---|---|---|---|
| **A** | **Membership in National Health Insurance Fund** | | |
| 1 | Yes | 19 | 21.1 |
| 2 | No | 71 | 78.9 |
| | **Total** | **90** | **100.0** |
| **B** | **Membership in Community Health Fund** | | |
| 1 | Yes | 90 | 100.0 |
| | **Total** | **90** | **100.0** |

### 4.6.3 Challenges Encountered by Women Entrepreneurs

#### 4.6.3.1 Options in handling health issues

Table 4.6.3.1.1 shows, different options used in attending health issues. However, four options were identified namely use of National Health Insurance Fund, Cash payment, Community Health Fund, and Friends/relatives. An option; cash payment has emerged a leading which accounted 81.1%, while National Insurance Funds (13.3%) emerged the second in the list of identified health options.

**Table 4.6.3.1. Options in handling health issues**

| S/N | Description | Frequency | Percent |
|---|---|---|---|
| 1 | Using National Health Insurance Fund | 12 | 13.3 |
| 2 | Using Community Health Fund | 4 | 4.4 |
| 3 | Using cash payment | 73 | 81.1 |
| 4 | Assistance from friends/relatives | 1 | 1.1 |
| | **Total** | **90** | **100.0** |

#### 4.6.3.2 Health related challenges and its effect on loan repayment

Health challenge is one among the influencing factors to timely or delay in loan repayment. A loaned individual when fall sick may not be in a good position to pay back his/her consignment

timely. In view of this reality, the study sought to examine issues of loan repayment modality and health challenges. Table 4.6.3.2.1 presents views on whether health related challenges influence to loan repayment. However, majority (55.6 percent) agreed that health influences delay in loan payment compared to 44.4% who reported not to affect the payment schedule/modality.

**Table 4.6.3.2.1: Views on health challenges toward loan repayment**

| S/N | Respondents response | Respondents | Percent |
|---|---|---|---|
| 1 | Does affect | 50 | 55.6 |
| 2 | Doesn't affect | 40 | 44.4 |
| | **Total** | **90** | **100.0** |

### 4.6.3.3 Challenges faced during business operation

In any business operating circumstance, challenge is part and parcel of the business in question. In recognition to this reality, the study had an interest to observe the likely challenges which were pertaining to business environment of the surveyed sample respondents. As shown in Table 4.6.3.3.1; four major challenges including unfaithfulness of some customers/debtors, unreliable customers, inadequate capital for business operation, seasonality of business operation, and location of business were identified to be potential obstacles in business operation.

The result revealed that, majority (30 percent) responded; unfaithfulness of some customers being the main obstacle hindering business operation followed by 25.6 percent who reported unreliability of customers. In addition, inadequate capital among the interviewed respondent was observed to be an obstacle in high performance of the business as reported during the study period by 21.1 percent of respondents.

**Table 4.6.3.3.1: Identified challenges by loan beneficiaries during business operation**

| S/N | Description of Challenges | Respondents | Percent |
|---|---|---|---|
| 1 | Illness is not excuse for making repayment and business management | 1 | 1.1 |
| 2 | Unreliable customers | 23 | 25.6 |
| 3 | Location of business | 6 | 6.7 |
| 4 | Unfaithfulness of some customers/debtors | 27 | 30.0 |
| 5 | Inadequate capital for business operation | 19 | 21.1 |
| 6 | Seasonality of business operation | 11 | 12.2 |
| 7 | None of the above | 3 | 3.3 |
| | **Total** | **90** | **100.0** |

**An entrepreneurial woman as it was observed during field survey in Old Korogwe.**

## 4.7 The Revealed Facts on Study Expectations

In line of this study expectations (refer section 2.8), a Logistic regression and Kendall's Tau C were used to analyse the study expectations as elaborated hereunder as follows;

### 4.7.1 Client's membership to community health fund (CHF) is positively related to age, education, average income and status of being married

In analysing the above expectations, a logistic regression analysis was used to assess the relationship of the above-mentioned covariates to community Health Fund. This technique is being used given the binary nature of our outcome, i.e. being a CHF member or not. Therefore, in view of the above study expectation, findings have shown that there was insignificant (*P*=0.567) relationship between age and joining CHF. Education level of the respondents and joining to CHF, the findings showed that the relationship is insignificance (*P*=0.998). On the average, the income generated and joining to CHF showed insignificant relationship (*P*=0.219) while being married showed insignificant (*P*=0.466) results with joining of CHF.

**Table 4.7.1.1: Shows effect of age, marital status, average income, status of being married and education against membership to Community Health Fund (n=90).**

| S/N | Variables | B-Coefficient | P-Value(Sig) | Ex(B) |
|---|---|---|---|---|
| 1 | Age | 0.222 | 0.567 | 1.249 |
| 2 | Marital Status | -0.534 | 0.466 | 0.586 |
| 3 | Average income | 0.229 | 0.219 | 1.257 |
| 4 | Education | -19.438 | 0.998 | 0.000 |
| 5 | Constant | 16.764 | 0.998 | 19075260.724 |

-2 Log likelihood=51.667, Cox & Snell R Square=0.116, Nagelkerke R Square=.0.231, Chi-square=11.123, df=4

*(Find the discussion of the above result on page 81 of this report)*

### 4.7.2 Incorporating health related loan products is related to health cost paid for accessing health services.

In analysing the above study expectation, Kendall's Tau C Test was used to assess the relationship of incorporating health related loan products and cost paid for accessing health services. The findings showed that there was significant ($P$<0.05) relationship between necessity of incorporating health related loan products with average health cost paid direct for accessing health services.

