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COVID-19 and well-being of female borrowers in Lahore, Pakistan

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We study the effects of COVID-19 on a sample of 1227 female microfinance borrowers in low-income households in urban Lahore. The economic situation and self-reported physical and mental health status of women deteriorates after COVID-19. Moroever, their beliefs about the perceived benefits of health microinsurance change for the worse.

1. Introduction

The outbreak of COVID-19 had far reaching implications on physical health with over 348,000 cases of affected individuals in Pakistan as of 10th November, 2020[1]. In this brief, we explore the effects of the virus and government lockdown on well-being of microfinance borrowers from low-income, urban households in Pakistan.

We work with borrowers from a leading microfinance institution (MFI) in Pakistan. The MFI has an all-female client base, in urban and peri-urban areas of the country. Clients who borrow from the MFI are automatically enrolled in a health microinsurance (HMI) program. The program provides hospitalization cover up to PKR 30,000 per person, per year for the borrower and each member of the borrower's nuclear family. The average loan amount for our sample borrowers is PKR 27,000. Each loan has to be paid back in 12 equal monthly installments. The premium payment of PKR 150 per month for the HMI program is embedded in the monthly loan repayment installment. At present, the MFI is serving around 0.5 million low-income households across the country.

In January 2020, we initiated a telephonic survey with MFI borrowers to collect feedback on new features of the HMI program. By the time the government imposed a lockdown in March 2020, we had surveyed 40% of the sample. The remaining women were surveyed from May to June 2020. By this time, the government had started to ease the lockdown and transition towards a smart lock-down approach. This involved imposing a lockdown only in areas where infection rates were on the rise. To study the effects of COVID-19 and the lockdown, we disaggregate the sample into (i) pre-lockdown; i.e. women interviewed before the lockdown was imposed in March and (ii) post-lockdown; women interviewed after the lockdown was eased in May. We present findings for a sample of 1227 female borrowers.

The borrowers in our sample report around 25% lower average monthly household income in comparison to the provincial average in Punjab[2]. More than half of the borrowers report self-employment as their primary source of income. One third of the borrowers have no education. The median borrower in our sample reports middle school as the highest level of completed education.

[1] Retrieved from Covid-19 Health Advisory Platform by Ministry of National Health Services and Coordination `http://covid.gov.pk/`

[2] Average monthly household income reported in our sample is PKR 40,000 in comparison to the provincial average of PKR 55,189 for an urban household in Punjab (HIES, 2018-2019). Retrieved from `http://www.pbs.gov.pk/sites/default/files//pslm/publications/hies2018-19/TABLE_10.pdf`

2. Economic effects and coping strategies

In this section we untangle the impact of COVID-19 on socio-economic well-being and explore the coping strategies used by low-income households to mitigate these losses.

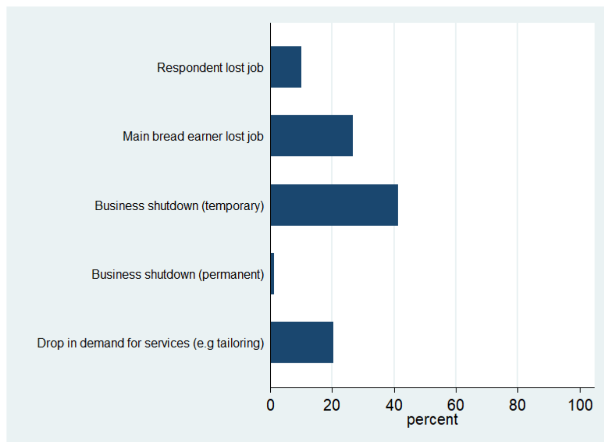


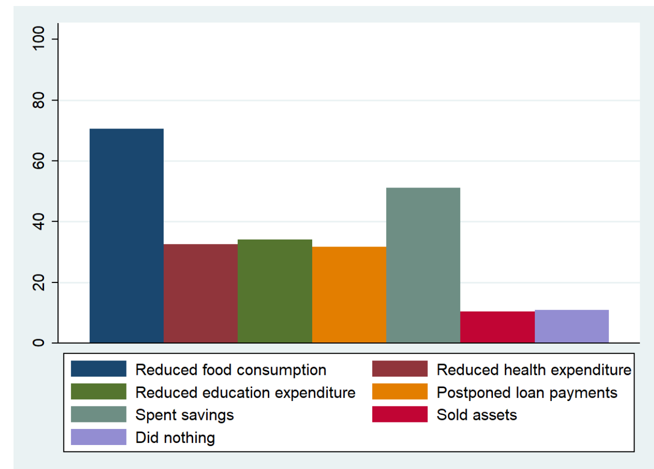
Figure 1: *Reasons for a Decrease in Household Income*

