Research Article

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Microfinance and health services: Experience and views of women in the VICOBA grassroots bank system

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INTRODUCTION
Village Community Banks (VICOBA) is a grassroots group-based microfinance model designed to support viable income-generating activities for the poor, especially women excluded from the formal sector. Integration of microcredit programs with health services is reported to have improved health and social outcomes in other contexts. This study aims to understand the experiences of women involved in VICOBA programs in the Moshi District of Tanzania and to explore their views regarding the potential for integration of VICOBA with health services, including health education.

METHODS
We conducted detailed interviews with 16 women involved in VICOBA to explore their views on the VICOBA model, including potential for integration with health services.

RESULTS
Women reported increased savings and more support for their children's education as a result of their involvement in the VICOBA program. With increased income, these women and their family members had better access to health care and improved housing and sanitation. In addition, the women felt empowered due to greater decision-making power and increased networking opportunities, including the sharing of information related to business practices and social welfare. They agreed the VICOBA program provides a unique opportunity to integrate microcredit with health education programs, which can lead to behavioral changes in health practices, promote uptake of preventive interventions and facilitate timely access to curative services among clients.

CONCLUSION
VICOBA improves the welfare of its clients and has the potential to be used as a platform for providing health-related services to members from hard-to-reach communities.

Key words: Village Community Bank; women's views; health care and education

INTRODUCTION

Village Community Banks (VICOBA) is a grassroots group-based microfinance model for the poor, especially women excluded from the formal sector. The model facilitates access to savings and credit services, providing members with the resources needed to improve their health and social welfare. The model also fosters clients' capacity to innovate and manage viable income-generating activities (Piprek, Altvater, Fuglesang, Helgesson, & Mashauri, 2010). Members meet weekly to contribute shares, collect loans or repay previous loans. The meetings support and motivate savings, social networking and sharing of valuable information related to business practices and social welfare. After a year the group is dissolved, dividends are paid to members, and the cycle restarts. Through VICOBA, clients have been able to improve savings, business growth, and access to credits and make investments in family health and children's education (Mukungu, 2013;

Geissler & Leatherman, 2015).

The model originated in Niger under the name of Mata Masu Dubara. The Social and Economic Development Initiative of Tanzania (SEDIT) and CARE International (CARE) modified the concept for adoption in Tanzania as VICOBA in 2002 (Piprek et al., 2010). Within five years, VICOBA had spread to 19 out of 25 regions in the country, with approximately 56,280 members. By 2009, the program had reached 27.9% of the rural communities that were initially underserved by financial institutions and approximately 30 billion Tanzanian Shillings had been collected as a revolving fund for the groups (FinScope, 2009).

Informal loan schemes have become one of the predominant mechanisms to address poverty in the Kilimanjaro Region, where 31.3% of the households are categorized as poor (National Bureau of Statistics, 2002). By 2014, the region had approximately 477 VICOBA groups, each with 25-30 members of whom 90% were women (WorldUnite!, 2015). A recent study in Northern Tanzania revealed that VICOBA had the widest coverage, reaching more women in poor settings than any other Microfinance Institution (MFI) (Kessy, Msuya, Mushi, Stray-Pedersen, & Botten, 2016).

Given their social mission, geographical coverage, routine group meetings and lending practices, VICOBA may serve as a unique approach for providing integrated services designed to address the economic and social needs of the poor. In addition, VICOBA provides social networking and capacity-building opportunities to its members through simulative training techniques, which may also be another entry point for integration of social services. Studies suggest that integrating health-related services, such as health education, with microfinance programs can improve knowledge, behaviors and access to health care (Geissler & Leatherman, 2015).

The steady increase in female participation in VICOBA within Tanzania is documented (Bakari, Magesa, & Akidda, 2014; Mukungu, 2013). However, views of women regarding their experience in the program, including their opinions on the potential for integrating health-related services, have not previously been documented. This study documents women's views on the financial and social benefits of VICOBA in Moshi District, Tanzania and the potential to expand the concept to include health education programs.

METHODS

Study design and population

The data presented here were collected as part of a cross-sectional population-based study that collected qualitative data. Qualitative methods were used to explore an understanding of the subject matter in a holistic manner. The study was conducted between October and December 2014 and included 900 clients from 101 MFIs operating in Moshi District, Tanzania. A description of the MFIs and clients has been published in a separate paper (Kessy et al., 2016). The MFIs included financial banks, non-governmental organizations, companies, savings and credit cooperative societies and the VICOBA groups. The current study uses data from in-depth interviews with clients from VICOBA groups.