**Table 4.7.2: Shows results on association between views on necessity of incorporating health related loan products and health cost paid direct for accessing health services, (n=90).**

| S/n | Method Used | Value | Asymp Standard Error | Approx. T[b] | Approx. Sig |
|---|---|---|---|---|---|
| 1 | Kendall's tau-c | -.067 | .033 | -2.063 | .039 |

***Note**: Health related product was learned or understood to be any practices of MFIs done with the intention of offering monetary services in the form of loan or insurances to increase direct access to health and medical services or any form of extension to enhance the health of the clients.*

# CHAPTER FIVE

## 5.0 CONCLUSIONS, DISCUSSIONS AND RECOMMENDATIONS

### 5.1 Conclusion

This study provides empirical evidences relating to the contribution of microfinance institutions in improving health services to women entrepreneurs in Korogwe-Tanga Tanzania using Vision Fund as case study**.** Specifically, the study aimed at (i) assessing the extent to which microfinance institutions implement health care service in the study area; (ii) examining the needs of microfinance institutions in supporting health care services to their prospective clients; (iii) analysing challenges encountered by women entrepreneurs in the management and operationalization of their entrepreneurial activities in the study area; (iv) suggesting strategies for supporting and promoting health care services as other products offered by microfinance institutions in their business operation.

Data for the study were collected from 2 focus groups of total 21 members, Manager and 90 beneficiaries who receiving loans from Vision Fund. Simple random and purposive sampling procedures were used as techniques for sample selection, and descriptive statistics model was employed to analyse the collected data. However, this part presents conclusions based on the major findings of the study.

#### 5.1.1 Focus group

Two focus group discussions were conducted in the study area. These discussions were done to find supporting qualitative facts on whether there has been a significance contribution of MFIs in the served community. In this view discussions were very productive in the sense that every participated member in the group had actively involved and at finally descriptions were drawn that; increased family affordability capacity to education costs of their children, business expansion, ability to handle health costs in case of illness and meeting of households requirements such as foods, clothes and utilities (water, kerosene and electricity costs) to mention few.

During the in-depth discussion, particularly on the area of incorporation of health related loan products in the microfinance sector; it was consistently argued that, provision of this particular loan product will act as a catalyst to individuals wishing to join the microfinance services; including increased access to health services (refer section 4.2.1 and section 4.6.2.1).

Similarly, it was learnt that, MFIs has contributed to a number of identified tangible benefits which are; increased household capacity to school fees payment to school going children, procurement of home facilities/utensils, expansion of business capital, facilitated renovation of household settlements, facilitated performing of agriculture farming (hiring of labour for land cultivation, planting, wedding and harvesting), and managed at least to construct new houses.

Moreover, skills development is another area learnt to be limited in provision as the observation was that loan management training was merely the institution focus though to the views of the focus group participants, more is required to develop their management and administration capacity and skills on the operation of business and entrepreneurial activities.

### 5.1.2 Managers

Microfinance institutions operations promote a varied number of loan services, and in the case of Vision Fund, service offered are limited to Kitita product, Premium product, Jiendeleze product and Biashara product. In each loan product a limited amount of loan is set. For instance; Kitita product has loan amount ranges from Tshs.1million to Tshs.10 million, while Premium product its loan amount is above Tshs.10.1 million. The group loan category is being classified into two products namely; Jiendeleze and Biashara. Each loan category differs in terms of group member as well as amount of loan disbursed to them. Jiendeleze product for instance; has membership ranging of 3 to 5 members and the loan amount disbursed to is ranging from Tshs.500,000/= to Tshs.5million while Biashara product is composed by 6 to 25 members and the loan amount disbursed to them is a range of Tshs.50,000/= to Tshs.5million.

Criteria for borrowers were learnt to be: a clients should have a running business aging at least 6 months; a client should age between 18 to 65 years; should be a Tanzanian; should have legal businesses which conform to the business regulations; a client being well known by local leaders

in his/her locality; and lastly but not least should be ready to guarantee all members in a group for the case of group loan.

Challenges play an influencing position in the business practice and perfection. In this regard, the microfinance institution was not exceptional to challenges such as existence of un-faithfully clients and failure to practicing according to the loan regulations and procedures.

The question of policy emphasis on issues of provision of health related product was learnt not to be on the practice and policy emphasis of the institution, the merely focus was learnt to be the sustainable welfare of the loaning community. However, the learnt observation is the need of this product to be incorporated by MFIs though the challenge is on the implementation modality of this policy initiative by micro-financing service providing institutions; such as the Vision Fund.

In view of skills development, emphasis has been on issues of imparting relevant loan administration skills, which were mostly facilitated in every loan cycle (refers to period of completion of the first loan cycle to the second concernment). As the basis for improvement in service delivery; customer care services; technological improvement; a servicing dedicated and committed staffs and provision of loan types which match clients' expectations have been part of the institution business.

All in all, quality of health services provision in Tanzania would remain a challenge as more is required to be done including resource requirement and allocation.

### 5.1.3 The respondents

The majority of surveyed sample respondents' (91.1 percent) were between the age ranges of 21 - 50 years old. This age range is a productive group that learnt to be actively involved in micro-finance services. However, it was observed that, majority had preferred group loan option than individual with the reason that, there is a collective responsibility and accountability among members to the failure or good performance of a group. The maximum years in the microfinance business is 12 years, and majority of the surveyed sample respondents, had so far spent a maximum of 6 years.

Accrued benefits has depicted a list of benefits from: business expansion; building of family house; sending children to better schools; payment of house rent; buying plots of land; buying cattle for farming; and buying of home facilities. In line of these benefits; business expansion has emerged a leading benefit accounted 30 percent (Table 4.5.4.1). These benefits and others do account for the contribution to the livelihood of the respondents. Moreover, in line of these benefits; women entrepreneurs were performed a number of activities listed as; food vending, goods selling 'retail shop', farm products selling, tailoring, women hair dressing saloon, glossaries/beverages selling, charcoal selling, and cloth selling.

In the context of this research study and to the performance experience; health related services support is not the institutions' policy, guidelines and regulations in place (refer section 4.2.1 and section 4.6.1.1). This experience is being observed during the survey and in group discussion as well as the management. However, it was learned that, payment to health facilities has been influenced by: good service and medical treatment provided, low health related costs and its affordability, accessibility of health services, and accepting of insurance card. All these were made subject to the financial capacity inclined to that particular sick individual(s), though there has been learning that government is intervening in health service provision through established and functioning health schemes such as NHIF and CHF of which both are biased to free health costs.