Around 90% of the sample report that their household income has decreased relative to before the lockdown. The economic cost of COVID-19 observed in our sample is in line with seminal work of Malik et. al. (2020),[3], which finds a 90% reduction in weekly sales and household income among a sample of 1000 microenterprise owners across the country. Figure 1 shows reasons underlying a worsening of borrower's economic situation. More than 40% of them report the decrease in income is due to a temporary shutdown of their business, another 20% report reduction in demand for their services (such as tailoring, salon services etc.) as the main cause, while the remaining 35% report own or main bread earner's job loss as the main factor behind a reduction in household income.

Availability of assistance from formal and informal sources is limited. While the federal government launched a social protection program, worth around PKR 1.2 trillion aimed at catering to 12 million households, only 12% of the sample borrowers received assistance from the government (four fifths of these received cash assistance while one fifths received in-kind assistance) and another 4% were assisted by NGOs. Around 10% were helped by family and friends.

Female borrowers report additional ways of dealing with the adverse economic consequences of COVID-

[3]Kashif Malik et al. "COVID-19 and the Future of Microfinance: Evidence and Insights from Pakistan". In: *Oxford Review of Economic Policy, Forthcoming* (2020).



Note: Figure shows the coping mechanisms employed by the respondents who experienced a reduction in their household income)

Figure 2: *Coping Mechanisms*

19 and the lockdown (Figure 2); out of the sample that report a reduction in their household income: 70% reduced food consumption, 50% spent out of their savings, 30% each reduced health and education expenditure, while another 30% postponed loan repayments. The coping strategies reported by our sample of female borrowers reinforce insights from recent studies. In rural Uganda, Mahmud and Riley (2020)[4] observe a 40% reduction in food expenditure and a 50% decrease in savings due to a COVID-19 induced worsening of the economic situation among a sample of 1277 rural households.

3. Physical and mental health

We observe a deterioration in the self-reported physical health status of women in the post-lockdown relative to the pre-lockdown period. The proportion of women who report feeling weak, tired, sick or extremely sick during most of the days increased from 20% to 26%. Recent work has shown that the adverse health effects of COVID-19 are expected to go beyond physical health; in Ethiopia, there has been a 3-fold increase in depressive and anxiety disorders after the pandemic[5]. We observe similar effects on mental health in our context. The proportion of women experiencing moderately severe anxiety increased from 10% to 28% while those experiencing

[4]Mahreen Mahmud and Emma Riley. "Household response to an extreme shock: Evidence on the immediate impact of the Covid-19 lockdown on economic outcomes and well-being in rural Uganda". Unpublished Manuscript. 2020.

[5]UN. *Policy Brief: COVID-19 and the Need for Action on Mental Health.* New York, 2020.

severe anxiety increased from 16% to 29% between the pre and post-lockdown period (Figure 3)[6].

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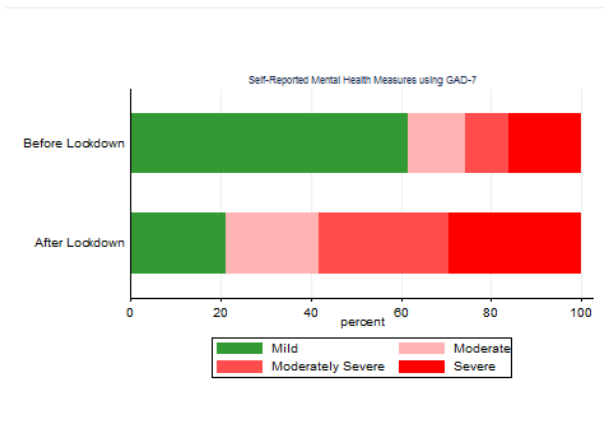

Each bar shows the proportion of respondents who report feeling anxious on a Likert scale of 1 (mild anxiety) to 5(severe anxiety)

Figure 3: *Self-Reported Mental Health*

In order to understand potential triggers to anxiety, we asked women about their main stressors during the pandemic. Around 70% of the women report being most stressed about income and availability of jobs while around 65% report health and education concerns as a major source of stress during the pandemic. Around 40% women report stress due to mobility constraints imposed by the lockdown. Finally, one tenth of women were concerned about increased stress levels in the family and its effects on the household environment(Figure 4)[7]