Moshi District is one of seven districts in the Kilimanjaro region. Based on the National Census of 2010, Moshi District was estimated to have 33,910 households with a total population of 200,000, of which 80,000 (40%) live below the poverty line (less than $1/day) (National Bureau of Statistics, 2010). For administrative purposes, the district is sub-divided into 15 wards of which five are urban and ten are peri-urban; the study was conducted in all wards. The peri-urban wards have high population density with limited access to formal financial institutions compared to urban wards.

Sampling procedures

A list of 39 VICOBA groups operating in the study area was obtained from the register of the Kilimanjaro VICOBA network. A stratification method was used based on urban and peri-urban wards in which the organizations were operating. Out of 39 VICOBA groups, 15 were randomly selected (five from urban and ten from peri-urban wards).

From the selected VICOBA groups, a list of 300 clients was obtained. Quota sampling method, a non-probability method usually employed to ensure equal representation from categories of a study population with different characteristics, was used to select 50 clients for interviews. The sampling method was employed to ensure equal representation from two categories: clients who had no formal employment and those who had been in the group for at least two years. Out of 50 clients, 30 consented to participate (10 from urban and 20 from peri-urban wards). Saturation was used to determine the final number of respondents, and the interviewer stopped after the 16th respondent because the interviewer was not getting any new information.

Interview process

Interviews were organized around two themes: a description of the client and the client's participation in VICOBA. Questions addressing the first theme were closed and intended to get general information on microcredit programs and the demographic and socio-economic characteristics of their clients. The second theme was guided by topics specific to the study objectives. Clients were asked about their experience of social benefits accrued through VICOBA participation, and specific probing questions were asked about access to education, food security and health care. Clients were also asked their views on improved income and women's empowerment, health-seeking behaviors, decisions about major household purchases and freedom of social interaction.

Clients were asked about their specific needs for join-

ing the microfinance program and whether such needs had been addressed. New themes arose directly from the interviewed women, including indirect health benefits and household investments in housing, water and sanitation. Questions that were considered sensitive, such as evidence of improved income, uses of the loan and negative effects experienced, were asked later during the interviews. This allowed respondents to play a more active role and offer freedom in the interview process. Respondents were asked follow-up questions on suggestions for improvements of the VICOBA program. Respondents were also asked if they consider VICOBA groups an appropriate platform for provision of health education. Another follow-up question inquired about specific health education programs relevant for integration within the VICOBA program.

The interview guide was pilot-tested among women from a VICOBA group operating in Hai District, a rural area similar to the study sites in Moshi District. Changes were made in language to make some questions more descriptive and easier to understand. The questionnaires were checked and corrected to ensure accuracy and fidelity to the study purpose.

Cell phones were used to fix appointments with the identified respondents. One-on-one interviews were conducted with 16 respondents by the first author. Most of the interviews were conducted at the respondents' households or businesses, and a few occurred at the area where they had their VICOBA meetings. Each interview lasted for approximately two hours.

Data collection and analysis

Interviews were tape-recorded and notes were taken during the interviews. Every evening after the interviews, the author expanded the field notes and listened to the tape-recorded interviews and summarized major issues. The recorded interviews were transcribed verbatim and translated into English. The data were then manually analyzed using content analysis approach, which included coding, identification of recurring themes, categorization and interpretation.

Ethical clearance was granted in Tanzania by the Kilimanjaro Christian Medical University College Research and Ethical Review Committee, certificate number 533/2014. The VICOBA clients gave their written consent to participate in the study. All respondents were asked and consented to be tape-recorded. Names used to report quotes are fictitious.

RESULTS

Characteristics of the participants

The average age of the 16 women clients interviewed for this study was 47.8 years. The majority of the clients (12) had primary education or less (Table 1), and 12 were married out of which four were household heads. Fifteen women had had four or more children, but only six women had four or more living children. Nine women had children under 18 years old, and only one woman had a child under 5 years old. The majority of their children were above 18 years old, and the oldest was 44 years old. All the clients had informal employment, and their main source of income was small-scale business and farming. Only one client was earning less than 50,000 Tsh (~$25 US dollar) per month, 62.5% of the clients were earning 50,000 to 500,000 Tsh (~$25-250) per month, and the rest were earning more than 500,000 Tsh (~$250) per month.

Table 1: Socio-demographic characteristics of study participants in the VICOBA program, Tanzania

Characteristic	Total	
	N=16	%
Age (years)		
25-35	2	12.5
36-45	6	37.5
46-55	3	18.8
56	5	31.2
Religion		
Christian	14	87.5
Muslim	2	12.5
Education level		
None	3	18.8
Primary	9	56.2
Secondary or higher	4	25
Education level of partner		
None	1	6.2
Primary	7	43.8
Secondary or higher	3	18.8
NA	5	31.2
Income per month (Tsh*)		
<50,000	1	6.3
50,000-500,000	10	62.5
>500,000	5	31.2
Marital status		
Married	12	75
Single	2	12.5
Widow	2	12.5
Number of children		
<4	1	6.3
4-6	10	62.5
>6	5	31.2

*Tsh is Tanzanian shillings (USD was equivalent to about Tsh 2000 during the time of study).

