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Microfinance and Mitigation of the Impacts of HIV/AIDS: An Exploratory Study from Zimbabwe

by
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EXECUTIVE SUMMARY

Microfinance has been advocated as a strategy to help households mitigate the negative economic impacts of HIV/AIDS. This study conducted in Zimbabwe addressed the following questions:

- What effect does HIV/AIDS have on microentrepreneurs and their households?
- Does microfinance assist client households to mitigate the negative economic effects of HIV/AIDS?
- How do illness and death affect the operations of microfinance institutions and participation in their programs?
- What can microfinance institutions do to lessen the impact of HIV/AIDS on their organizations and clients?

The Study. The study focuses on Zambuko Trust (Zambuko), a non-governmental organization that provides credit and business management training to microentrepreneurs. Zambuko's legal status prevents it from accepting voluntary deposits. It operates primarily in urban areas and small towns, and more than three-fourths of its clients are women. Zambuko loans to microentrepreneurs who join together in a group of five to six individuals to co-guarantee loans to its members, and to individual microentrepreneurs with an individual guarantor. Zambuko also has a Trust Bank product for the poor that requires borrowers to attend eight hours of training prior to receipt of their loan and to attend bi-weekly meetings.

The study is based on a re-analysis of survey data from 338 clients of Zambuko Trust and 241 non-client microentrepreneurs interviewed in 1997 and re-interviewed in 1999. The respondents resided in Harare, Chitungweza, Bulawayo and Mutare and more than two-thirds were poor. Half of the client respondents had taken at least one additional loan since the 1997 interview. Because Zimbabweans are reluctant to talk about household members with HIV infection, proxy indicators were used to classify respondent's households as HIV- affected since 1997. The proxy indicators included chronic illness or death of an adult household member, and taking in orphans or sick persons.

In addition, in late 2000 and early 2001, focus groups were held with 140 randomly selected clients and with 33 Zambuko staff and officers, and interviews conducted with senior managers of Zambuko. The implications of the quantitative and qualitative findings were discussed at a forum, in September 2001, attended by 32 representatives of microfinance institutions, HIV/AIDS service organizations and donor organizations in Zimbabwe.

Findings and Conclusions. In 1999, 40 percent of both client and non-client respondent households were possibly affected by HIV/AIDS. The HIV-affected households differed significantly from the unaffected households: the monthly income for affected households was Z$535 less; the proportion of household members who were not economically active was greater in the affect households; and affected households were less likely to seek medical treatment due to lack of funds. In spite of the negative effect of HIV/AIDS on the household economy, the affected households had been able to adjust so that the schooling of their children and their food consumption patterns were similar to unaffected households.

The analyses indicate that microfinance assists client households to mitigate the negative economic effect of HIV/AIDS. When affected clients were compared to affected non-clients, the households of affected clients had a greater number of income sources than those of affected non-clients, indicating that credit had permitted these households to pursue an income smoothing strategy. Also, a significantly greater proportion of boys ages 6 through 16 living in affected client households were in school, suggesting greater investment in the household's human resources. Participation in Zambuko's program also positively influenced the financial management patterns of affected clients.

Zambuko has instituted a number of policies to manage risks to its financial portfolio. For example, it strictly enforces the group co-guarantee of loans. In January 2001, it began charging a mandatory insurance fee of one percent to cover the outstanding loan of deceased clients.

In the opinion of Zambuko clients and staff, loan repayment problems in 2000 were due more to economic conditions in the country than to illness and death. (The value of the Zimbabwe dollar dropped 50 percent between 1997 and 1999). When illness or death cause a group member to have difficulty meeting her loan installments on time, as long as she had been a member in good standing prior to crisis, the loan groups normally allow her to remain for the next loan cycle.

There was general agreement among Zambuko staff and clients that a loan to someone in the midst of a crisis was more of a burden, than a help. Caregivers are normally unable to devote adequate time to their enterprise and have extra expenses to meet. For similar reasons, both clients and staff felt that Zambuko's policy of only loaning to economically active microentrepreneurs was justified.

Loan officers and clients participating in the focus groups made a number of suggestions on ways microfinance programs might better assist clients coping with chronic illness and death. The representatives from microfinance institutions, HIV/AIDS service organizations, and donor organizations attending the forum on microfinance and HIV/AIDS also suggested ways that microfinance organizations might better address the impact of HIV/AIDS on their institutions and clients. Moreover, they called for a permanent forum and identified an organization to facilitate the forum.

Recommendations. The following are the key recommendations arising from the study and the forum with key stakeholders. Additional program level recommendations are provided in the report.

- Microfinance institutions operating in countries with high inflation rates need to ensure that their interest rates and fees keep pace with inflation, so that their capital base is not eroded. A mandatory fee to insurance the loan against the death of the client appears to be a prudent measure. The terms and conditions should be distributed in writing to clients, and the insurance fund managed in a transparent manner.

- Development assistance organizations should focus more attention on assisting governments to strengthen policies that directly influence the ability of households to mitigate the negative economic impact of HIV/AIDS on them.

- More attention should be given to the regulatory framework of microfinance institutions to enable them to broaden their products and services to meet the demands of HIV/AIDS affected households and safeguard client deposits.

- A set of simple tools should be developed and tested that organizations could use to better estimate HIV/AIDS affectedness and poverty among their clients.

- MFI managers and boards of directors need to consider HIV/AIDS from the standpoint of the organization, its outreach and its client base. They need to actively focus on ways to manage the potential risks of loan delinquency and defaults. Also, they need latitude to experiment with different services and products to better address the needs of affected households. They should test new approaches, services and products to determine costs and impact.

- In countries where HIV/AIDS is widespread, MFIs should pilot test criteria and procedures that lessen the burden on loan groups when members are unable to make a loan installment due to chronic illness or death in the household.

- Mandatory insurance against death of a borrower appears to be a prudent measure for MFIs to adopt, but the funds should be managed in a transparent manner.

- Participatory approaches should continue to be used to identify ways to ameliorate the negative economic impact of HIV/AIDS on households and to stimulate collaboration among organizations.

- A similar study should be undertaken in a more stable economic environment to better understand the potential of microfinance to ameliorate the negative economic impacts of HIV/AIDS on households.

I. INTRODUCTION

Microfinance has been advocated as a strategy to help households manage risks, including the negative effects of HIV/AIDS. Promotion of microfinance is linked to assumptions about microfinance institutions (MFIs) reaching poor households and the positive impacts of MFI programs on clients and their households. Underlying this attention is the premise that MFIs are or can become financially self-sustainable.

In the past decade, microfinance has been promoted as a viable strategy for improving the lives of the poor. The upsurge in interest has been accompanied by attention to the sustainability of the microfinance services provided by non-governmental organizations, through charging commercial rates of interest and using sound business practices. This type of microfinance institution (MFI) offers small-sized loans and may also provide business development services, health and nutrition education, and other types of services.

Recent studies of microfinance programs have documented that most of the clients hover around the poverty line, slightly above and below it. MFIs provide a valuable source of credit for these households. Some programs reach the very poor, but they are not normally the main group accessing the services. Recent impact studies have documented the positive impact of MFI programs, but the impacts have tended to be more modest in scale than often assumed (Sebstad and Cohen 2000;Barnes 2001; Dunn and Arbuckle 2001; Chen and Snodgrass 2001).

This study responds to the need for empirical data to better understand the economic impact of HIV/AIDS on households and the role of microfinance in enabling households to cope with the economic effects of HIV/AIDS. It also considers the impact of chronic illness and death upon MFIs. The study includes suggestions on possible steps to enable MFIs to mitigate the potential negative impacts of HIV/AIDS on their financial portfolios and clients.

The study is classified as exploratory since proxy indicators were used to categorize households as HIV/AIDS affected. It centers on microentrepreneurs who joined a microfinance program and a comparative group of non-client microentrepreneurs. This framework excludes attention to the potential of microfinance to prevent HIV/AIDS among vulnerable groups, and microfinance as a strategy to strengthen community groups to care for the terminally ill.

A. Objectives and Scope of the Study

Objectives

The primary objective of the study is to better understand the relationship between microfinance programs and the ability of households to cope with chronic illness and death in a country with a high HIV prevalence rate. The secondary objectives are to better understand a) how chronic illness and death affect microfinance programs, b) the negative economic impact of chronic illness and death on affected households, and c) measures that might mitigate the negative impact of HIV/AIDs on microfinance programs and their clients.

The following key questions guided the study.

- To what extent do microentrepreneurs and their households experience illness and death?
- How do illness and death affect households?
- When taking into account whether they were affected by illness and death, how do clients of MFI programs differ from non-client microentrepreneurs?
- Does participation in a MFI program mitigate the economic impact of chronic illness and death upon households?
- How do chronic illness and death affect the operations of MFIs and participation in their programs?
- What measures might be taken to mitigate the potential negative impact of HIV/AIDS on households and MFIs?

The study is exploratory since it uses proxy indicators to identify households that were HIV-affected. No attempt was made to verify the reasons for the chronic illness and death, since HIV infection is hidden in a veil of silence in Zimbabwe. People are reluctant to know if they are infected and to talk about infected family members and friends. Hence, the analysis of the survey data employed proxy indicators to identify households that were HIV-affected.

Scope of the Study

This study builds on the work undertaken by USAID's Assessing the Impact of Microenterprise Services (AIMS) project in Zimbabwe. The assessment centered on Zambuko Trust (Zambuko), which has more clients than any other organization providing services to microentrepreneurs in Zimbabwe. Loans are its main product, supplemented by orientation training on business management and informal business management advice from loan officers. The AIMS assessment included a two-stage survey of Zambuko clients and non-client microentrepreneurs conducted in 1997 and 1999, as well as two rounds of interviews with nine case study respondents. The report on the results focuses on whom Zambuko reaches, the role of microfinance in the household economic portfolio and the impact of participation in the program on continuing and departing clients, their households and enterprises (Barnes 2001). (Annex 1 summarizes the results of the AIMS assessment and their implications.)

In this study, we were first interested in exploring the extent to which HIV/AIDS was affecting the households that participated in the survey. Respondent households were classified as possibly affected by HIV/AIDS during the 1997 - 1999 period if they met one of the following criteria:

- a member chronically ill and unable to work in the six months prior to the 1999 interview, or
- absorbed one or more of the following into their household since the 1997 interview and the person remained for more than six months: a sick person, an adult due to death in prior household, or a child due to one or both parents having been sick or died, or
- serious illness of respondent, spouse or household member 20 years old or older, which caused a financial crisis since the 1997 interview, or

- death of spouse or household member 20 years old or older, which caused a financial crisis since the 1997 interview.[1]

Then we sought to determine whether there were significant differences between the households that were possibly affected by HIV/AIDS and those who were not. The results suggest the impact of HIV/AIDS on affected households.

Second, we were interested in whether participation in a microfinance program helps those who become affected by HIV/AIDS. To explore this question we divided the respondent microentrepreneurs from the survey into four groups, as indicated below. Thereafter, we analyzed the differences and similarities in key characteristics of the households in 1997 and 1999, and changes between the two years. For ease of presentation the report focuses on the affected clients and affected non-clients. After identifying the differences in the basic characteristics of the households, we analyzed the impact of microfinance on affected clients, their households and enterprises.[2]

Four Comparison Groups by Client and Affectedness Status

Possibly HIV-affected clients	Other clients
Possibly HIV-affected non-clients	Other non-clients

Third, we aimed to better understand the extent to which chronic illness and death had affected the operations of the microfinance institution, and measures taken by Zambuko to lessen the potential negative effects of HIV/AIDS on its financial portfolio. Also, we wanted to learn staff perspectives on issues related to HIV/AIDS. Fourth, we wanted to understand dynamics within loan guarantee groups related to HIV/AIDS, whether participation in a microfinance program was influenced by illness and death, and former and current clients' ideas on ways organizations might better assist microentrepreneurs who are affected by terminal illness and death. Lastly, we sought the opinions of other key stakeholders – microfinance, HIV/AIDS and donor organizations - on the implications of the findings for MFIs, HIV/AIDS service organizations and donors in Zimbabwe.