As far as health related challenges and its associated effects is concerned; the study revealed that; health challenges do affect the modality of loan payment; and supporting reason of this situation is that, majority of the respondents were taking group loan, which acted as a mechanism to control group behavior and their practice. Individual might be tempted not to pay back the loaned amount for making repayment once health challenge occurs.

However, unfaithfulness of some customers, unreliable customers, and inadequate capital for business operation, business operation, and location of business were the major challenges. It was learnt that; unfaithful customers are experienced when entrepreneurs lend goods to customers in agreement to pay back; but it happens that they do not work on the way agreement was made. Similarly, unreliable customers were mentioned because customers purchasing behaviours changing from one season to another; this implies that, during high season or medium

and low season customers tend to change hence influence business as well. Therefore, during these periods, customers buying behaviours and practices change towards the types of goods that are offered in the market.

### 5.2 Discussions

This study aimed to find out the contribution of microfinance institutions in improving health and health care to women entrepreneurs in Korogwe district, Tanzania. The specific objectives of the study were to examine the challenges encountered by women entrepreneurs in the management and operationalization of their entrepreneurial activities in the study area as well as to assess the extent to which microfinance institutions implement health care service in the study area. In addition, the study aimed to examine the needs of microfinance institutions in supporting health care services to their prospective clients and to suggest strategies for supporting and promoting health care services as other products offered by microfinance institutions in their business operation.

The majority of the participants in the study who perform entrepreneurial activities were younger (refer Table 4.4.1; 65.6 percent of 21- 40 age group and 25.6 percent of 41-50 age group). This finding reflect the reality that, young women entrepreneurs are not behind the move to poverty reduction efforts in their households' level. This finding is in consistent with the observations by (Beall Jo and Kanji 1999) and Estapé-Dubreuil and Torreguitart-Mirada (2010) that women are active contributors to their family and society welfare at large.

Active engagement in entrepreneurial activities is the opportunity available to most women who just attained their primary education compared to those who have attained the secondary and college education. In fact, the informal sector is regarded as a prime opportunity to the less educated individuals. In consistence with this reality, Monye *et al*.(2009) in their study on self-employed women in Edo State have found a positive significant contribution on the businesses and family life of rural dwellers (less educated) that have access to micro finance institute services.

Contrary to what has been reported in the area of capacity development, the results are not very encouraging as most of respondents (66.7 percent) had attained primary level of education;

which is sought to be a challenge in handling management issues of their business at a professional demand as other studies reported a positive significant impact between management of microfinance credit and attained education level ( Endrias Geta *et al*., 2013) .

In examining marital status; majority women (65.6 percent) are married than reported single and others (refer Table 4.4.1). This is indications that, majority participating in entrepreneurial activities are married which give an implication that they play their families roles responsively. This would also imply that, households responsibilities are not left to men in their families rather women plays a very crucial part for the welfare of their families for improvement of household income, poverty reduction and far most livelihood improvement. This fact is in consistence with the observation made during the focus group discussion when a concern was raised about health services accessibility where the married women shown their participation in economic activities to support their men's incomes. Interestingly, the results of this study is in agreement with Endrias who finding that; unmarried women are less likely to utilize microfinance services compared to married one(Endrias Geta et al. 2013).

**Roles played by respondents at household level**

It is interesting to note that in all women interviewed in this study, 65.6 percent were housewives and small proportion had other tasks. This finding is supported by the reality that, majorities play a significance position in their households which was also learnt during the group discussion and are not excluding them –selves from doing entrepreneurships activities. In supporting this fact, Maru and Razia, (2013) reported that many women entrepreneurs have low business performance compared to their male counterparts but still the rate of participation in the informal sector of the economy is higher than males. This participation raises their households' income and economic power thus reducing economic dependence on their husbands.

**Factors influencing selection of loan product type, preference and reason for selection**

On the question of loan product preference by majority participants, the study found that loan repayments by group members was much easier to manage as every individual in a group is accountable for anything happening regarding loan repayment. In addition, accountability of individuals within a group extends during when group member fall short in term of repaying

his/her loan timely and or when get sick (ill). This observation was made during the survey (refer section 4.5.2) where 91.1 percent of the interviewed respondents were opted the group loan type. The drawn lesson from this is that, the group was used as a bond or collateral by individual(s) towards accessing loan services (refer section 4.3.2). In consistence with this finding, a study by (Morduch, 2003) found that, group lending secure collateral, save transaction cost, easy to get information and can facilitate education training which might value as a way to improve levels of health and knowledge. This is in support with the argument made by the manager that, most of clients/loan borrowers prefer loaning in a group (refer section 4.3.2) which is also supported by the argument that most of microfinance institutions prefer their clients to lend in groups ( Guerin et al. 2013).

**Types of business owned and performed by women entrepreneurs**

In this study selling of farm products have emerged to be a leading business performed by majority who accounted 28.9 percent (refer section 4.5.3 and its presentation reflected in Table 4.5.3.1). The reason for their engagement in this business activity could be due to small capital requirement to start run the business and the reality that can easily be mobilized within their farm localities hence made available and accessible in the market located within their reach. Apart from farm products, other business performed among the interviewed respondents involved; food vending, goods selling 'retail shop', tailoring mart, women hair dressing saloon, glossaries/beverages selling, charcoal selling, and readymade cloth/second hand cloth selling. This is the experience that in most cases women entrepreneurs have low business performance. This is in consistence with Maru and Razia, (2013) findings on women entrepreneurs' performance against their male counterparts that, though still low their participation in the informal sector of the economy is higher than males.