[6]These difference are statistically significant at 1 percent level of significance. To gauge the prevalence of anxiety, we used the standardized 7-item General Anxiety Disorder (GAD-7). The scale is a sum of responses to a series of questions and ranges between 0 and 21. These questions ask for the frequency with which a woman felt nervous, anxious, on the edge, irritable, afraid, restless, worried and unable to relax over a given time period. A cumulative score less than 5 indicates mild/no anxiety, between 5 and 10 moderate anxiety, between 10 and 15 moderately severe anxiety and more than 15 severe anxiety. For further details, see (Robert L Spitzer et al. “A brief measure for assessing generalized anxiety disorder: the GAD-7”. In: *Archives of internal medicine* 166.10 [2006], pp. 1092–1097)

[7]Responses were on a likert scale ranging from ”least stressed” to ”most stressed” for each of the following:(i) Own health or the health of their family members; (ii) own stress level/stress level of other household members leading to arguments; (iii) own income/household income; (vi) job security/availability of jobs in the future; (v) education and learning of their children; (iv) limited mobility due to restrictions on travel and public transport.

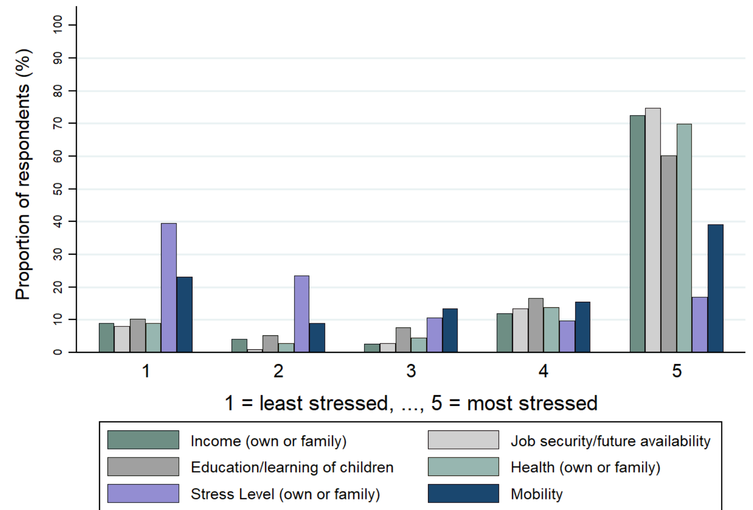

Figure shows the proportion of respondents who report feeling stressed on a Likert scale of 1 (Least stressed) to 5(Most stressed)

Figure 4: *Stressors during the COVID-19 crisis*

4. Perceptions

We observe a substantial change in women's beliefs about the perceived benefits of the HMI program (Figure 5). Firstly, women consider the program to be less affordable despite no changes in the interest (price) charged on loans. Secondly, only about one-third of the women (in comparison to two-thirds before the lockdown), regard the program as (i) well-suited to health needs; (ii) useful for facilitating access to health services and (iii) helpful in improving the health status of women and their family[8].

5. Conclusions

We conclude with three key insights on the basis of the analysis done in this paper. Firstly, we find that the economic situation of households in our sample has worsened. This is in line with recent studies on the impact of COVID-19. If the adverse economic consequences of the pandemic are not adequately addressed through a comprehensive social protection policy the crises could have lasting effects on well-being. The existing coping mechanisms that low income households are adopting such as reducing

[8]Women were asked the extent to which they agree (or disagree) with each of the following statements about the HMI program: (i) The program is affordable; (ii) The program has enabled me to prioritize my health and the health of my daughters (iii) The program has enabled me to avail medical services for myself and my family; (iii) The program has improved my health status and/or my family's health status.

Note:Each bar shows the proportion of respondents who report agreement on a Likert scale(1 strong disagreement) to 5 (strong agreement to the statements above)

Figure 5: *Perceptions about HMI*

food consumption as well as health and education expenditure could increase vulnerability to disease and create learning gaps in the future.

Secondly, we observe a deterioration of physical as well as mental health amongst our sample of female microfinance borrowers. While a lot has been said about the physical health effects of the pandemic, there is limited evidence and discussion on its implications for mental health. It is important to note that almost all the women in our sample have not directly been affected by COVID-19 yet we see such large adverse effects on mental health indicating negative spillover effects.

Lastly, we observe that the perceptions of female borrowers have changed for the worse. Women are more pessimistic and uncertain about the future and they perceive the HMI program to be less valuable. These changes in perceptions could in part be explained by the ongoing liquidity and financial crises that they are faced with and (or) because the HMI program is not suitably tailored to their specific needs.