B. Approach and Comparison Groups

Definitions of Key Terms

A *household* is defined as one or more persons who usually live and eat together, whether or not they are related by blood, marriage or adoption; and, the individuals recognize each other as members of the same household. Using USAID's definition, *microenterprises* are very small, informally organized business activities (not including crop production) undertaken by low income, poor people. Microenterprises are further defined as having ten or fewer employees, including the owner operator and any paid or unpaid workers (USAID n.d.). For the purposes of

[1] The researchers acknowledge that adult illness and death can be caused by factors other than HIV/AIDS, but consider that these indicators are appropriate for capturing the economic impact of HIV/AIDS on households.
[2] The analysis also included the other clients and other non-clients, but only the results for the two affected groups are discussed.

the study, no attempt was made *a priori* to determine if a respondent met these criteria. Judging from the survey findings, all of them met the employment criteria and two-thirds were poor, measured in terms of daily per capita income, adjusted for purchase power parity and asset accumulation. [3]

Mixed Methods

Quantitative and qualitative approaches were used to gather information. The AIMS assessment of Zambuko included a longitudinal study of a randomly selected sample of Zambuko clients from Harare, Chitungwiza, Bulawayo and Mutare.[4] It also covered a randomly selected group of matched non-client microentrepreneurs from these areas. The initial round of the survey was undertaken between September and November 1997. The follow-up survey was carried out the same months in 1999, to control for seasonal variation (Barnes and Keogh 1999). Annex 2 provides a description of the survey methodology.

The survey findings are complemented by information gathered in focus groups and key informant interviews in December 2000 and January 2001. Focus group discussions were held with a randomly selected sample of a) clients who participated in the survey and b) current clients in the four survey areas. In total, 140 microentrepreneurs participated in the sessions. Also, 33 loan officers and branch managers from the Bulawayo, Mutare and Harare regions (the latter region includes Chitungwiza) participated in focus group discussions and seven senior managers of Zambuko were interviewed. Annex 2 contains more information on the approach used.

Thirty-two persons from MFIs, HIV/AIDS support organizations and donor agencies participated in a one-day forum in Harare on September 13, 2001. After the study's findings were presented, three groups containing a mix of persons from different types of organizations, discussed the implications of the findings in relation to what is currently being done and what else might be done. Later three groups – MFIs, HIV/AIDS service organizations, and donors – met to discuss what their 'sector' might do. Highlights of the small group discussions were reported back to all participants.

[3] The method used to define poverty lines is described in the following section.
[4] These urban areas contain the majority of Zambuko's clients.

Statistical Methods

The survey data were analyzed using two statistical methods that take into account the possibility that the comparison groups might have differed in 1997 in ways that may have affected the findings in 1999. First, the gain score analysis examines the change in performance from the initial survey to the follow-on survey. As such, it does not assume that the two groups were similar in 1997 on the variable analyzed.

Second, to identify the impact of HIV/AIDS on households and the impact of Zambuko on clients and their households, a special statistical approach was used. An analysis of covariance (ANCOVA) approach was used that took into account differences between the comparison groups in 1997 on values for specific, moderating variables. The following moderating variables were used in the ANCOVA analyses: poverty level of the household, household economic dependency ratio, whether or not the household was affected by illness or death between 1995 and 1997, and the 1997 value for the variable analyzed. The ANCOVA procedure statistically "matches" individuals in the comparison groups (e.g. affected clients and affected non-clients) on their 1997 measures on the variable analyzed (e.g. household income level) and on the moderating variables. It then uses the average difference between the matched groups on their 1999 measure of the variable analyzed to estimate impact (see Annex 2).

The gain score analyses and ANCOVA analyses, as well as other tests used, involved statistical tests of significance on the differences found between the comparison groups. For the reader unfamiliar with statistical tests of significance, the test indicates the probability that the observed result is not just a chance coincidence. In this report four levels of significance are used: <.01, <.05, <.10 and <.15. A <.05 result signifies that there is a probability of between 1 and 5 in 100 that the apparent difference between the comparison groups would have occurred due to chance; it indicates that there is a positive correlation between the dependent variable (e.g., affected clients/affected non-clients) and the independent variable (e.g., number of income sources). The smaller the probability (e.g., <.01) the stronger the case that the difference is not due to chance. When the probability is <.15, the results are considered as marginally significant, but the review of the statistical data suggested that the difference is meaningful.

Comparison Groups

As mentioned above, the survey data were analyzed by using two comparison groups – *possibly HIV-affected* microentrepreneurs and *other* microentrepreneurs. Then data were analyzed across four comparison groups: possibly HIV-affected clients, possibly HIV-affected non-clients, other clients and other non-clients. For ease of reading, the possibly HIV-affected respondents are often referred to as *HIV- affected* or *affected*. It is important for the reader to remember that participation in Zambuko's program preceded the events that led to classification of the borrowers by whether or not their household had been possibly affected by HIV/AIDS.

The classification of the survey clients and non-clients is based on the status of the respondent in 1997.[5] The reader should note that between the two surveys approximately half of the 1997 clients did not take another loan from Zambuko; hence, in 1999 many of those classified as

[5] The non-clients who had become Zambuko clients since the 1997 interview and the AIMS case study respondents were excluded from the database, resulting in a sample of 579 respondents.

clients were former clients. The analyses are based on a sample of 579 respondents: 338 clients and 241 non-clients. In 1999, in 36 instances a knowledgeable household member provided responses since the 1997 respondent was not available during the study period. These substitute respondents were excluded from the analyses of characteristics of the respondent, and impacts on the individual borrower.

C. Organization of the Report

Section II provides highlights of Zambuko Trust and its microenterprise development program. It also highlights key contextual factors – inflation and HIV/AIDS prevalence rates - that influenced the findings. In Section III the findings from the survey are presented, summarizing key characteristics of the respondents and their households, the differences and similarities between HIV/AIDS affected and other respondents, and the effects of affectedness. Then the HIV-affected clients and non-clients are analyzed and the impacts of participation in Zambuko's program are identified.

Section IV centers on the opinions and experience of Zambuko staff and officers and former and current clients. This section focuses on actions of Zambuko to mitigate the impact of HIV/AIDs on its program and clients, the dynamics within loan co-guarantee groups, and suggestions for ameliorating the impact of HIV/AIDS on Zambuko and its clients. In Section V the results of the forum are summarized. The final section discusses the results and their implications. A summary of the key findings and conclusions of the AIMS assessment are located in Annex 1. Annex 2 discusses the study design and methods, and Annex 3 contains additional tables.

II. ZAMBUKO TRUST AND ITS CONTEXTUAL ENVIRONMENT

The assessment centers on Zambuko Trust (Private) Limited (Zambuko). This section begins with an overview of its mission, organizational structure and geographic coverage. Then Zambuko's lending products, methods and terms are described. Data are presented on Zambuko's financial portfolio, including the number of loans outstanding at the end of the year and the percentage of female clients. The section concludes by highlighting macroeconomic conditions in the country and the HIV/AIDS epidemic.

A. ZAMBUKO TRUST

Objectives and Coverage

Zambuko, a partner in the Opportunity International Network, emerged from the efforts of a group of Zimbabwean business, community and church leaders who joined together in 1990 to establish a microenterprise lending organization. The name Zambuko means *a bridge* in the Shona language and reflects the mission of the organization: "to be a bridge between the marginalized, the unemployed and opportunities for enterprise and income generation." Its stated goal is to become a self-supportive and viable organization.

Zambuko's objectives focus on facilitating the expansion of microenterprises, creating employment opportunities within the microenterprise sector, and promoting the transition of microenterprises to formal enterprises. Its service objectives are provision of loans, training in business practices and management, and on-going business support services to clients. Its objectives include ensuring that women are equal recipients of loans and services.

Zambuko, which started its operations in February 1992, is incorporated under a Certificate of Incorporation and is regulated under the Companies Act. It is wholly owned by Gesher Trust, a welfare organization, which is constituted in terms of a Notarial Deed of Trust executed in 1991. Zambuko is a licensed 'moneylender,' registered in accordance with the provisions of the Money Lending and Rates of Interest Act, which regulates interest-bearing loans. As a moneylender, Zambuko is not permitted to accept voluntary deposits.

Over the years, Zambuko's organizational structure and geographic coverage have undergone changes that reflect expansion of the program, lessons learned, and utilization of best practices in the microfinance industry. In its initial stage, Zambuko served Harare and Domboshawa, a rural agricultural area approximately 20 kilometers from Harare. The experience in Domboshawa, which coincided with a prolonged period of drought, led Zambuko to focus on urban and peri-urban settings, and to shy away from loans for crop production activities. This focus coincided with the burgeoning of microenterprise firms in urban areas.

Zambuko is structured with a headquarters, and five regional offices, with branch offices under each. The regional offices perform largely management functions, such as monitoring of the branches and enforcement of steps to reduce delinquencies and defaults. Regional offices are

also responsible for handling all loan applications and clients with loans over Z$25,000.[6] In late 2000, Zambuko had 25 branch offices under five regional offices. By the end of the year 2000, the full-time personnel numbered 130, including 19 in the headquarters office that contains the audit and accounts officers. That year the loan officers were given the title of business development officers. (Herein the terms are used interchangeably.)

Products and Methods

Initially Zambuko provided loans to individuals, but in 1995 it started providing group-guaranteed loans (Box 1). Potential clients are encouraged to form a group of 5 to 10 members. After being in a group scheme, a client might ask and be approved for an individual loan product. Resistance to group-guaranteed loans outside of Harare and Chitungwiza, however, led Zambuko to continue to issue loans to individuals who would pledge a non-essential asset and have a co-guarantor. Both individual and group members are required to attend an initial one-half day orientation session prior to receipt of the loan. At the session, the and good, basic management practices are explained.

Box 1. Zambuko Products and Methods

Individual	The requirements are 1) a personal guarantor, and 2) pledge of a movable fixed asset. Where feasible, loans are provided to a cluster of individuals who are either resident or conduct business in the same area and work together in some way. The individual is required to attend a half-day training session prior to formal application for a loan.
Group	A self-selected group of five to ten persons, who either reside or conduct businesses in the same geographic area, co-guarantee each other. A non-essential movable asset is pledged by each member against the loan. Each person is required to attend a half-day training session prior to formal application for a loan.
Trust Bank	This is a variant of the village banking model and is aimed at poorer women. In 1997 it consisted of a self-selected group of 5 members who co-guaranteed loans to each of its members, and 5 to 7 groups formed a center**.** This was changed in 1998 to a group of 20 - 30 members co-guaranteeing loans to its members. Members are required to attend one-hour training sessions for 8 weeks prior to receipt of loan and are expected to attend bi-weekly meetings. Loan installments are made monthly.

Zambuko also has a special loan product under its Trust Bank program. The methodology includes group formation, intensive business training and orientation for eight weeks prior to receipt of first loan, six-month loans and bi-weekly group meetings covering topics of concern to members. During the orientation period there is a compulsory savings requirement that is equivalent to the first loan payment installment. When begun the Trust Bank program focused on women, but later men were able to join the program. This program is targeted at microentrepreneurs from poor household or communities. The business development officers responsible for Trust Bank groups report directly to their branch officers, but are overseen by the Trust Bank Coordinator in the headquarters office.

[6] The Zimbabwe dollar is used throughout this report. One U.S. dollar was equal to Z$11.9 in September 1997 and to Z$38.1 in September 1999. The survey data were analyzed adjusting the 1999 dollar values to take into account inflation since 1997.