**The benefits acquired through MFIs**

The results of this study showed that benefits gained from women involvement in MFI services were expand their business, building a house as well as sending their children to better school. The present findings seem to be in consistent with study conducted by Bakhtiari, (2006) who found a significant benefit of MFIs to lives of the families, especially to poor women on improving their own lives, lives of their members, communities and their nations at large. This is

in particular to those who always seek and in the end access microfinance services which help them with business empowerment, assets creation such as expansion of household income; managing social investments including increased capacity to enrol their children in better schools and construction of better houses. The likely emphasis was reported by Maru and Razia, (2013), that, more women who taken loans enable them to invest in and expand their business and in consequences they are able to employ themselves. Hargreaves *et al*, (2007) supported that; loans received by women through MFI were found to have wider household level benefits. This observation support the findings reported during focus group discussion in section 4.2.2 and during survey described in section 4.5.4 and its presentation made in Table 4.5.4.1 of this report.

**MFIs provision of health related loan products**

This research study revealed that no health related loan product (refer section 4.6.1.1) is being accessed to sample surveyed respondents, and the same was reported during FGDs (refer section 4.2.1). This observation support the findings revealed by the Vision Fund Manager who reported that, neither the existing organization policy nor regulations support provision of health related loan product to clients/customers. This finding is in consistence with the views of (Wolfensohn, 2000) who reported that; the main emphasis of microfinance service in the community is on interventions for poverty reduction and skill empowerment than direct intervention to health issues. In this regard, operation of many microfinance institutions are vested in micro-credit business which is the most dedicated business to the target of household income improvement through provision of loan services to individuals of which women are being active participants.

However, despite this observation; in the Focus Group Discussions (FGDs), majority respondents suggested health related loan products to be incorporated in business operationalization as it would influence more individuals joining loan service schemes which will increase assurance to health service affordability. These FGDs observations are supported by field survey in section 4.6.2.1; and unfortunately, the response is not in line with the MFIs policy demand and credits operation regulations (section 4.3.3).

Health is a challenging issue as it touched all participants during the focus groups discussion. In their support all participants' have shown their concern and wishes if health related services such as health insurances to be part of MFIs services. This is because incorporation of health services

doesn't benefit only the clients of MFIs but also with other family members. This is to support the views by Leatherman *et al*., (2010), that accessibility of health related programs and services by MFIs not only benefiting the clients but also the household.

This is by one side but in other side health cost become the issue being debated by most of participants, providing the same explanations that once health related are to be incorporated by MFIs will help in reducing health cost which has to be paid to service providers. This support explanation by Leatherman et al,(2010) that, MFIs clients use to reports on the difficulties caused by health cost when sick, where it threatening their loan repayment, savings deposits and other households assets to pay for health care expenses.

In examine issue of CHF; a concern was raised among FGD participants arguing that, the primary goal of the CHF in delivering of health services to people had been so challenging as the results most of participants have suggested more on MFIs to incorporate health related services. The observation is that, incorporation of health related loan services might replace the dysfunction of CHF although in this regards is the thing which needs further investigation. The need to join the CHF is positive among respondents as was observed in FGDs and filed survey but the worry is based on the way and modernity used in services being provided which is also seems to be a challenge to quality health service provision and which in most cases not reliable. This observation supports the finding by (Kamuzora and Gilson, 2007), who finding that apart from CHF long term operation in Tanzania still there is low level of joining the scheme by majority where among the reasons identified for this failures is the quality of services being offered by CHF.

Moreover, all participants acknowledged the work of MFIs performance when showing that MFIs services have a positive influence on their lives. For instance during focus group discussion it was revealed that, MFIs to some extent helped them to offset various challenge in their families; this is because MFIs have empowered them with financial capacity to initiate their own entrepreneurial (refer section 4.5.3) activities which helped them to have capacity of meeting their lives' demands. This support the views by Mushumbusi *et al*. (2013), that

entrepreneurship activities helped women to increase their ability to contribute to their families support which increase their role in the household decision making.

Furthermore although most suggest about skills development during FGDs but health education was not left behind in the discussion. The FG participants were on the view that, incorporating this kind of education will help to widen up their understanding on management of hygiene and environmental issues and other health education related matters. Their concern is that, are not used to meet regularly as a group, but through MFIs, they find them automatically have an opportunity to meet regularly and discuss related issues of importance to their health. This however, is a good view as will help to offset some of health challenges which just needs awareness in order to combat them. This observation support the Leatherman *et al*.(2010), who explained that, most of microfinance delivering health education shown improvement, and this improvement will improves knowledge that leads to developmental changes associated with health outcome in areas such as maternal health and child health.

As reported in this study, 97.8 % of the interviewed sample respondents have shown a significance of MFIs in improving household health. This response signifies the contribution of MFIs to health services to their customers in the study area. Nevertheless, loan services that are made accessible to the interviewed sample respondents' help them to meet health related costs among themselves and their family member, which can also be justified by earned benefits as presented in section 5.4.4. Similarly in the studies by (Leatherman, 2012); MFIs are capable of contributing to health improvement by addressing financial barriers which enhancing access to health services.

The general analysis regarding health facilities revealed that; majority of the surveyed sample respondents chooses public health facilities compare to private. Quality of the services (considers also issues of effectiveness and efficiency in provision) was not the pushing factor rather than low cost which is possibly, the result of implementation of cost sharing policy in the health sector. The national health policy encouraging communities to contribute through user fees in health facilities to complement government financing, and most targeted are the poor and vulnerable group who cannot afford to pay health services (MOHSW, 2003). This practice

support the reason that, the majority who perform small entrepreneurial activities mostly prefer public than to use private facilities due to high health related costs as the meager income earned from their small investments does not guarantee them to manage those health expenses due to the mounting family social commitments . For example in average it costs Tsh, 10,000/= to Tsh 25,000/= one day per bed if patient is hospitalized in private facility, and the said costs excludes other medical bills and services.

The findings of this study revealed that, majority did not join the health insurance funds (refer Table 4.6.4.1). Reason for the observed situation could be attributed by decrease in community awareness and mobilization of the communities to join the health insurance funds. Other reason can be inefficiency of health service delivered through health insurance schemes. A lot of has been discussed during group discussion in section 4.2.1 and filed survey. This shortfall indicating that, government mobilization campaign for public to join Community Health Fund as health initiative is not yet surfaced to majority; therefore raising more community awareness to health insurance schemes is required including revisiting of the operationalization of the funds.

