



Impact of Microfinance Plus Programmes in Uganda



Intervention

More than three fourth of the population in Uganda lives in rural areas and a large number depends on subsistence farming. Although the percentage of the poor has decreased, their absolute number did not change accordingly because of the population growth.

BRAC's development model followed an integrated approach to maximize synergistic benefits from financial and non-financial services. BRAC Uganda kick-started its *Microfinance Programme* in 2006 and building upon that, it gradually expanded to health and agriculture sector. Its "Microfinance plus" model provides different sectoral services to multiply the impact.

Microfinance was designed to provide financial services through village-level groups of typically 20 to 25 members. These groups were managed by credit officers (COs) who offered uncollateralized microloans for up to 12 months, with weekly repayments. The *Agriculture programme* developed sustainable value chains to increase agricultural productivity and food security. Extension services and high-quality inputs were offered by the community agriculture promoters (CAPs) while model farmers (MFs) mentored general farmers (GFs) on improved agricultural practices. The *Health programme* lined up community health promoters (CHPs) to sensitise on health issues, refer severe cases to nearby health facilities, offered basic curative services and low-cost medicine through weekly door-to-door visits.



Research

Impact Evaluation of BRAC's Microfinance Plus Programmes in Uganda: Quasi-Experimental Design (Barua, 2013, Kampala: [BRAC IERC](#))



Method

A *difference-in-differences* (DID) method was applied to estimate the impact of BRAC programmes on household income, asset and vulnerability. The study ran from 2009 to 2011, following 8,768 households from 550 local councils (LCs) in 26 districts. The LCs for the comparison group were randomly selected within a distance of 6 to 9 km from the nearest BRAC branch offices. The impact of the following groups was compared with the comparison group:

- (i) microfinance (ii) health (iii) agriculture
- (iv) microfinance and health (v) microfinance and agriculture



▲ 74

pp per capita income in microfinance & health group

▼ 26 & 18

pp covariant shocks in microfinance & agriculture and microfinance & health group

▲ 20

pp more likely to use cash-savings to cope with shock by microfinance & health group

▲ 95

pp savings by microfinance & health group

▲ BRAC programmes have a larger impact when combined

The combination of programmes demonstrated significant impacts compared, *firstly* to the comparison group and *secondly* to each silo programme. As opposed to the comparison group, the impact on per capita income was found to be the highest by **74 percentage points** (pp) among the groups where the participants received 'microfinance and health' services simultaneously, followed by 'agriculture' (56 pp), 'microfinance and agriculture' (55 pp), 'health' (50 pp), and 'microfinance' group (41 pp). Further analysis confirms that the combined impact of 'microfinance and health' participants is greater than 'microfinance' and 'health' separately.

The findings on shock-coping mechanisms affirm that the participants from the combined programmes are more resilient in general. For instance, self-reported covariant shocks on income reduced by 10 pp, 12 pp, and 9 pp for 'microfinance', 'agriculture' and 'health' group participants respectively while this figure is **26 pp** and **18 pp** for 'microfinance and agriculture' and 'microfinance and health' participants respectively. This is largely because programme participants were regularly visited by one or other programme staff and thus may be 'more well-informed' about possible community-level shocks.

An easier strategy of coping-with-shocks among the surveyed households is the usage of cash saving followed by other worse copying mechanism. Participants of the 'microfinance and health' were **20 pp** more likely to use cash savings to cope with community-level shocks. Overall, this impact estimate of 'microfinance and health' participants is significantly greater than that of 'microfinance' (6 pp) or 'health' (8 pp) groups.

The trend of larger impact of combined programmes than of the comparison group and each silo programme remains the same with regard to cash savings and expenditures on education. The 'microfinance and health' group increased savings by **95 pp** and their combined effect is greater than that of their silo impacts (37 pp and 34 pp respectively). Similarly, 'microfinance and agriculture' participants spent more on education for their children by 38 pp, followed by 'agriculture' (28 pp) and 'microfinance and health' (26 pp) groups.

➤ Way Forward

This study, in consistent with similar studies, reaffirms that complementing microfinance with other sectoral interventions is more effective than implementing each of them separately. While offering financial services at the doorstep does help the poor, it may not be enough unless they are combined with other sectoral interventions. The results of the 'microfinance and health' group with its largest effects emphasised the importance of synergy in achieving development objectives. To that, this mix potentially holds a key to multiplying the impact and, thus, reducing poverty.