Loan Terms and Application Procedure

Table 1 compares the loan terms between August 1997 and August 1999. The interest rate increased from 32 percent to 45 percent, representing a 41 percent increase, while during the same period CPI inflation rate rose substantially. Business development officers are responsible for on-site review of the information in the loan application, an appraisal of the microenterprise, and vetting of the applicant and loan amount. They may determine that the applicant should get a smaller amount than requested. In addition, they are to discuss and agree with clients on the repayment period for individual and group loans, and the practice indicates that loans are usually for 9 to 12 months. The branch officer reviews and approves applications. Each loan officer is assigned a number of persons for whom s/he is responsible. This responsibility consists of follow-up visits to check on the client, provision of informal business advice, and reminders to clients to make their loan repayments on time. The loan officer issues warnings when the loans are delinquent.

Table 1. Comparison of Loan Terms in August 1997 with August 1999

	August 1997	**August 1999**
Interest rate per annum; straight line basis	32%	45%
Application fee	Z $70	Z$200
Processing fee	3.5% on loans less than Z$5,000; 4.5% on loans greater than Z$5,000)	Replaced with 5% administrative fee
Late payment fee	5% of principal in arrears.	Same
Initial deposit	10% of approved loan amount, refunded if loan conditions met.	Not required. Replaced in October 1999 with savings requirement of 7 ½% of approved loan amount initially plus 7½% amortized over life of loan.
Size of loans: individual and group lending program	Between Z$2,500 and $15,000, with repayment period of 6 to 12 months, and for loans greater than Z$15,000, an 18-month repayment period. Maximum initial loan size of Z$5,000.	Same.
Size of loans: Trust Bank	Maximum initial loan of Z$2,500, with Z$9,000 the maximum for subsequent loans. Repayment period 6 months, but increased with size of loan.	Same.

Until mid-2000, individuals within a loan group would individually make their loan installments. Since then, the group co-guarantee of members has been strictly enforced. The repayments must be made as a group, rather than as individual members, and the amount due from all members must be paid, or a late payment fee is applied. By late 2000, the interest rate stood at 48 to 53 percent. Well-paying clients on their fifth or greater loan cycle pay the lower rate, clients on their third and fourth loan cycle paid 50 percent, and the newer clients paid 52 percent. Application fees were eliminated for repeat clients. In January 2001, the administrative fee was

increased to six percent, with one percent of the amount for insurance of the loan upon death of the borrower. As of mid-2001, the other provisions remained the same as noted for August 1999.

Client Base

Approximately 80 percent of Zambuko's clients are women. Zambuko classifies the enterprises for which the loans were secured into five sectors: manufacturing, trade, services, food preparation, and agriculture. Nearly half of its borrowers are traders and approximately 40 percent are manufacturers, involved primarily in knitting and sewing. Agriculture (such as market gardens, livestock trade, and poultry raising) accounts for approximately eight percent; five percent are engaged in service activities; and less than one percent have enterprises focused on food preparation, largely due to government enforcement of regulations governing enterprises engaged in food preparation. The sector distribution of Zambuko clients in 1996/97 paralleled the distribution of manufacturing and commerce in micro and small enterprises nationwide in 1998 (McPherson 1999).

Financial Data and Program Growth

Zambuko's loan portfolio grew rapidly from approximately 3,940 outstanding loans in August 1996 to 15,950 two years later (table 2). The rapid expansion of the program in 1997 into 1998 contributed to the increase in delinquency rate (i.e. loans overdue for more than 30 days) during this period, as inadequate attention was given to quality of the portfolio in contrast to size of the portfolio. Economic stresses from inside and outside the clients' households are also likely contributors to the rise in the delinquency rate. Since 1999 the measures taken by Zambuko have helped to reduce the delinquency rate. By the end of 2000, Zambuko had nearly 9,700 loans outstanding.

Table 2. Zambuko Loans and Rates, September 1995 – December 2000*

	Sept. 95-Aug. 96	Sept. 96-Aug. 97	Sept. 97-Aug.98	Sept. 98-Dec. 98	Jan. 99-Dec. 99	Jan. 00-Dec. 00
Loans Outstanding at End of Year (number)	3,934	10,558	15,947	13,380	12,244	9,696
Loans to Women (percentage)	77%	77%	78%	79%	83%	81%
Average Loan Size (Z$)	n.d.	2,537	3,036	5,517	5,496	10,162
RATES						
Nominal Annual Interest Rate Charged by Program	32%	32%	35%	37%	45%	50%
Inflation Rate	18%	18%	30%	30%	61%	62%
Official Exchange Rate	10.3	11.9	32.0	37.0	38.0	55.0
Delinquency Rate (30+ days) (percentage)	19%	16%	25%	7%	6%	2%

Source: Zambuko Trust Financial Records and, for the exchange and inflation rates, issues of the *Monthly Bulletin of the Reserve Bank of Zimbabwe.*

*The fiscal year was from September 1 through August 31, but was changed in 1999 to coincide with the calendar year.

Zambuko's enactment of measures to reduce the delinquency rate coupled with donors halting their assistance due to the political situation in the country account for the reduction in the

number of loans extended in 1999 and 2000. Over the years, a number of donors have assisted with the establishment, expansion and strengthening of Zambuko. During the assessment period the main donors were the Australian Agency for International Development and the U.S. Agency for International Development. Funding was also received from the Humanist Institute for Cooperation with Developing Countries (HIVOS), a Dutch NGO, and Opportunity International.

B. Contextual Environment

Macroeconomic Environment

The macroeconomic context influences the operations of microfinance institutions. The larger environment also influences the circumstances, options and choices of households and owners of microenterprises. In 1998 an estimated 25 percent of Zimbabwe's working population were employed (including self-employed) in micro and small enterprises. Between 1991 and 1998 the number of microenterprises increased by 30 percent in the urban areas. Increases in the urban population, job retrenchment and consumer prices contributed to these growth rates. In 1998 approximately 45 percent of the enterprises were engaged in trade, which tends to have low entrance costs (McPherson 1998).

Economic stresses were prevalent in the period leading up to the AIMS survey in 1997. The stresses included macro-level structural changes in the economy, a period of severe, widespread drought, and high levels of inflation. This combination resulted in economic hardship for the majority of the population but also spurred a relaxation of regulations governing microenterprises (Barnes 2001).

Weak economic policies, governance problems, unsustainable levels of public spending, and high levels of domestic debt have characterized the period since 1997. Examples include weaknesses in parastatal finances arising from delays in tariff adjustments, government intervention in the Democratic Republic of the Congo conflict from August 1998 onwards, election-related tensions and output disruptions associated with the direction of land reform and resettlement (IMF 2001). By the first quarter of the 1999 fiscal year, interest payments on domestic debt amounted to Z$4 billion, which was more than the total amount of Z$3.7 billion originally budgeted for the Ministry of Health and Child Welfare (Machipisa 1999).

Inflation has been on an upward trend since 1997. The annual inflation rate as measured by the Consumer Price Index (CPI) in the 12 months after the launching of the AIMS survey in September 1997 was approximately 31 percent. The annual CPI rate rose 70 percent over the next 12 month period and then rose to 62 percent from September 1999 through August 2000 (table 3).

Table 3. Annual Increases in the Consumer Price Index, September 1997-2000*

1997	1998	1999	2000
14.4%	31.7%	69.7%	62.0%

Source: Central Statistical Office, *Quarterly Digest of Statistics*, June 2000 and Reserve Bank of Zimbabwe, *Monthly Review*, October 2000.

The CPI data reveal that the cost of basic necessities increased substantially between 1997 and 1999 and continued to rise in the year 2000 (table 4). The price for food, medical care, and transport and communication more than doubled between September 1997 and September 2000. The year-on-year increases were particularly high in 1999. As a result, business establishments tended to cut back on the number of employees and some businesses closed, as documented in numerous articles in the Zimbabwean newspapers during this period.

Table 4. Zimbabwe Consumer Price Index for Selected Items, 1997-2000

	1997	1998	1999	2000 (Oct.)
1990=100				
Food	658.0	1,072.1	1,680.9	2,507.3
Rent, rates and electricity	467.0	519.4	705.2	1,069.2
Medical care	774.9	895.9	1,743.0	2,595.2
Transport and communication	486.3	789.3	1,297.8	2,379.9
Education	438.2	536.1	732.8	1,045.6
Year-on-year Percent Change				
Food	18.9	62.9	56.8	47.6
Rent, rates and electricity	23.8	11.2	35.8	55.0
Medical care	8.8	15.6	94.6	146.6
Transport and communication	24.2	62.3	64.4	121.6
Education	44.1	22.3	36.7	46.6

Source: IMF, *Zimbabwe*: *Recent Economic Developments, Selected Issues, and Statistical Appendix,* January 2001.

HIV/AIDS Epidemic

The negative impact of the macroeconomic environment on households has been exacerbated by the social and economic effects of the high incidence of HIV/AIDS in Zimbabwe. In mid 1999, the population of Zimbabwe was estimated to be between 9 and 11.9 million, with approximately 43 to 54 percent under 15 years of age.[7] While life expectancy prior to the AIDS epidemic was 65, it is projected to decrease to approximately 39 by 2005. The population growth rate in 1999 was considered to be only 1.8 percent, whereas the annual growth rate between 1980 and 1995 was estimated to be 3.1 percent.

An estimated one-quarter of the adults aged 15 through 49 are HIV/AIDS infected. Overall, an estimated 1.5 million adults and children were infected by the end of 1999. Deaths due to AIDS were estimated to be 130,000 in 1997 and 160,000 in 1999. Some 624,000 children under age 15 are estimated to have lost their mother or both parents by the end of 1999 (UNAIDS and WHO 2000). Recent data reveal that 10 out of every 100 children die before they reach age five (DHS 1999).

[7] Two sources via the internet, the CIA Country Fact Book and the UNAIDS fact sheet on Zimbabwe, vary greatly. The IMF (2001) using government statistics places the 1999 population at 11.9 million.

III. SURVEY FINDINGS

This section starts with a general introduction to the survey respondents. It then compares the affected households with other households, addressing key similarities and differences between them and the impact of affectedness. The last part centers on the two affected groups – clients and non-clients. It highlights the differences and similarities between them, and the impact of participation in Zambuko's program on the affected clients, their households and enterprises.

A. Key Characteristics of Respondents and Their Households

Affectedness

Forty percent of the clients and 39 percent of the non-clients were from households that were possibly HIV-affected in 1999. Illness of spouse, self or another household member 20 years old or older was the most common indicator of being HIV-affected (table 5). There was a relatively high rate of death of a spouse or another household member 20 years or older among the affected households. Clearly 34 percent of the affected client households and 24 percent of the affected non-client households had experienced the death of an adult member in the past two years. One-fifth of the affected households reported a chronically ill member and slightly more than one-quarter had absorbed a person into their household that was ill or as a result of illness or death in their previous household.[8]

Table 5. Distribution of Illness and Death Among the Affected Clients and Affected Non-clients, 1999 (percentage)

	Clients N = 134	Non-clients N =94	Total N=228
Serious illness of respondent, spouse, or household member > 20 years the last 2 years	47	55	50
Death of spouse or other member > 20 years the last 2 years	34	24	30
Absorbed new household member due to illness or death the last 2 years	30	27	29
Chronically ill household member, the last 6 months	22	19	21

Nearly half of the households classified as HIV-affected in 1999 had suffered from serious illness or death of a household member between 1995 and 1997. The affected clients (35 percent) were significantly more likely than the affected non-clients (23 percent) to have experienced a crisis due to illness of a household member in the two years prior to the 1997 interview (<.05). Between 1995 and 1999, the affected clients experienced illness or death in more ways than the affected non-clients: 2.6 and 2.3 respectively (<.05).