**The obligation of NHIF and CHF members to cash payment for health services**

In Tanzania United Republic, implementation of Health Insurance Funds (HIFs) has been the country's priority. This approach is done purposely, to support the objective of the government of health improvement to every Tanzanian. The present HIFs funds in the country include; National Health Insurance Funds which favor those working the formal sector of the economy while Community Health Fund (CHF) support those communities and individuals working out of the formal system of employment.

In view of this finding the analysis which is depicted is that, being a member of either NHIF or CHF does not guarantee individual an excuse to the question of directly payment when seeking for health services. Therefore, it is the duty of the all to ensure affordability when the situation require otherwise. However, cash payment option is being preferred mostly by the surveyed sample respondents because is a quick approach to solution when ones fall sick (ill). Basically, in the implementation context of Tanzanian, this approach is mostly applicable. Nevertheless, though the working populations particularly those working in the formal sectors of the economy

are the automatic members of NHIF, in some circumstances are forced to pay out of their pocket to secure the challenging issues in accessing health services of themselves and their families in both private and/or public health facilities.

**The observed variables to CHF membership**

However in view of study expectation, that an individual chances of getting or being a members of CHF increases with the age, the analysis has shown that this relation is not significant at 0.05. This, observation is supported by the reality that, one is continue to be a member of CHF as far as s/he contribute to the fund, and the more one get aged his/her contribution capacity goes down since because the means to get money is subjected to his/her continuity in engagement in performing a productive activities for economic gains. Moreover, membership in CHF is not permanent but is subject to periodicity of one year payment to the fund.

This is contrary to study by Jütting, Johannes P, (2007), who found that the probability of paying more for treatment increase with age, which is also a context based. The observed insignificance is due to the expenditure made in buying health related services which in one way or another influenced by the fact that, as ages prolong a probability of self-employed individual to continue in CHF is likely subjected to limit. This is supported by Pampel (2000) who wrote that, when the exp(B) value exceeds 1, it influences the odds ratio of the occurring outcome to increase. In lining to our findings the age exp(B) is 1.249 which in this case exceed 1. Therefore in this regards age can affect association with community fund.

Furthermore; an individual status of being married with chances of being a members of CHF was measured, and the analysis shows that the relation was not significant at 0.05. This insignificant is supported by the reality reported during FGDs that, most of men's income is small; therefore imply the same challenge toward CHF membership. This fact is supported by the reality of average income generated findings which shown the existence of insignificant relationship with joining Community Health Fund. Jütting *et al*. (2007), views support this when reported that, income is an important variable to determine household whether to join CHF or not.

In view of education the results have shown that there is insignificant relationship between education levels of the respondents and joining Community Health Fund. This insignificant can

be explained by the reality that, regardless which level of education; as awareness increases among individual influences the decision to join such health schemes. The general observation can be elaborated by the reality that, majority of interviewed women has attained primary education (refer Table 4.4) compared to those who attended secondary and college education; therefore influencing the results.

The necessity of incorporating health related loan products with average health cost paid direct for accessing health services was measured, and the results shows negative relation between the two variables. This is in the reality that, once health related loan products is incorporated in MFIs services there is possibility of decreasing health costs which are paid direct for getting health services. This observation confirms the observation by Leatherman *et al*, (2011) that; the poor use variety of mechanisms for financing direct health costs. However, the author was commented further that, integration of microfinance and health protection services can be a multiple win for both microfinance providers, clients and their families.

**Final remarks**

The study of this nature provoked a wider scope and involvement of many institutions of this nature to be surveyed in order to have widened knowledge on acquisition and facts which are pertinent to give more strength to the observations and findings of studies of this nature. In particular, however, the study showed that, majority surveyed preferred group loan category rather than individual because there is a higher level of group collectivity, responsibility and accountability to any situation that the group performance would be passing through, and foremost commitment by all is that bounding them.

However, even though, the study had revealed, none performance experience of the microfinance institutions in provision of health loan related services as the fact of the policy, guidelines and regulations requirement; yet it is true that, the operation of many microfinance institutions still play a considerable contribution in the area of household health improvement through income spending to issues of health services. Moreover, this learnt experience exposes microfinance institutions to seek the possibilities of shifting in the perspective to review governing laws and regulations to the question of embracing provision of loan product related towards health services improvement.

**Limitations of the study**

In performing any field work, challenges are unavoidable, and in view of this study, the following challenges were encountered as described below:

- The bureaucratic operationalization to some institutions was questionable in the sense that, it was not easier to get a quick pass and even a smooth way for laying out logistics leading to data gathering, following a stretched length of time required to be spent in requesting their permission. As the results, in view of going along these MFIs, gathering of the research data had to be done in Vision Fund. However, in some instances, despite making a prior appointment with government officials their co-operation was questionable.

- Limited time in data gathering has been a challenging moment coupled with costs involved to make a researcher moving from one area to another.

- Participation among the respective individuals was another challenge. The reality remains to be that, in some circumstances the researcher had to cultivate a spirit of getting them freely involved and willingly to share what is of their views to meet the requirement of the research study.

## 5.3 Recommendations

In view of the major findings of the study and the above conclusions, the following recommendations are made.