Client experiences on how they spent the loan

All clients reported that they had realized their basic economic and social needs as a result of VICOBA. Increased income and savings expanded their business projects and contributed to their ability to access health

care, education for their children, and housing for themselves and their families. A total of 13 clients reported having established new projects or expanded the existing ones.

'…Before I joined the program I had no single chicken at home, but now I have more than 50 chickens in my poultry project, which was expanded using capital from VICOBA.… Also I bought dairy cattle and now I sell milk, eggs to earn money, which in addition to the other business, my capital and business have increased and grown more than 100%.' (Mary, age 42, operating a retail shop)

Investment improved savings and business

Clients were asked if their incomes increased after joining VICOBA. All clients except one reported higher incomes, which was reflected in increased savings, business expansion and improved value of the households. When further probed, the clients reported having experienced improvements at different levels.

'...VICOBA has improved my savings; before I was saving about 2,500 in a week, but now I can save up to 50,000 a week. ...now I am planning to connect electricity to my house.' (Regina, age 62, food vendor)

'...my capital has increased in more than 100%...I managed to expand my business and secured a loan for my husband's business.' (Neema, age 42, operating a retail shop)

Investment in children's education

The majority of clients invested in their children through paying for secondary education, including compulsory school contributions.

'...I used income from VICOBA to pay for education of our son whose father had no idea or any plan on financing the studies...' (Fatty, age 45, operating a drug dispensing shop)

'...I managed to pay for the living costs of my daughter who is at the university...' (Mwajaa, age 50, running poultry project and selling food)

Investment in health care

The study revealed that each VICOBA group had direct and indirect health benefits. Direct health benefits included financing health care of the family members through improved income levels. Another benefit was the establishment of a community fund that issues interest-free loans to clients for financing health-related matters affecting their household family members.

'...I received community fund from my colleagues which helped in paying for health care services when I was sick...' (Mirma, age 49, operating timber business and grocery)

The majority of clients reported other indirect health benefits. This was demonstrated through successful investments in the general household, such as improved housing, water and sanitation. More than half of the clients reported having improved their households by accessing piped water.

'...I managed to build a decent block house and connected pipe water using VICOBA loan...' (Magreth, age 42, operating a retail shop and a mobile money transaction service)

Social networking and empowerment in decision-making

Clients also acknowledged fruitful social networking opportunities resulting in improved social security, social status and information sharing. A total of 11 clients reported improved networking and sharing of valuable information, especially on breaking through their investment plans and other social information related to health and life in general.

'Social unity and cooperation among members has improved my networking with friends...' (Fatty, age 45, operating a drug dispensing shop)

'I now network with my fellow women in fighting poverty and contributing to the family welfare...before that I was just staying idle and dependent...' (Halima, age 45, selling food)

The majority of clients demonstrated personal confidence and greater decision-making power on financial and non-financial matters. They reported being transformed from passive receivers to active decision-makers on family and personal matters and becoming business managers and independent individuals.

'...Previously I had no business, but now I manage my business and I can stand on my own...' (Maria, age 25, sells second-hand clothes)

'...VICOBA has improved my confidence and financial power beyond explanation...I believe I could survive without my husband's support.' (Halima, age 45, operating a drug dispensing shop)

Strategies on innovations to improve performance of VICOBA

Clients were asked to give their personal views on the strategies required to improve the program. Clients recommended expanding the VICOBA model to include other programs such as agricultural and entrepreneurial skills training, instead of restricting activities to credit and financial-related services. When probed on the rationale of such integration, they responded that agriculture is a key economic driver, and it is mainly practiced in rural areas where a majority of women live. Therefore, microfinance services may be a useful tool in providing input required

for agriculture.

Clients also suggested providing a more organized entrepreneurial skills training among VICOBA clients. Specifically, they suggested training covering key areas of business operation, including documentation, report writing and preparation of business plans. Clients considered such training important to grow financially and manage their businesses more sustainably.

Health education potential

Clients spontaneously mentioned health education as another possible direct health benefit for clients; however, this potential was untapped in VICOBA. When participants were asked to respond "yes" or "no" on whether VICOBA programs could be used for health education, all said "yes." However, the participants expressed having limited access to health information on diseases threatening their lives. They suggested that a health education facilitator could take advantage of routine meetings and social networking among VICOBA members as an avenue of integrating health education into the existing program.