[8] The cases of chronically ill persons are also captured in the more general question on serious illnesses. These cases suggest an advanced stage of HIV infection.

Respondents

Most of the survey respondents were women since Zambuko loans primarily to women. In 1999 the respondents tended to be 41 years old, with eight years of education (table 6). The majority were married and 16 percent were widowed.

Table 6. Socio-demographic Characteristics of the Respondents

	HIV-affected		Others		Total
	Clients N=124	Non-clients N=88	Clients N=194	Non-clients N=137	N=543
% Female	87	85	85	85	85
Average Age, 1999	42	40	41	40	41
Average Educational Level[1]	7.6	7.0	8.2	7.3	7.7
Marital Status, 1999					
Married	63	67	75	77	71
Widowed	25	22	11	10	16
Single/divorced/separated	12	11	14	13	13

[1] Significant difference between other clients and other non-clients (p=<.01).

Participation in Zambuko's Program

The intensity and extent of participation in Zambuko's program did not differ significantly between the HIV-affected clients and the other clients. In 1997, approximately 60 percent of the client respondents were on their first loan. After completion of that loan, 42 percent of the affected client respondents and 48 percent of the other clients continued to participate in Zambuko's program: they took one or more loans between 1997 and late 1999. The average sum of all loans received was similar for the affected clients and other clients (table 7).

Table 7. Participation in Zambuko's Program by Affectedness Status

	HIV-affected Clients	Other Clients
Participation Indicators	N=134	N=204
% New Clients in 1997	60	61
% Continued since 1997	42	48
Average Number Loans	2.1	2.2
Average Sum All Loans (Z$)	5,821	6,435
Continuing Clients and Amount Borrowed Since 1997	N=56	N=99
Average Sum Since 1997 (Z$)	6,416	6,870

Program departure, however, does appear to be associated with having a chronically ill household member in 1999 and recent widowhood. Thirteen percent of the departing clients compared to five percent of the continuing clients had a chronically ill household member (<.05) at the time of the 1999 interview. Also, among those who had become widowed after 1997 and had not remarried, the continuation rate was only 38 percent, compared to 49 percent of those who were not widowed in 1997 nor in 1999. These findings suggest that certain types of affectedness influence program departure.

B. HIV-affected Respondents Compared to Other Respondents

Household Demographics and Poverty Levels

The age of the respondent does not appear to be related to being HIV-affected. In 1999, on average the HIV-affected respondents were 41 years old and the others 40 years old. As might be expected, more of the affected respondents than the other respondents were widowed: 25 percent and 11 percent respectively. Widowhood among the other respondents reflects that they were widowed in 1997 but had not remarried and not experienced HIV-related events in their household since then. In 1997 both groups averaged 5.6 household members, whereas by 1999 the affected respondents averaged 5.8 members and the others had 5.6 members. The change in the size of the households may be associated with affected households taking in sick persons and orphans.

The household's poverty level does not seem to influence whether it becomes HIV-affected. Poverty was defined using global standards related to purchase power parity to determine per capita a day income. Then taking into account key expenditures and assets, each household was categorized as extremely poor, moderately poor or non-poor.[9] In 1997, there were no significant differences between the two groups based on their poverty level. Thirty-nine percent of the households that became affected and 35 percent of the others were extremely poor. By 1999 movement out of extreme poverty (and remaining in extreme poverty) was not associated with the affectedness status of the household.

However, HIV-affectedness appears to be associated with households falling into poverty. In 1997, 26 percent of the households were not poor. Two years later, among those who were not poor in 1997, more of the HIV-affected households (57 percent) than the other households (33 percent) had fallen into poverty (<.01). Movement into poverty appears to be related to an increase in the proportion of household members who were economically inactive. The findings, however, do not indicate that movement into poverty was associated with the household absorbing a person who was either ill or had experienced illness or death in their previous household.

Household Economic Situation

HIV-affectedness is significantly associated with the proportion of the household's members who are economically active, the role of enterprise income in the household's economic portfolio and the ability to seek medical treatment. Affectedness is linked with a rise in the proportion of the household's members who are economically inactive, that is its economic dependency ratio (table 8). In 1999, the HIV-affected households had a significantly higher economic dependency ratio (40 percent) than the other households (32 percent). Moreover, between 1997 and 1999, the change in the household's economic dependency ratio was significantly greater for the affected households.

[9] The extremely poor are those households under the US$1 a day per capita poverty line, the moderately poor were between US$1 and $2 a day per capita poverty lines, and non-poor were above US$2 a day per capita poverty line, taking into account key expenditures and assets (see Barnes 2001).

Households may earn income in a variety of ways: microenterprises, salaried or wage employment, rental property, sale of livestock or crops, casual labor and remittances. Yet, in 1997, 38 percent of the respondent households were exclusively dependent on their enterprises for their livelihood.[10] By 1999 only one quarter of the respondent households were exclusively dependent on their enterprises for household income. These findings reflect a general decline in the role of enterprise income in the household's economic portfolio.

Between 1997 and 1999 the proportion of the household's income earned from its enterprises decreased for both comparison groups. The average ratio of enterprise net revenue (profit) to total household income dropped from 75 percent to 55 percent for the affected households and from 66 percent to 57 percent for the other households. The change between the two years was significantly greater for the affected households (<.01), suggesting that illness and death influenced the extent of the decline. For both groups, the decline is partially, but not fully, attributable to 51 households no longer having an enterprise. When these households were excluded from the analysis, the decline between 1997 and 1999 was less. Among households with enterprises both years, the ratio of enterprise income to total household income decreased from 75 to 62 percent among the affected households and from 66 to 60 percent among the other households (<.05). Both analyses reveal that affectedness is linked to the extent of the decline in the relative contribution of enterprises to household income.

Table 8. Key Differences Between HIV-affected Households and Other Households (percentage distribution)

	HIV-affected	Other	Statistical Significance
Economic Dependency Ratio			
1997	31	29	
1999	40	32	<.01
Gain score change	.6	2.8	<.01
Ratio of Enterprise Income to Total Household Income	N=221	N=282	
1997	75	66	<.01
1999	55	57	
Gain score change	-20	-9	<.01
Did Not Seek Medical Treatment When Needed in Past 6 Months Due to Lack of Funds (1999)			
Yes, unable to seek treatment	18	9	<.01

Affectedness was also associated with a lower level of household income. In 1999, the monthly income of affected households averaged Z$3,343, which was significantly less than the Z$4,142 earned by the other households (p=<.05). The affected households' per capita monthly income of Z$706, however, did not differ significantly from the Z$655 earned by the other households. In 1999 affected households were more likely than the other households to have not sought medical treatment when needed in the last six months due to a lack of funds: 18 percent compared to nine percent respectively. Not seeking treatment was more common among the poor, affected households than the other poor households. The reason may be related to a more constant need for medical services in the affected households.

[10] Exclusively is defined as 95 percent or more of their income the month prior to the survey was from household enterprises.

Impact of Affectedness on Households

It is generally known that HIV/AIDS has a negative, economic impact on affected households. The analysis, which controls for specific differences in 1997, suggests the ways HIV/AIDS negatively impacted respondent households (table 9). The findings suggest that HIV infection influences the amount of income the household earns from its enterprises, which in turn affects the household's overall monthly income level. The monthly household income level for HIV-affected households was estimated to be Z$525 less than for other households. Also, the monthly net revenue in the household's enterprises was Z$521 less a month for the affected households than the other households. The results imply that affected owners and their household members spent less attention to positioning their enterprises in a competitive and declining market.[11]

Table 9. Impacts of HIV-Affectedness Suggested by the ANCOVA Analyses

Findings: 1999 compared to 1997*	Statistical Significance
<u>At the household level</u>, affected households compared to other households had:	
▪ lower level of monthly household income (Z$535)	<.15
<u>At the enterprise level</u>, affected household compared to other households had:	
▪ lower level of monthly net revenue in matched enterprise (Z$628)	<.01
▪ lower level of monthly net revenue from all the household's enterprises (Z$521)	<.05
▪ fewer person hours worked last week in matched enterprises (13 person hours)	<.05
<u>At the individual level</u>, affected respondents compared to other respondents had:	
▪ greater proportion with an individual savings account with a formal institution (6 percent)	<.10

* The analysis took into account specific initial differences in 1997, including household poverty level, household economic dependency ratio, and whether or not the household had a crisis due to illness or death of a member between 1995 and 1997. The 1999 dollar values have been adjusted to 1997 constant values to take into account inflation. Matched enterprise refers to the enterprise for which the client had taken their 1997 loan, and the non-client selection criteria included having an enterprise in the same sector as the client.

The findings do not suggest that the affected microentrepreneurs worked fewer hours in the household's enterprises. However, the respondents from affected households spent fewer hours in their matched enterprises (the enterprises for which the clients had received their 1997 loans and against which the non-clients were matched) in 1999 than did the other microentrepreneurs. The findings imply that the matched enterprise of the affected respondents was less important in the household's economic portfolio in 1999.

An interesting finding is that affectedness appears to be linked to the microentrepreneurs having a personal savings account with a formal institution in 1999. In spite of the highly inflationary environment, it seems that the affected microentrepreneurs feel the need to have a personal

[11] The findings for 1997 and 1999 are given for these impact variables and other variables in Annex 3.

savings account. They probably have greater need to ensure access to funds for emergency situations.

On a number of other socioeconomic indicators, the impact analysis suggests that the HIV-affected households were similar to the other households, thus it appears that the affected households were no worse off than the other households, when differences in 1997 were taken into account. For example, no statistically significant differences between affected households and other households were suggested by the results of the ANCOVA analysis on: per capita monthly income; frequency of consumption of specific, nutritious food items; proportion of the household's boys and girls aged 6 to 16 in school; the proportion of the household's boys and girls aged 6 to 21 in school; and person-hours worked in household enterprises.

C. Comparison of HIV-Affected Clients and Non-clients.

Demographic Characteristics and Poverty Level

The HIV-affected clients tended to differ from the affected non-clients in a number of ways (table 10). In 1999 the affected clients' households were larger and had a higher economic dependency ratio. Also, widowhood had risen more among the affected clients than the affected non-clients.

Table 10. Key Differences Between HIV-affected Clients and Non-clients (percentage distribution)

	HIV-affected Clients	HIV-affected Non-clients	Statistical Significance
Average Household Size	N=134	`N=94	
1997	5.9	5.2	<.05
1999	6.2	5.4	<.05
Gain Score	.3	.3	
Economic Dependency Ratio	N=134	N=94	
1997	31	30	
1999	43	37	<.10
Gain score change	11	7	
Widowhood			
% that became widowed since 1997	16	9	
Poverty Status			
1997 Extremely Poor	34	46	<.10
Moderately Poor	37	39	
Not Poor	29	15	<.01
1999 Extremely Poor	24	39	<.05
Moderately Poor	45	34	<.10
Not Poor	31	27	
Did Not Seek Medical Treatment When Needed in Past 6 Months Due to Lack of Funds (1999)			
Yes, unable to seek treatment	22	13	<.10

In 1997 significantly more of the affected clients than affected non-clients were not poor. By 1999 however the proportion in each group that were not poor tended to be similar, reflecting greater movement out of poverty by the non-clients. The findings on changes in the poverty status of households reveal that significantly more of the affect clients, than the affected non-clients, had moved out of extreme poverty. The analysis on movement into and out of poverty, however, implies that household structure was a stronger influence than microfinance upon the movement (Barnes 2001).

Household Economic Situation

Between 1997 and 1999, the net revenue (profit) from the matched enterprises decreased for both the affected clients and non-clients. When all the household's enterprises were considered (table 11), the results also revealed a decline. Nevertheless, households of the affected clients had a higher level of monthly income from enterprises than those of the affected non-clients. The findings highlight that the enterprise profit levels in affected households had not kept pace with inflation.