### 5.3.1 Policy recommendations to MFIs; Vision Fund and the government

a) Support provision of related health loan product is not the business consideration of many operating microfinance institutions (MFIs). This study finding had also proofed it to be the question of institutions' governing laws, guidelines and regulations that operates. In order to off-set the situation there is a need for MFIs policy makers in their priorities to consider provision of health related loan product, as will continue promoting sustainable in existence of vibrant economic enterprises and business activities that give

a direct impetus to the question of microfinance business operation (increase performance of loan portfolio) and local people business grow hence poverty reduction.

b) The need of having skills development and empowerment strategy was observed to be an institutional priority though type of the intended empowerment skills was limited to the question of business operation and management. As it was positively commented on its significance; therefore, continuing emphasizing the question of facilitating business management and operation skills will significantly imparting among individual entrepreneurs a self-assurance business spirit and confidence to business works.

c) Based on the finding on the question entrepreneurs business operation, the analysis indicated that, momentum of business grow is being influenced by many factors including unfaithfulness of some customers, unreliability of customers, inadequate capital for business operation, seasonality of business operation, and location of business. It is in this context; continue imparting the practical and business proactive decision making spirit and attitude to customers in the micro-financing sector is a necessary action which should persistently be done.

d) Accessing health services is a must decision that driven a sick individual to act; though availability of quality health service is a subjecting challenge to the government and private providing health institutions. Therefore, the authorities in question required to commitment to the implementation of health policy mostly in resource planning and efficiency allocation towards improvement in health service availability and accessibility to all citizen regardless of their financial capacities and limitation.

e) In view of government implementation of health scheme policy; finding has shown that, people (most working in informal sector of economy) are not active participants in health insurance scheme such as CHF. Therefore, the recommendation put forward regarding this observation to the governing authorities (public leadership in particular) is to continue rising awareness and community mobilization campaigns toward joining Community Health Fund (CHF). The purpose is to increase their benefits to the funds and foremost improvement of health facilities.

f) The need for MFIs to incorporate health related loan products in their business operations because this will improve health services to their respective clients.

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# APPENDICES

## Appendix 1: Checklist for Focus Group Discussion

GUIDING QUESTIONS TO BE ADMINISTERED TO FOCUS GROUP DISCUSSION

i. What are your views if health related loan products are to be one of the microfinance services available to you as prospective members of the microfinance institutions?
    - Is it appropriate health related loan products like insurance to be one of MFIs services?

ii. Think over the tangible benefits you have gained so far since you became an active participant in MFIs services; what can you describe so far?
    - To what extent did you benefits from joining MFIs?
    - Can you explain about health benefits so far from you experience?

iii. What improvement would you suggest to be taken into consideration by microfinance service providing institutions?
    - Are there any improvements of loan services by MFIs?
    - What are your views on such improvements?

iv. Did you participate in any skills development training pertaining to administration of entrepreneurial activities and loan management under the facilitation of your MFI?
    - Do you remember any skill development facilitated to you since joined MFIs?
    - How far was it helpful to you?

## Appendix 2: Questionnaire to be Administered to Manager

QUESTIONNAIRE TO BE ADMINISTERED TO MANAGERS

**PART I: GENERAL INFORMATION**

i. Date of interview……..
ii. Name of the Manager.....
iii. For how long have you been working in your full capacity? .....
iv. Please mention years that your organization has been in microfinance operations?

**PART II: LOAN SERVICES**

i. What loan product types are provided by your institution?
ii. What criteria do you use to assess your prospective clients?
iii. What have been the most challenging factors for your institutions operations?
iv. What is your institutional policy emphasis on health services provision as among loan products accessible to your prospective clients?
v. In your views, do you think provision of health related loan product is important and necessary ways to supporting and promotion of effective quality loan services delivered by your institutions?
vi. Is there any skills development and loan administration and management packages offered to your clients?
vii. How often this capacity building packages is being provided?
viii. If it required by the country policy to administer issues of health loan related products to clients; what do you think might be the potential challenges in responding to this policy requirement?

## Appendix 3: Questionnaire to be administered during field survey

EXPLORATORY STUDY ON MICROFINANCE AND HEALTH IN KOROGWE

Dear respondent, I am requesting you to participate in this study by filling in a questionnaire and respond to a few questions. As an interviewee you are very important part in this study because you present many of clients/loan beneficiaries in Korogwe district who are not in the selected sample. I assure you that your answers will only be used for scientific purposes in the framework of this study. Thus, **YOUR INFORMATION WILL BE TREATED STRICTLY CONFIDENTIALLY** and will be presented in the form of statistical reports.

It should be noted that the findings emanating from this study will be an important tool for policy makers, government, microfinance providing institutions and other development agencies such as NGO's, CBO's to better design or fine-tune their development policies, design specific planning intervention strategies and develop long-term research policies aimed at continuing supporting directly health strategies to microfinance facilities lending individuals. Thank you very much for your kind participation and God bless you abundantly.

### PART I: BACKGROUND INFORMATION

i. Date of interview.....
ii. Name of Respondent.....
iii. Age of respondent.....
iv. Gender/Sex ……...
v. Role in the household.....
vi. Education level of the respondent …….
vii. Employment status……
viii. Marital Status.....
ix. Family member in the age groups

| Sex/Age Group | 0 - 5 | 6 – 10 | 11 - 15 | 16 – 20 | 21and Above |
|---|---|---|---|---|---|
| Male | | | | | |
| Female | | | | | |
| **Total** | | | | | |

**PART II: LOAN SERVICES AND PERFORMED ACTIVITIES**

i. Please mention the duration of accessing loans services?.....
ii. Please mention the product type you have been accessing to date .....
iii. Why do you prefer such loan type? …….....……..
*iv.* What are the reasons for such selection? …….....……..
v. Please can you mention the entrepreneurial activities you have been administering?....
vi. Can you list benefits accrued sine you started performing entrepreneurial activities? ...
vii. What is your average level of income earned monthly?.....

**PART III: HEALTH IMPROVEMENT**

i. Did you accessing health and health care support related loan product?.....
ii. If No; what do you think is a reason for not accessing loan health related product?..
iii. Do you think accessing MFI services has contributed to health improvement to you and your household members?.....

**PART IV: NEED OF INTEGRATION HEALTH PRODUCT**

i. Do you think incorporating health related product in MFIs operationalization is necessary?.....
ii. If Yes; what is your views? .....……..
iii. If No; what is your views?
……
iv. Give reasons to support your views in question (ii) above……..
v. Give reasons to support your views in question (iii) above …….