'...We are geographically disadvantaged hence can't be reached easily with health information...awareness on health issues is very limited among hard-to-reach clients.' (Agrica, age 63, running poultry and piggery projects)

Regarding the types of health education programs, participants proposed preventative interventions on the common causes of mortality and morbidity in Tanzania. Specific health intervention programs suggested were provisions of education and sensitization on diseases like HIV and AIDS, cancer, diabetes and hypertension. Other recommended areas were provision of education programs on reproductive health, including family planning and nutrition, especially for women with children under the age of seven.

Negative experiences

Clients were asked if they ever experienced any negative effects of the VICOBA program. Only one client reported having a negative experience with the group. When probed, the client explained that she was asked to contribute money to pay for a group member whom she guaranteed, but the member failed to repay the loan on time. Key challenges reported included limited capital resulting in too small loan amounts for borrowing and a lack of entrepreneurial skills among clients. Clients pleaded for government support so that VICOBA could access adequate capital to facilitate larger loans.

'...Government through women's development fund should enhance source of capital for soft loans to VICOBA clients...' (Paulina, age 49, running a retail shop)

DISCUSSION

Study participants in the VICOBA program increased their incomes through savings and profits, which increased access to health care and education for children and improved housing, clean water and sanitation. The clients also experienced empowerment in decision-making and social networking. Participating women acknowledged VICOBA as an appropriate platform for health education programs. However, inadequate capital and entrepreneurial skills training impaired the growth and sustainability of the program. VICOBA may have tremendous potential for implementing not only business, but also health education.

The positive transformation of the lives of VICOBA clients demonstrates how access to initial capital can improve the lives of the poor. The findings are in line with previous studies in similar settings. Studies revealed that after a two–year period, participants in microfinance programs showed increased income, assets and savings compared to non-participants, and they reported greater profits from their micro-businesses (Jan et al., 2011; Dunbar et al., 2010; Pérez et al., 2012). These studies support the philosophy of the VICOBA model, which aims to empower less privileged community members, especially women excluded from the formal sector (Bakari et al., 2014; Hamad & Fernald, 2015).

The findings suggest that microcredit programs could have other positive effects on health, education and family welfare outcomes. The study concurs with other findings from the Philippines and South Africa, which confirmed that increased profit from microcredit programs results in improvements in several welfare-related outcomes (Cameron Stuart, 2015; Hamad & Fernald, 2012).

The improved economic and social status of the VICOBA clients increased their confidence. Clients had the opportunity to socialize and network among themselves and with other colleagues. Networking enhances information sharing in matters affecting women's social lives and business investments. These findings are similar to another study in Tanzania that revealed that VICOBA had empowered its members with different skills, enhanced their confidence and improved their status in the community (Bakari et al., 2014).

The study results suggest that utilizing the VICOBA platform to provide health education has great potential, particularly for poor women who often bear dual burdens of poverty and ill health (Geissler & Leatherman, 2015). These findings are supported by other studies that have concluded that integrating health-related services with microfinance improves health knowledge and health behaviors (Leatherman et al. 2012; Geissler & Leatherman 2015).

Other MFI clients reported having improved their knowledge on health and practices in the areas of breastfeeding, diarrhea treatment and immunization as a result of education on the topics provided by the microfinance

program (Leatherman & Dunford, 2010). VICOBA program meetings could be used to provide health education, where the groups or peers could serve as change agents, learn from each other and share and network with non-members too.

This study has several limitations. Questions on personal financial matters are considered sensitive. This might have contributed to fear of disclosing accurate financial information. Another limitation was recruitment of clients from similar socioeconomic settings. This might be linked to the early saturation following repetition of similar responses. The study is cross-sectional in design and therefore does not allow causal inference about the results.

CONCLUSION AND RECOMMENDATIONS

VICOBA is an emerging model that improves the welfare of women, children and households. Women participating in VICOBA experienced improved finances and social benefits and gained social support networks, which are best described in increased savings and assets accumulation, access to health care, decision-making capabilities and support for their children's education. The model may be used as a platform for addressing key health-related services, including health education to members from hard-to-reach communities. The VICOBA model should be integrated with knowledge and competency-building skills that strengthen clients' welfare and capacity to manage their investments more efficiently and sustainably. Further research is required to assess how involvement of women in microfinance programs influences welfare of the households, including family nutrition.

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CONFLICT OF INTEREST

The authors declare they have no competing interests.

AUTHORS' CONTRIBUTIONS

JK and BG conceptualized the study and study design, developed the tools and significantly contributed to development of the manuscript. SM, BP and DM reviewed the tools, advised on data collection and reviewed the manuscript critically. DM and SM coordinated data collection and entry, JK and DM analyzed the data and JK and BG drafted and finalized the manuscript. All authors read, revised and approved the final manuscript.

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