When monthly income is considered in relation to household size, between 1997 and 1999 the households of affected clients were able to increase their per capita monthly income by Z$21, whereas it decreased for the affected non-clients. The findings on per capita monthly income and household enterprise income for the affected clients imply that their households had become more reliant on non-enterprise income. [12]

Table 11. Average Total Net Revenue from Household Enterprises Last Month, 1997 and 1999 (Zimbabwe dollars in 1997 constant values)*

	Possibly HIV-affected	
	Clients N=104	Non-clients N=73
1997[1]	2,672	1,822
1999[2]	2,215	1,630
Gain Score	-456	-192

*Analyzes those with enterprises in 1999 and with complete information for both years. Outliers (values more than three standard deviations from the mean) were removed.

[1] Significant differences between: affected clients and affected non-clients (p=<.05);

[2] Significant difference between: affected clients and affected non-clients (p=<.10);

In spite of the higher, average per capita income level for the affected clients, significantly more affected clients (22 percent) than affected non-clients (13 percent) reported that their household did not seek medical services when needed during the six months prior to the 1999 interview due to a lack of funds. The higher economic dependency ratio and greater extent of illness and death among the affected clients, compared to the affected non-clients, may have contributed to this outcome.

[12] All of the 1999 income and net revenue data were adjusted to 1997 constant values to take into account inflation. See tables in the Annex 3.

Impact of Microfinance on Affected Clients

The impact analyses suggest a limited but important, number of ways that participation in Zambuko's program had a positive impact on HIV-affected clients and their households (table 12). The ANCOVA results suggest that affected client households had more sources of income than the affected non-client households, indicating that these clients had followed an income smoothing strategy. Also, the affected client households, compared to the affected non-client households, had a higher proportion of the household's boys aged 6 to 16 enrolled in school, indicating investment in the human resources of its members.

Zambuko's program also appears to have had an impact on the way affected clients manage their finances. In 1999, 13 percent more of the affected clients than the affected non-clients insisted on a deposit when they extended credit to their matched enterprise customers. Also, 16 percent more affected clients than affected non-clients had an individual savings account with a formal institution. In addition, the average number of ways the respondent saved was higher for the affected clients than affected non-clients. These differences imply that Zambuko's business management training has a positive impact on the way affected clients manage their money.[13]

Improved Financial Management

In May 1997 when she received her first Zambuko loan, Ms. Mlanga, a 32 year old divorcee with a four year old son, had few household assets and lived in one-room that she rented. In late 1998, Ms. Mlanga took in her chronically ill and widowed sister. The sister's in-laws sent her away when they took over her deceased husband's property and care of her children. To accommodate the sister, Ms. Mlanga moved into a two-room rental unit without electricity. Ms. Mlanga attributes the training she received from Zambuko to her ability to manage her meager financial resources. Using the budgeting skills she acquired, she is able to pay her rent on time and buys groceries in bulk. She says that if it were not for Zambuko, she would not have achieved what she has so far.

Mrs. Chikaro started borrowing from Zambuko in 1994. Prior to becoming a client, she did not have any confidence in her enterprise and herself because her enterprise was struggling to survive. Her husband, the household's main income earner, became ill and then died in early 1997. During his illness, her enterprise activities were disrupted since she devoted time to caring for him. After her husband died, she continued to borrow from Zambuko. Her savings and loans enabled her to buy a knitting machine and build a rental unit adjacent to her house. She has managed to support herself and her four children. She reports, "someone coming into my house would not know that there is no man," since she is doing well meeting all of the household expenses by herself.

The ANCOVA results also suggest a negative relationship between participation in Zambuko's program and employment in the household's enterprises.[14] In 1999, the number of person hours worked in the matched enterprise the week prior to the interview was 13 hours less for the affected clients than the affected non-clients. The reason might be associated with a decline in the importance of the matched enterprise to the household economy. Nevertheless, affected client respondents worked eight hours less the week prior to the interview in all household enterprises than did the affected non-clients. Since affected client households had a higher economic dependency ratio and more household members, the reason may be associated with fulfilling other responsibilities.

[13] Table 15 in the Appendix A, table 15 contains the findings for 1997 and 1999, and changes between the two years on the impact variables.

[14] The analysis does not include the matched enterprises that had ceased operation since 1997.

Table 12. Impacts of Microfinance on Affected Clients Suggested by the ANCOVA Analyses of the Survey Data

Findings (1999 compared to 1997) [1]	Statistical Significance
<u>At the household level</u>, HIV-affected clients compared to HIV-affected non-clients had:	
• greater number of household income sources (.23)	<.01
• higher proportion of the household's boys aged 6-16 in school (5%)	<.10
<u>At the enterprise level</u>, HIV-affected clients compared to HIV-affected non-clients had:	
• fewer total person hours a week in their matched enterprise (13 person hours)	<.15
• worked less hours the previous week in household enterprises (8 hours)	<.05
• greater proportion that insist on a deposit when extending credit to customers (13%)	<.10
<u>At the individual level</u>, HIV-affected clients compared to HIV-affected non-clients had:	<.01
• greater proportion with an individual savings account with a formal institution (16%)	<.01
• saved in more ways (.43)	

[1] These estimates are derived from the impact analysis that was conducted on the four comparison groups. The analysis took into account specific initial differences in 1997, including household poverty level, household economic dependency ratio, and whether or not the household had a crisis due to illness or death of a member between 1995 and 1997.

D. Discussion and Conclusions

The classification of households using proxy indicators of HIV/AIDS indicates that 40 percent of the microentrepreneurs' households were HIV/AIDS affected. This is higher than the official HIV/AIDS prevalence rate of 25 percent. The difference is likely due to the study including households that had absorbed orphans and sick persons, and those that had experienced death of a household member.

By 1999 the affected households compared to the other households had higher economic dependency rates, were more likely to be poor, had been unable to seek medical treatment when needed due to a lack of funds, and had a lower monthly income level. The findings indicate very negative economic impacts of HIV/AIDS on households. Related to this, affected microentrepreneurs appear to be more likely to have a personal savings account with a formal institution. This suggests that they try to position themselves to have access to cash for emergencies and extraordinary expenditures.

Client households that were possibly HIV-affected tended to have more household members and higher economic dependency ratios than the non-client households. Participation in Zambuko's program appears to have had a positive, but limited impact on the affected clients. Factors external to the household appear to have influenced the survey results, as indicated in the following section.

IV. PERSPECTIVES OF ZAMBUKO OFFICERS AND CLIENTS

This section explores issues linked to HIV/AIDS mitigation from two perspectives: Zambuko's officers and managers, and former and current clients. From an institutional view, a microfinance program is concerned both with reaching its target group of microentrepreneurs and becoming a financial viable organization. From a client perspective, they want access to loans, but may have difficulties repaying them.

A. Microfinance Perspective

A number of issues are addressed from the perspective of program officers and managers. How do illness and death affect Zambuko's operations and financial portfolio? What are the views of managers and officers on the involvement of HIV-infected microentrepreneurs and those affected by chronic illness and death? What has been the experience of business development officers related to chronic illness and death in client households? What has Zambuko done to mitigate the potentially negative impact of HIV/AIDS on the program and its clients? What measures do officers suggest to address the HIV/AIDS situation among microentrepreneurs?

Business development officers are the interface between the microfinance program and its clients. Their job is to represent the organization and implement its policies. Their responsibilities include encouraging microentrepreneurs to join the program; explaining the program's products, policies and procedures; conducting an assessment of the loan applicants; following up on clients, especially those in arrears; and providing business development advice. Branch officers have the responsibility of approving the loan applications based on a review of the business development officers' assessments and recommendations. Since the business development officers and the branch officers are the clients' main point of contact with the program, their opinions and experiences provide valuable insights on the situation.

Impact of HIV/AIDS on the Program

The impact of HIV/AIDS on a microfinance institution (MFI) may be in terms of loan defaults, loss of clients, staff absenteeism and loss of staff members. Zambuko has no basis for determining the impact of HIV/AIDS on its program. One reason for the lack of data is the veil of silence around admitting being infected and acknowledging infection among family members and friends.

Loan guarantors and pledged assets have mitigated the impact of illness and death on loan repayments. In 2000, Zambuko kept information on the loan amounts written off due to death of the client. The amount written off was less than one-half of one percent of the loans outstanding at the end of the fiscal year. The low rate is partially attributable to the guarantors repaying the outstanding loans of deceased clients. Information from the AIMS survey and the focus group discussions imply that the client death rate between 1997 and 1999 was less than 1.5 percent per annum. Zambuko's recent enactment of a mandatory insurance fee to cover the outstanding loans of deceased clients should enable them in the future to know the number of clients who

have died, the percent of clients that year who died and the amount written off due to client deaths.

Zambuko's staff is primarily in the high-risk age range of 20 to 45 years old. Since its establishment in 1992, Zambuko has lost only one staff member due to death. Zambuko senior managers consider that Zambuko has a rather low risk of loosing staff due to HIV/AIDS since it is a Christian organization that recruits religious persons. Senior managers had no basis for estimating the amount of absenteeism because of persons caring for the ill or attending funerals.

Loans to Sick Persons

Zambuko has a policy against loaning to persons who are ill, because of the risk associated with the ability of the individual to repay their loans. The business development officers are required to note on the loan assessment form whether the person looks healthy. The officers described instances where they had turned down an application from someone who died shortly thereafter. Nevertheless, there were notable examples of the officers recommending approval of loans to microentrepreneurs who were ill.

Loaning to Those Who Are Ill

A group loan member confided to her loan officer that she was HIV-positive. At her request, he talked with her group members and they consented to allow her to remain in the group for the next loan cycle.

A woman who appeared to be very ill applied for an individual loan to invest in her small hotel. The loan officer told her that she needed the proper legal documents for her business. After some months she brought the documents and she was given a loan based on his recommendation. She died but her family paid-off the loan and the business is still thriving. Without the appropriate legal documents, her business would have probably closed.

The officers generally feel that "giving an ill person a loan is like putting them and related persons in a trap." At the same time, they acknowledge that clients normally do not tell them that they are ill, and the officers often cannot judge the person's health status by how the person looks. Death of a client is not an unusual occurrence and the loan officers have been responsible for ensuring the guarantors pay the outstanding debt. Fortunately, the new loan insurance will eliminate future cases of hardships on families and guarantors if the borrower dies. It will also relieve the business development officers from being placed in the unenviable situation of collecting on the loans of deceased clients.

Death of Clients With Individual Loans

A client who took an individual loan of Z$12,000 died, then her husband died. Her son took over responsibility for repayment of the outstanding loan, but when relocating to the rural areas he had a car accident and all of his property was destroyed. "Despite this, the son is struggling with the loan installments and sometimes makes one payment in two months."

When a Bulawayo loan officer went to check on a client with an individual loan, he found her ill. When he went back at a later date, he found the husband ill too. He prayed with them and bought them some bread. On his next visit, he found that the client had died. Zambuko stopped charging interest on her loan, and her son is currently repaying the amount outstanding.

Loans to Persons Affected by Illness and Death

When asked about loaning to persons who are affected by chronic illness or death of a household member, the officers' distinguished between persons applying for group loans and those asking for an individual loan. Prior to each loan cycle, the members of a loan group decide who should be in their group. In cases where the group has helped a member pay her installment, the officers noted, "if the member shows appreciation and commitment to pay back members who bailed her out, they normally let her stay."

In regard to individual loans, in one region, there seems to be a tendency to deny an individual loan to a woman if her husband is chronically ill. Loan officers stated that illness in the household has a negative effect on the woman's enterprise. The woman has to devote lots of time caring for her sick husband, take him for medical treatment and, if hospitalized, spend time visiting there. This caregiver role is socially expected of her and the wife normally wants to perform it. This causes her to neglect her business. Therefore, these officers are reluctant to give a loan to a woman with a chronically ill husband.