**PART V: SOCIAL SERVICES ACCESSIBILITY**

i. Where do you access health services for you and your family?.....
ii. If is private owned health facilities; give reasons for the decision to go there.
iii. If is public owned health facilities; give reasons for the decision to go for there
iv. Based on either of your responses in above, how willingly were you to pay the associated health related
costs?.....

v. Are you a member of National Health Insurance Fund (NHIF)?.....

vi. If YES, are the member of your family also member to NHIF? ……

vii. Are you a member of Community Health Fund (CHF)?.....

viii. If YES, are the member of your family also member to CHF?.....

ix. If YES to NHIF, have you in one particular time/moment required to pay out health costs from your own pocket for you and the family the household member?.....

x. If YES to CHF, have you in one particular time/moment required to pay out health costs from your own pocket for you and the family the household member?.....

**PART VI: ENCOUNTERED CHALLENGES**

i. How did you handle health challenges for effective health condition improvement……

*ii.* How health related challenges affected your works and in particular, loan repayment?

iii. In your views, what can you identify out as potential challenges during your business operationalization?.....
...

## Appendix 4: Dodoso la kujazwa na wateja

### SEHEMU YA KWANZA: TAARIFA ZA AWALI

i. Tarehe ya usaili .....
ii. Jina la msailiwa .....
iii. Umri wa msailiwa .....
iv. Jinsia/Jinsi……
v. Nafasi yake katika kaya .....
vi. Kiwango chake cha elimu……
vii. Ameoa/Kuolewa.....
viii. Wana familia/wategemezi kwa makundi ya umri

| Jinsi/Umri kwa makundi | 0 – 5 | 6 - 10 | 11 – 15 | 16 - 20 | 21 na zaidi |
|---|---|---|---|---|---|
| Wanaume | | | | | |
| Wanawake | | | | | |
| Jumla | | | | | |

### SEHEMU YA PILI: HUDUMA ZA MIKOPO NA SHUGHULI ZA ZINAZOFANYWA

i. Lini umeanza kuchukua mkopo?.....
ii. Ni aina gani za mikopo mnazopata kama wateja? Tafadhali zitaje…….,…..,……
iii. Upi kati ya aina hizo unapendelea Zaidi? na kwa nini unapendelea?
iv. Ni shughuli gani ya ujasiriamali unayoiendesha kutokana na mkopo uliopata?
v. Matumizi ya mkopo yanatumika kwa shughuli gani nyingine mbali na shughuli ya ujasiriamali
vi. Nini matokeo ya mkopo ambao ulikuwa unausimamia/uendesha?
vii. Ni nini kiwango cha kipato unakipata kwa siku/wiki/mwezi?

### SEHEMU YA TATU: HUDUMA ZA AFYA

i. Tangu ujiunge na mikopo inayotolewa na Taasisi ya fedha ulishawahi kupata mikopo inayohusiana na afya ama huduma za afya kama vile bima?.....
ii. Kama jibu ni hapana ni nini unaweza kukiainisha kama sababu ya kutopata huduma hiyo?.....
iii. Unafikiri kupata huduma za taasisi za mikopo zinachangia katika kuimarisha afya za watu wa kaya yako?

**SEHEMU YA NNE: UHITAJI WA KUWA NA HUDUMA ZA AFYA KWENYE TAASISI ZA FEDHA**

i. Kwa maoni yako unafikiri kushirikisha utoaji wa huduma za mikopo ya afya au bima kwenye taasisi za mikopo ni muhimu?
ii. Kama ndio toa sababu?.....
iii. Kama sio nini maoni yako?.....
iv. Toa sababu za kukazia maoni yako katika swali la (ii) hapo juu
v. Toa sababu za kukazia maoni yako katika swali la (iii) hapo juu

**SEHEMU YA TANO: HUDUMA ZA JAMII**

i. Ni wapi unapata huduma za afya na familia yako?
ii. Kama ni kwenye hospitali binafsi tafadhali toa sababu zilizokufanya uamue kwenda huko?
iii. Kama ni hospitali ya umma tafadhali toa sababu zilizokufanya uamue kwenda huko?
iv. Kwa kuzingatia majibu yako hapo juu,ni kwa vipi ulikuwa tayari kulipa gharama za matibabu?
v. Kwa wastani ni kiwango gani cha gharama unaweza kuzilipa kwa siku/wiki ama mwezi kwako na familia yako?
vi. Je wewe ni mwanachama wa mfuko wa bima ya afya ya Taifa(NHIF)?
vii. Kama ndio,je jamaa wa familia yako ni wanachama pia?NHIF?
viii. Je wewe ni mwanachama wa mfuko wa afya ya jamii?(CHF)?
ix. Kama ndio,je jamaa wa familia yako ni wanachama pia? CHF?

x. Kama ndio kwa NHI(….) au CHF (…..),ulishawahi kulazimika kulipa gharama za huduma za afya kutoka mfukoni mwako kwa ajili yako na familia yako?

**SEHEMU YA SITA: CHANGAMOTO ZA HUDUMA ZA AFYA**

i. Unawezaje kumudu/kukabiliana na changamoto zinazohusiana na mambo ya afya kwa kuhakikisha zinaboreshwa?.....

ii. Ni kwa vipi changamoto za afya zinaathiri kazi zako, zaidi ulipaji wa mkopo?

iii. Kwa maoni yako,nini unaweza kukiainisha kama changamoto katika uendeshaji wa shughulizako za kiujasiriamali?

## Appendix 5: Dodoso la kujazwa na meneja

**SEHEMU YA KWANZA: TAARIFA ZA JUMLA**

i. Jina la meneja……..

ii. Ni kwa muda gani umekuwa ukifanya kazi na hii taasisi?

iii. Na ni kwa muda gani taasisi yako imekuwa ikijishughulisha na mambo ya mikopo?

iv. Na ni kwa muda gani taasisi yako imekuwa ikifanya kazi hapa Korogwe?

v. Unao wafanyakazi wangapi katika Taasisi yako

**SEHEMU YA PILI: HUDUMA ZA MIKOPO**

i. Ni aina gani ya amana/dhamana ya mkopo taasisi yako inatoa?

ii. Ni kigezi gani mnatumia kutathmini wateja wenu kuwapa mikopo?

iii. Ni changamoto zipi kubwa umekuwa ukizipata katika uendeshaji taasisi yako?

iv. Je taasisi yako inayo sera inayohusu ushughulikiaji wa mambo yahusuyo afya kwa wateja wake?

v. Kwa maoni yako unafikiri utolewaji wa huduma za afya ni muhimu na ya maana, kama njia ya kusaidia na kuhamasisha utolewaji wa huduma bora za afya?

vi. Je kuna kuendelezwa kwa maarifa yoyote kwenda kwa wateja

vii. Kama ndio ni maarifa gani yamekuwa yakitolewa kwa wateja wako?kama sio toa sababu?

viii. Kama ikitokea nchi inataka kutoa sera ya kushughulikia mambo ya afya kwa wateja wako;ni nini kinaweza kuwa kikwazo kikubwa katika utekelezaji wa sera hiyo?

## Appendix 6: Muongozo wa Maswali ya Majadiliano kwa Vikundi

i) Ni nini maoni/mtazamo wako kama huduma za afya au bima zikawa zinatolewa kama sehemu ya huduma za mikopo kwako kama mteja wa taasisi za fedha?

- Je ni sawa huduma za afya kama bima zikawa mojawapo wa huduma zinazotolewa na taasisi zinazotoa mikopo?

ii) Ni faida gani umezipata mpaka sasa tangu ujiunge na taasisi za mikopo,eleza faida ulizozipata?

- Ni kwa kiasi gani umefaidika tangu ujiunge na Taasisi zinazotoa mikopo?
- Unaweza elezea kuhusu faida za kiafya ulizozipata kutokana na uzoefu ulionao?

iii) Ni maboresho gani yafanywe na taasisi za fedha katika kuboresha utoaji wake huduma

- Je yapo maboresho yoyote katika huduma za mikopo kwa Taasisi za mikopo?
- Nini maoni yako juu ya maboresho hayo?

iv) Ni faida gani za kiafya umepata tangu uanze kupata mkopo?

v) Je umeshawahi kushiriki katika kuendelezwa kimaarifa na taaisisi ya fedha/inayotoa mkopo?

- Je ulishawahi kuendelezwa katika ujuzi wa aina yoyote tangu ujiunge na Taasisi za mikopo?
- Ni kwa kiasi gani imekusaidia?

## Muhtasari wa Majadiliano ya Vikundi

Katika majadiliano ya vikundi kwa maeneo ya mada zilizojadiliwa; muhtasari wa majadiliano yote umekazia na kuonyesha yafuatayo; uhitaji wa kushirikisha masuala ya huduma za mikopo au bima za afya kwenye taasisi zinazotoa mikopo kuwa ni muhimu na zitasaidia katika kuimarisha huduma za afya, na zaidi zitawavutia watu wengi kujiunga na taasisi zinazotoa mikopo kwani watu watakua na uhakika wa matibabu ya afya zao. Na vile vile itasaidia katika suala la kupunguza ugumu wa maisha kwani kuwa na uhakikia wa tiba au bima ya afya unasaidia katika kupunguza gharama za moja kwa moja ambazo mtu angezipata au kuziingia na hivyo kumfanya aelekeze fedha hiyo kwa ajili ya mambo mengine ya mahitaji ya familia na majukumu mengine.

Hata hivyo katika majadiliano hayo, suala la kuhusu mfuko wa afya ya jamii (CHF) liliibuka, kwani katika majadiliano wanakikundi wengi wameonekana kuuzungumzia sana, na waliowengi wamesema si kwamba hawapendi kujiunga na mfuko wa afya ya jamii tatizo ni mpaka katika utoaji wa huduma na ni kwa hospitali ndogo tu na hata hivyo ni kwa magonjwa madogo madogo ikitokea kuna suala la rufaa kwenda hospitali kubwa huwa hauwezi kusaidia katika gharama za matibabu. Katika majdiliano pia ilionekana kwamba pamoja na jitihada za serikali za kuwapa wananchi huduma za afya kupitia CHF hususani wale masikini lakini kuna changamoto kubwa katika kuwapatia wote huduma kama inavyopaswa.

Suala la ugumu wa maisha lilijitokeza katika majadiliano kwa kuwa ni sual lenye changamoto zake,lakini wote kwa pamoja walionyesha kukazia kwamba ipo haja ya watu kujiunga kwenye taasisi za mikopo ambazo hutoa zao la afya ambalo litatumika kama bima kwani mfuko wa afya wa jamii hausaidii watu kwa sasa na hata kama upo ni wachache wamejiunga. Kuhusu uboreshwaji wa suala la huduma za mikopo,imeonekana kuwa kanuni na taratibu zinazowezesha utolewaji wa mikopo umepitiwa kwa ajili ya kuboreshwa,hata hivyo imeonekana riba za sasa zinazotozwa kwa wateja zipunguzwe kidogo. Ila pamoja na hayo imeonekana kuwa uboreshswaji wa huduma za mikopo ni tumaini jipya kwa wanawake wajasiriamali.

Katika maeneo mengine ya majadiliano, imeonekana kuwa  elimu ama ujuzi wa mambo ya ujasiriamali unatakiwa uendelezwe, na katika hilo washiriki wamesisitiza sana kwa kuwa itawasaidia sana kupata maarifa ya kiujasiriamali na uzoefu wa kufanya biashara kwa ubunifu zaidi.
Vile vile imeonekana kuwa pamoja na elimu ya ujasiriamali suala la elimu ya afya ni muhimu kupewa kipaumbele na ni muhimu kutolewa hususani kwa wanawake wajsiriamali ambao suala la afya ni la msingi kwao,kwani afya ikiboreka kupitia elimu watajiamini hata katika kuongoza biashara zao. Na afya iliyozungumzwa ni pamoja na ya mazingira wanayoishi na usafi kwa ujumla.