Officers in one region stated that borrowers with individual loans who are unable to meet a loan installment due to illness or death in the family might have their payments deferred to the following month. When the arrears problems continue, the officers usually attach the pledged asset first and if it did not cover the full amount owed, then contact the guarantor. This was done, they said, because guarantors normally expect to be used as the last resort. When asked to meet their contractual obligations, the guarantors will ask the business development officers if they had sold the pledged asset and are unwilling to pay if this has not been done.

Reasons for Difficulties Repaying Loans in 2000

Officers participating in the focus group sessions were asked for their opinions on the main reason why clients had difficulties in 2000 with repaying their loans. Their responses were categorized into common themes. Thereafter, the participants were asked to identify those factors that they considered to be the main reasons. Their responses provided the following results.

- The economic climate was most commonly ranked as the number one reason why clients had difficulty repaying loans in 2000. The officers who cited this as the main reason mentioned a number of factors. Most clients have problems selling their products because their customers no longer have the same buying power, due to inflation. To attract buyers, clients have tended to lower their profit margins (in inflation adjusted values). Also, some customers have relocated to the rural areas to escape the economic hardships of urban life.

- The political climate tended to be the second most commonly reported reason for difficulties repaying loans. This reason is related to the high proportion of clients who sell their products in rural areas. They were affected in the following ways. First, there were those who were unable to collect on the credit extended to farm workers since the invasion of commercial farms caused the laborers to flee. Second, they lost their market because of farm invasions. Third, persons traveling to rural areas were harassed due to

the political tension associated with the national elections, thus those selling at schools and other sites outside the commercial farms were negatively affected.[15]

- Illness and death was the next most commonly rated reason. Interestingly, two branch officers cited it as the number one reason, based on explanations given by clients in default. Officers acknowledged that the illness and death might be from HIV/AIDS, but often another reason is given. As one officer put it: "AIDS has killed them or is eating them. If they have someone suffering from AIDS, they concentrate on looking after the sick person and neglect the enterprise." Also, when the main income earner falls ill, the overall household income is reduced drastically and other income has to be used to pay hospital fees and other medical expenses.

Program Responses

Zambuko has instituted a number of measures and policies to better manage its loan portfolio, which in turn has helped to reduce its risks related to HIV/AIDS. In addition, the Trust Bank program has included measures to help clients cope with HIV/AIDS.

- As mentioned previously, in January 2001, Zambuko initiated a mandatory insurance fee to cover the outstanding loans of deceased clients. The fee was set at one percent of the loan. Zambuko will need to monitor fees collected and payouts to determine if the fee amount is too low or too high.

- To assist with covering loan defaults, Zambuko has initiated a mandatory savings requirement. The borrower is to be given her savings at the end of the loan cycle, minus any funds used to cover the borrower's loan installment.

- Two policies were instituted in 2001. Business development officers are to reassess the enterprises and assets prior to recommending the client for another loan. This policy was instituted since the situation may have changed since the previous assessment. Second, Zambuko will not allow business development officers to take on new clients if more than five percent of his current clients are delinquent in paying their loan installments.

- As a Christian organization, Zambuko has counseled its officers to pray with the client when that person is ill, dying or affected by illness or death. This helps to uplift the spirit of the individual and demonstrate compassion.

- The Trust Bank program began a funeral insurance scheme in 1997. It was initiated by the Trust Bank Officer in reaction to the needs expressed by clients. The funeral scheme was operated and managed independently of Zambuko, under the management of officers elected by the members since Zambuko itself cannot accept voluntary deposits. Each member would contribute a specified amount and as long as they continued to contribute according to the stated agreement they would be covered. The insurance covered the client, spouse and children in the household, with declining amounts paid out depending

[15] The AIMS analysis reveals that 60 percent of the client respondents were operating in long distance markets in 1999.

on who died. The scheme floundered after its first year and then folded. It was revived in 2000, but as discussed in the next part, clients appear to have lost confidence in it.

- The Trust Bank's bi-weekly meetings of clients offer the opportunity to cover topics related to HIV/AIDS. In 2000, a representative from the Ministry of Health spoke at the Trust Bank group meetings about caring for HIV infected persons. Based on feedback from focus group participants, clients receiving this training found it extremely useful. Also, a specialist was brought in to talk to the groups about legal issues facing women. This is particularly important in terms of women dealing with relatives' claims on their deceased husband's property.

Suggestions

A number of suggestions arose during the focus group sessions with Zambuko officers. No attempt was made to formally critique each or to reach consensus.

- The majority of the officers voiced that Zambuko's target group is, and should be, the economically active. In one session, an officer argued that Zambuko as a Christian organization had a responsibility of helping even the terminally ill. Others in his group, however, felt that loans would burden not help these people. Officers pointed out that microfinance organizations like Zambuko need to make money to cover their costs as well as help households. These two objectives are not necessarily compatible.

  In another session, some officers felt that Zambuko ought to take a more active role in helping people caring for terminally ill family members. They recommended that a special fund be established with donor monies that could be used to target such individuals and cover defaults. They thought that another organization should manage the fund, since its management would burden Zambuko.

- Officers felt that they need to be more capable of dealing with situations they encounter related to terminal illness and death. Business development officers are seen as helpful and thus they are sometimes asked "unusual questions." Working among the people, they also encounter sensitive situations. They are often caught "off-guard." The situations range from a person confiding that she or a household member is HIV infected, to dealing with a client grieving the loss of her husband and unable to pay her loan, to a woman asking for legal advice. Zambuko managers have counseled them to pray with the person. This helps to bring some solace. Training especially related to communicating with HIV-affected clients was broadly welcomed. "That would really help us, because now we are depending on our intuitions." "We are just holding on and do not know what to do. Please in your report highlight that we need counseling skills."

- A number of officers in Harare and Chitungwiza could knew of HIV/AIDS service organizations. In comparison, officers in Bulawayo and Mutare seemed less aware of such groups in their city, possibly because the organizations are smaller and fewer in number. There appeared to be a need for greater awareness about services available in the community to which the officers could refer persons.

- Officers stated that Zambuko should modify its system of tracking loan delinquencies. Currently even though a client dies, the person's name remains on the list and this reflects poorly on the officer.

- Some officers felt that since the economic situation is unstable and illness and death frequent, smaller loans with shorter repayment periods (three to six months) might reduce the risk of loan defaults. As one officer pointed out, the current economic situation and prevalence of HIV/AIDS make it difficult to predict if individuals can meet their loan obligations over a 9 to 12 month period. At the same time, the officers acknowledged that short-term loans might increase operational costs.

- In a couple of sessions, officers suggested that Zambuko business development officers encourage clients to teach a teenage or adult child to operate their business. This would help ensure continuity of the business if the client becomes too sick or has to care for a sick person. It would also provide the child skills that would help them earn a living if they become orphaned.

- In one region in particular the officers applauded the idea that this study would take their views to the senior managers and supporters of programs concerned about the impact of HIV/AIDS. They expressed concern about the vulnerability of Zambuko given the current situation in Zimbabwe. They felt that their views and experiences should be solicited more often and liked the idea of an outsider assisting with the process since then they felt freer to express opinions.

B. Client Perspective

What are the attitudes of members of loan guarantee groups toward individuals from households affected by chronic illness and death being a member? To what extent do illness and death affect a client's ability to pay their loans and remain in the program? Do group members provide a support function? What are the opinions of microentrepreneurs about affected persons' participating in their loan guarantee group? The views and experiences of current and former clients reveal the relationship between illness and death and participation in Zambuko's program. They also place illness and death in the larger context of factors influencing ability to pay loans and program participation. This section closes with a discussion of the participants' suggestions for services to help those who take care or support people with terminal illness and persons affected by death in their household.

Vetting of Members of Loan Guarantee Groups

There was general agreement among current clients that when deciding who should be a member of their group the criteria include trustworthiness, hardworking, and someone whom they know. These criteria are the ones suggested to them by Zambuko. Participants explained how they define each of the criteria. Trustworthiness means a commitment to meeting obligations. It implies that the person will be diligent in meeting loan obligations. Hardworking relates to the effort put into the enterprise to generate revenue and savings, which would enable the borrower to repay her loan. Knowing the person is also important. To many this means that the person is a neighbor or works near other members.

Those owning or purchasing their residence tend to be preferred, although some groups accept lodgers who have resided at the same place for a long time. Others accept lodgers as long as they have a relative near-by who is known to the group. Renters are considered high risk since they are difficult to track down if they move. Examples of problems with lodgers "running away" without paying their loans were given.

The ability to relate and communicate with members was often mentioned. Groups did not want a member who would cause problems. For example, a Bulawayo group specifically wants persons who are "understanding and willing to assist for a month if a member has difficulty meeting a loan installment payment." They do not want someone who is "selfish."

The groups may also apply other criteria. In one instance the health status of the individual was explicitly stated as a criteria. A member of a loan co-guarantee group in Harare that was formed in 1999 stated that they look for "one who is not constantly ill because it would give us repayment problems." Later participants were asked: "If Zambuko had a policy of writing off the loans of deceased clients, would your group allow sick persons to join?" The answer was "no," because the sick person would probably be unable to work enough in her enterprise to enable her to meet monthly loan installments. This was considered important since Zambuko requires group loans to be paid in full or otherwise each member is assessed a late fee. The response also indicates a recognition that HIV-infected individuals experience a number of health problems as the infection progresses.

The response above should not be interpreted, however, as a universal refusal to allow the sick to participate. An example was given in Mutare of a group with a sick person who had "worked hard to the end and would struggle and still managed to pay her installments." This loan group incorporated the 23 year-old daughter of the deceased member because her mother was such a hardworking and trustworthy person.

Reasons for Difficulties Repaying Loans in 2000

Similar to the exercise with the business development officers, current clients were asked the reason why clients had difficulties in 2000 with repaying their loans. They were asked to base their responses on actual cases. When participants were from the same loan group, they collaborated on providing a joint response. After all the responses were given and categorized into common themes, the participants were asked to identify the first and second main reasons.

- In all but one of the sessions, 'economic conditions' was most often ranked as the top reason why people had difficulty repaying their loans in 2000. A number of factors were cited. Participants pointed to inflation, less profit, fewer customers due to economic hardships, devaluation of the Zimbabwe dollar, retrenchments, creditors not paying on time because they had problems such as illness and death in their families, and increases in prices for rent, food, school fees, and transport. The microentrepreneurs noted that the price of their inputs increased on a regular basis and they were constrained from charging a reasonable profit margin due to hardships facing their customers.

- 'Illness and death' was most often selected as the first and second main reason by participants in Bulawayo. In Mutare it tended to be ranked as the second, common reason. Harare participants seldom rated illness and death as a main reason, possibly

because most had group loans. As a Harare participant explained, and others in his session agreed, "Illness and death are now part and parcel of everyday life." The response implies that clients have adopted coping mechanisms so that illness and death do not interfere with their ability to make loan repayments.

- The other reasons cited were disruption of markets due to the political climate and loan terms.

Loan Repayments and Illness and Death

Loan co-guarantee groups have responsibilities for the debts of their members. As mentioned above, since mid-2000 Zambuko has enforced the group guarantee loan condition: each group's installment must be paid in full, otherwise each member is charged a late fee. Also the reader may recall that for loans extended prior to January 2001, the loan group was responsible for paying the outstanding loan of deceased members. Group responsibility meant that if the group did not collect the money from the deceased person's family, group members had to pay. As an Mbare participant explained, "Initially Zambuko wrote off loans of people who had died, but they stopped after realizing that some people would go to the officers and lie that some had died when she/he was alive."

Examples of Loan Co-Guarantee Groups Dealing with Death of a Member

A Mutare group member had left instructions that her children should pay off her loan using the money generated from renting one of the rooms in her house. She had the written instruction 'stamped' (notarized) at the police station. When she died, her instructions were implemented without difficulty. This group makes a practice of discussing with members what should be done to recover the loan money if they die. Instructions are written in their savings passbook and the members are expected to inform their spouse or another family member about these instructions.

A Highfield group member died only three days after receipt of her loan so the funds were still in her bank account. Neighbors informed the husband and upon their advice he withdrew the money and would not honor the wife's debt. In spite of appeals to the husband and mother-in-law, the group members ended up repaying her loan.

Two Trust Bank groups reported paying the loans of deceased members since the deceased had paid their installments on time prior to their death. Another group paid off half of the deceased member's loan and then Zambuko wrote-off the remaining balance.

Group members normally assist a member who has difficulty meeting their loan installment because she is ill or coping with illness or death of a household member or close relative. The group, however, normally expects to be reimbursed. Some groups have established special group savings account to enable them to provide short-term assistance. Group members may also lend support to members in other ways, although this does not appear to be a normal practice. It depends on situation, personal ties and the ability of the members to assist.

Support from Group Members

In Bulawayo, a group that has a joint enterprise as well as individual enterprises, gave a member Z$1,000 when her husband was in the hospital and she had run out of money for bus fare for the hospital visits. They also visited him. The member did not have to pay back the money to the group because it was given as an expression of support during the difficult times she was going through. The group paid for her loan installment from their group enterprise savings, after Zambuko refused partial payment of the group loan and had taken an asset from the affected person. The asset was returned upon payment of the installment. Later the woman was able to reimburse them for the loan installment using her husband's pension money.

A group member's husband died in a car accident shortly after the client received her loan so she used the funds for the funeral. The group paid her loan installments. Since her husband's parents took all the property, the group contributed Z$2,500 so she could start afresh. "She is currently active in her enterprise and managed to pay this month's installment. We hope she is going to get back on her feet and repay us."

Those with individual loans have no group members to help them. It appears that husbands, sons and daughters may be asked for money to cover the loan installment of a sick client. In these cases the client does not usually have to reimburse the money. When the case and evidence justify leniency, Zambuko officers sometimes grant a grace period for good clients with individual loans

Deferring Loan Payments of Clients with Individual Loans

A Harare client experienced problems meeting her loan installments because her brother died, and then his wife died shortly afterwards leaving six orphans in her care. She went to Zambuko with the death certificates and court papers and explained that she had not been able to trade due to these deaths. Zambuko gave her a grace period.

An unmarried, Mutare client was able to have an installment deferred when she was ill. Due to illness she had to temporarily close her sewing enterprise. Although she has assistants, she was unable to be there to instruct and supervise them. The loan officer visited twice and found her unwell, so he granted her a grace period since she was a reliable client with a successful business.

Participation and Ability to Cope with Illness and Death

Participants were asked whether there would be a difference between a Zambuko client and a non-client microentrepreneur in their ability to cope with illness and death in the family. The responses tended to vary by loan product and the timing of the loan and the event.

In sessions with group loan members, some participants felt that the non-client is better off because the client has to worry about the sick person while at the same time she worries about how she will meet her loan installment payment. Other participants in these sessions felt that the Zambuko member is better off because they have funds to fall back on to "make ends meet". One person explained: "If the problem came early when one has just received the loan, the individual might not be able to cope well and therefore be worse off. But if one has been given a loan and has managed to invest and start generating profit that person is better off." The Trust Bank participants felt that before 2000 a member was better off coping with illness and death because they had savings, but not in 2000 due to economic conditions.

In sessions composed mainly of persons with individual loans, the participants tended to feel that outstanding loans created hardships on those affected by illness and death. They emphasized that the loans must be repaid irrespective of the person's situation and late fees are charged if the loan is in arrears.

Illness and Death Affecting Continuation in the Program

The way groups treat persons who had been ill, or experienced difficulties due to illness or death in their household or among extended family members, tend to be similar. As long as the individual had been a good member and met loan installments in a timely manner before experiencing problems due to illness or death, the person is normally allowed to remain in the group during the next loan cycle. As the Chitungwiza participants remarked, "We must do this because it might be one of us the next time." The woman from Bulawayo who had told about her group helping the woman whose husband was ill and then died explained: "The group said that she should feel free to continue as a group member since the repayment problems she had had were not of her own making."

The amount of the subsequent loan, however, might be more modest. The Mbare participants advise members who have had repayment difficulties due to illness or death to take a smaller-sized loan, but do not drop them. In another session, a group member recounted how one of their members wanted a larger loan but the others appealed to the loan officer to recommend a smaller amount since the individual was likely to die. The loan officer teased them about being able to foresee the future, but agreed. The group members were correct and the member died that year.

The Trust Bank responses tended to vary from the other participants, possibly because they have shorter loan cycles and the burden falls on a larger number of people due to the larger sized loan co-guarantee groups. Trust Bank groups gave examples of advising members who had experienced difficulties making repayments, to "rest" from the program during the next loan cycle. One Trust Bank group, however, had problems because a member insisted on getting another loan and the loan officer was unaware of the problems the woman had caused the group since there was no record of them having paid for her. In this case, the participant telling the story dropped out of the loan group since she did not want to be in a group with such a person.

Some persons self-select to "rest" between loans or drop out of the program. For instance, two of a group's five members did not want to take another loan due to illness in their households and the other members decided to stop borrowing until they were all ready to seek another loan. The remaining members made this decision rather than to add new members to their group that they did not trust as much to repay their loans on time.

Departing the Program to Care for the Sick

An elderly, former Bulawayo client made dresses and knitted sweaters. She traveled to the rural areas where she sold them for cash or bartered for maize that she would then bring into town to sell. Then her unmarried son fell ill with tuberculosis and she had to relocate to the rural areas to take care of him. Then her son-in law also fell ill with tuberculosis. When her son died she moved to Masvingo to assist her daughter in caring for the son-in-law. This meant that her business activities were disrupted since she had to spend a lot of time caring for the sick, so she was unable to continue in Zambuko's program. She intends to borrow again once her caretaking responsibilities are completed.

The sessions revealed instances in which members of the group depart because of the burden of paying for other members. The Trust Bank participants in particular talked about the burden and problems associated with the group co-guarantee. They felt that smaller, more cohesive groups would be better than what they have (10 to 28 members in their loan co-guarantee groups).

It was apparent from the discussions that reasons other than illness and death causing lack of payment were not treated compassionately. Examples of individuals not investing their loan funds in the business and laziness were given as reasons for excluding persons in the subsequent loan cycle. A number of other reasons account for departures from the program. The most frequently mentioned was leaving Zambuko's program because the person relocated.[16] Relocation is sometimes associated with marriage. Also, most of those who had customers on the commercial farms had their markets disrupted because of the politically motivated upheavals on these farms and hence some of these clients ceased borrowing from Zambuko. In the nine focus group sessions only five individuals were identified as having secured a loan from another institution after leaving Zambuko's program.

Departure from Zambuko's program does not necessarily signify that the former clients had not achieved their objective for joining. Most gave examples of how they had benefited, often citing the acquisition of enterprise or household assets.

Knowledge of HIV/AIDS Support Organizations.

Participants were asked if they knew of any organizations that assist people caring for those affected by AIDS. In the Highfield's session, nine out of the ten participants stated that they were looking after orphans, whom they believe are a result of AIDS. One woman reported that she used to go to the Highfields (a section of Harare) social welfare office but it no longer assists them. Another said that her church tries to help such individuals. One person explained that her brother died of AIDS and left orphans, but to get help is difficult because on the death certificates they write reasons other than AIDS. Other participants in the Highfield session did not know of any organization.

In the session with current clients in Bulawayo, a few said that they had heard about the New Start Center on the radio and television. The others did not know of any organization. In the session with the Bulawayo survey respondents, only one person knew a source: the Matebeleland AIDS Council. None of the Mutare participants knew of any HIV/AIDS support organizations. One participant remarked that during the year 2000 people came and asked them to register children that had lost both parents. Those who registered had to pay a Z$20 registration fee. "Up to now we have not heard anything from these people and nothing has happened."

Suggestions

The last part of each session focused on participants' suggestions on services to help those who take care of or support people with long-term illness and those left because of death in their family. The suggestions given all focus on Zambuko. Although the participants were

[16] Two of the nine AIMS case study respondents had relocated to the rural areas in 1998-1999, suggesting that this was a common strategy for coping with economic stresses in urban areas.

encouraged to think beyond Zambuko, they gave suggestions focused on the organization that they know and in which they have confidence**.**

Across the sessions, the following were most frequently mentioned.

- Defer payment to a later date and not charge interest and late payment fee.
- Initiate a mandatory insurance scheme to pay-off the loans of deceased members.
- Create a voluntary funeral policy product to cover members of the client's family, that is the spouse and unmarried children.

Provision of a grace period and deferring a loan installment payment were mentioned in most groups. The responses were associated with suggestions that Zambuko accept partial payment of group loan installments, especially if only one person had not paid. Most groups also suggested that Zambuko institute an insurance policy that would write-off the loans of deceased clients.[17] They thought that Zambuko should ask for proof of death, such as a death certificate. In a session in Bulawayo, at first participants did not like the idea of a loan insurance scheme, but a participant with a loan from the Self-Help Development Foundation stated that they have insurance that is well managed and works well. After this, most of the participants agreed that it might be a good idea to have insurance that would pay off the loan if the client died. Only the Highfield participants not like the idea of paying another fee, even if it were to pay-off the loan of a deceased client.

Zambuko Viewed As a Financial Institution

A suggestion in Mbare that Zambuko assist if the member dies, such as buying a coffin, was met with an immediate "no" from the others. "I think you are asking for the impossible. Let us say that you have an account with Standard Bank, would you ever go to Standard Bank to say bury me?" The participants indicated that it would be bringing shame to them if they expect Zambuko to carry their personal problems as if "it is a crime to make us their members."

There was much less agreement over the need for a voluntary funeral insurance scheme through Zambuko. Most of those who were not in favor of the idea already have insurance through a funeral parlor or belong to a burial society associated with their neighborhood, church or special interest group. Yet, some who already have insurance felt that an additional source of funds would be helpful. In one Chitungwiza session, participants favored a funeral fund specifically to cover unmarried children, spouse and member. Four of the eleven participants were already members of burial societies but still wanted Zambuko to set up a fund to "top up" assistance received from burial societies, churches and neighborhood support groups.

The sessions in Bulawayo and Highfield, as well as those with current Chitungwiza and Mutare clients, did not favor a funeral policy through Zambuko. Most of the participants from these areas already had some type of coverage. Funeral costs were estimated to cost between Z$5,000 and Z$25,000 depending on whether the body had to be moved to another location and whether the funeral was in an urban setting or rural area.

[17] Since Zambuko had just initiated its loan insurance scheme on new loans, the participants were unaware of the most recent policy change.

The Trust Bank clients felt that additional funds from a Zambuko-related funeral fund would be of assistance and also convey the image of Zambuko as being concerned about its clients. They stressed that the fund should be properly managed. They expressed dissatisfaction and distrust of existing funeral fund for Trust Bank clients. It had been revived in 2000, and participants stated that they initially contributed Z$100 but had not contributed again since no one ever came to collect the money. In regards to the first funeral fund associated with the Trust Bank, a number of complaints were lodged. The payouts were not forthcoming in the agreed upon amounts and in a timely manner. This led members to stop contributing to the fund.

Other suggestions were also given.

- Chitungwiza clients suggested that Zambuko encourage its members to have savings that are specifically for emergencies. While clients have savings accounts these get used to meet a number of demands. The participants liked the idea of a limited access account. Another suggestion was that a social support fund, not funded by clients, should be established to repay loans not paid due to illness and death in the family.

- Participants in Bulawayo expressed interest in workshops on how to care for HIV-infected people because at the moment they are always afraid that if they are in physical contact with an infected person they will get the disease. Also, Bulawayo participants suggested it would be good if informational workshops were held for Zambuko clients so they would know where to go for assistance related to HIV/AIDS.

- A couple of sessions in Harare and Chitungwiza with group members ended with participants stating that they had learned a lot from the experiences shared by others. They felt that it would be good for group members to come together more often to share their experiences in dealing with difficult situations.

C. Discussion and Conclusions

Both Zambuko officers and clients tend to regard the economic conditions in the country as having a more negative impact on the ability of clients to repay their loans than the prevalence of HIV/AIDS. The negative impact of the economic conditions appears to be more widespread than the negative impact of HIV/AIDS. The pervasive negative economic climate reduces households' ability to cope with HIV/AIDS.

Clients tend to consider that loans help microentrepreneurs to improve their ability to cope with future illness and death. However, individual borrowers and many group members consider loans a burden if serious illness or death occur when the microentrepreneur has a loan outstanding. The latter view reflects the opinion expressed by Zambuko officers. Both Zambuko officers and clients tend to agree that loans should be for the economically active, not those who are chronically ill.

Zambuko officers appeared to have a good understanding of the dynamics within loan co-guarantee groups and of their clients. Both officers and clients thought it was a good idea for Zambuko to initiate an insurance scheme to cover the loans of deceased clients. Officers felt that

they needed to be better equipped to communicate with HIV infected and affected clients; clients felt that they needed more information on HIV related topics and know where to seek help. The two groups tended to focus on different ways to reduce the impact of affectedness on loan repayments.

It should be noted that Zambuko's legal status does not permit it to adopt some of the suggestions made in the client sessions. Since Zambuko is not able to accept voluntary deposits, it cannot establish voluntary savings services nor set up a voluntary funeral fund. It might, however, serve as a conduit to help clients link up with institutions that can provide these services.

An interesting observation from the focus groups with clients was that the Mbare female and male participants were more business-like in their attitudes, approaches and opinions than those in the other groups. Mbare clients work in one of the most vibrant microenterprise market areas in Zimbabwe. Mbare participants seemed to regard Zambuko as a banking, not a social, institution and weighed suggestions against this standard. The reason probably is associated with them having no other options for credit and not wanting to increase the financial risks to the MFI.

V. MITIGATION MEASURES SUGGESTED BY KEY STAKEHOLDERS

A one-day forum for microfinance institutions, HIV/AIDS related organizations and donors to discuss the implications of the findings led to a number of suggestions. Thirty-two people participated in the forum organized by the Zimbabwe Association of Microfinance Institutions (ZAMFI) and Management Systems International (MSI) and financed by USAID's Horizons Project in cooperation with USAID's AIMS Project. The forum took place in Harare on September 13, 2001.

The main activities were:

- a presentation of the findings from the study on the relationship of microfinance and households coping with illness and death in Zimbabwe, followed by a question period and small group discussions of the most interesting or surprising findings;
- three groups, each containing a mix of persons from different types of organizations, discussing the implications of the findings in relation to what is currently being done and what else might be done, followed by a report back to all participants; and
- three groups – MFIs, HIV/AIDS-related organizations, and donors – discussing the implications of the findings to what their "sector" might do, followed by a report back to all participants.

A major outcome was the call for more collaboration and information sharing between the different types of groups represented at the forum. This will be facilitated by ZAMFI.

A. The Mixed Group Discussions

The discussions in the three groups elicited the following comments. Time did not permit a discussion of the feasibility and implications of each suggestion. Also, no attempt was made to reach a consensus on the suggestions mentioned below or to prioritize them. The comments are categorized according to the group to whom they were primarily addressed.

Microfinance institutions

- A sector level approach should be taken, rather than to leave it to individual MFIs, to address a number of HIV/AIDS issues. This is important since many organizations are relatively small. As a sector MFIs should be able to mobilize resources.
- Consider the household, not just individual microentrepreneur, when giving loans. MFIs cannot ignore that money in the household is fungible. They should permit start-up activities and different household members to conduct their economic activities funded by one loan. Upon death of a client, another person from the household should be eligible to fill that person's place in a loan group or with the loan institution, although the person should receive the loan amount for first time borrowers. MFIs might consider providing loans to household members rather than individuals.
- MFI managers should discuss HIV/AIDS as both a client issue and a management issue. They might consider whether they should: have loan officers educate clients on

HIV/AIDS issues, have specialists on the staff to educate clients, collaborate with a HIV/AIDS-related organization to provide the education, or provide referrals.

- MFI boards of directors and donors should reconsider their policy/position on the timeframe for MFI financial sustainability, profitability and productivity. They should think beyond these to consider the implications of HIV/AIDS on MFIs and microentrepreneurs.
- Focus more on delinquency management and how to manage risk. Supporters of MFIs need to be more flexible and understanding about loan loss reserves, given Zimbabwe's HIV/AIDS situation and economic conditions.
- Need new financial products, such as insurance and short-term (e.g. six month) loans for microenterprise activities. Products should be responsive to actual needs and capacities, based on research and experience.
- MFI staff and officers should receive training related on HIV/AIDS so that they are better informed. Clients also need educated on HIV/AIDS issues.
- Should study the impact of HIV/AIDS on households and households' coping strategies in order to structure products and services to reach more households.
- Should actively target HIV/AIDS-affected households or individuals, and might provide short-term loans for the affected households.
- Pilot an approach that incorporates HIV/AIDS messages and reaches HIV/AIDS- affected individuals with microfinance products.
- MFI solidarity groups should be used to help people affected by AIDS.
- Need to modify existing products or develop new products, such as insurance, that would prevent exclusion.
- Should track changing impact of HIV/AIDS on clients and their institutions. Should focus on the effect of HIV/AIDS on program participation and continuation rates.

Microfinance institutions and HIV/AIDS service organizations

- Need to work together to identify the best approaches for combating the denial of HIV/AIDS. MFIs should support and be active in the current momentum to speak out.
- Should strengthen linkages and cooperation between MFIs, HIV/AIDS service organizations (HASOs), donors and other service organizations. Need a permanent consultative forum to develop strategies to address the MFI-HIV/AIDS nexus and related issues, and to follow-up on progress made. There needs to be more cooperation and collaboration between HIV/AIDS NGOS with income generating programs and MFIs. There should be cross-collaboration of HIV/AIDS service organizations and MFIs; this implies overcoming turf issues and competition for resources. Need to think through a culture of learning and sharing between MFIs, HASOs and donors. Need to have a convergence of thinking among MFIs and HASOs about clients, outreach and programs.
- Need to better understand how program clients are coping with the impact of HIV/AIDS. MFIs/HASOs/donors need to understand who stands to benefit from MFI services and who will benefit from the services of AIDS support organizations. Also need to understand more about youth, their coping strategies, opportunities and the feasibility of microfinance.
- Should address the situation and demand in rural areas. There is an increase in caregivers and children out of school.
- Need to give a platform for MFI clients and others to express their views on the ways/strategies to combat HIV/AIDS.

HIV/AIDS service organizations

- Need more, widespread non-financial approaches that focus on infected individuals, such as post test clubs and treatment for AIDS.
- New, innovative thinking is required to address the gaps in existing programs and approaches. Those falling between the gaps include youth, terminally ill, and caregivers who are stretched to the limit.

Donors and HIV/AIDS service organizations

- Should be more open to covering the risk of MFIs willing to offer products for HIV infected individuals.

B. The Sector Group Discussions

Meeting with others from their respective sector, participants from the MFIs, HIV/AIDS service organizations and donors discussed what else they should be doing as a sector group in addition to on-going cooperation. Again, no attempt was made to reach a consensus or to prioritize the suggestions. There tended, however, to be general acceptance of these by the sector participants.

Microfinance institutions

- ZAMFI members should have a workshop on HIV/AIDS.
- ZAMFI should facilitate networking of MFIs and HASOs to permit them to work together.
- Those MFIs already doing something related to HIV/AIDS should be given a platform to share their experiences. MFIs should share information so that everyone can advance on the learning curve.
- Should collect data, liaise with the Zimbabwe AIDS Council, WHO and others and come up with an action plan. It is important for all MFIs to have a policy, develop an appropriate culture and be proactive in establishing ways of addressing the impact of HIV/AIDS on their institutions and clients. It was pointed out that some institutions are not worried about their portfolios because they give grants and are dependent on outside funds.
- Should encourage government to have a sound HIV/AIDS policy.
- Should network with insurance companies in order for clients to be accorded better, affordable premiums for life insurance and health insurance. Also the sector should lobby insurance companies for affordable premiums to cover MFI loans to borrowers who die.

HIV/AIDS service organizations

- Should give affected families microfinance skills and loans.
- Should impart skills to families and people living with HIV/AIDS so that they can work instead of acquiring a culture of dependency upon relief.
- Should encourage families to work together as a team or unit rather than individually on their own income generating activities.
- Need to be active in breaking the silence about HIV/AIDS.
- Should work in partnership with MFIs in the prevention and mitigation of HIV/AIDS and care of those infected and affected.

- Should consider specialized HIV/AIDS – MFI programs for rural areas targeted especially at women and youth.
- Should be active in promoting prevention of HIV/AIDS education at workplaces.

Donors and other financial support organizations

- Should adopt a more realistic policy/stance on the timeframe for MFI financial sustainability that takes into account the situation in Zimbabwe.
- Should provide more resources for MFI technical capacity building, to cover items such as additional staff, piloting new products and expansion into rural areas.
- Should work together to ensure no double dipping: implementing organizations billing more than one donor for the same thing.
- Should adopt a strategy to ensure a general consistency in approaches, rather than fund conflicting approaches and duplicate efforts.
- Need to look for real opportunities to empower people and institutions/organizations to move away from a donor dependency syndrome.
- Should not drive institutional strategies but rather accept that clients' needs are paramount and accept strategies built on client inputs.

C. Outcome

The participants agreed that the forum should be considered as a start to networking and collaboration between HASOs, MFIs and donors. An idea for further sharing of information was proposed. It was agreed that ZAMFI should be the lead facilitator of a permanent consultative forum that would bring interested organizations together.

VI. CONCLUSIONS AND RECOMMENDATIONS

The study's findings and conclusions together with the suggestions from the focus groups and forum have implications for microfinance programs and policies in countries with high HIV prevalence rates. Both policy and program recommendations arise from the study.

A. Conclusions

Extent Households Experience Illness and Death. The findings based on proxy indicators of HIV/AIDS reveal that during a 24 month period between 1997 and 1999, forty percent of the households had been affected. Illness of the respondent or another household member aged 20 or older was the most common event. The rate of households reporting the death of a member aged 20 or older was relatively high.

Ways Illness and Death Affect Households. Households affected by illness and death, compared to other households, appear to be in a worse economic situation. They had a higher economic dependency ratio, were more likely not to see medical treatment when needed due to a lack of funds and to be poor. The impact analyses that controlled for specific initial differences in the households, suggest that the affected households had a lower level of household income, and a lower level of monthly net revenue from their household enterprises.

Ways Affected Clients Differed from Affected Non-clients. The affected clients appeared to be more disadvantaged than the affected non-clients in terms of their household's economic situation and structure. More affected clients than affected non-clients had become widowed between 1997 and 1999. Also, the average household size and the economic dependency ratio in 1999 were higher for the affected client households. The affected clients were more likely to report that their household did not seek medical services when needed due to a lack of funds.

Impact of Zambuko on Affect Clients and their Households. Participation in Zambuko's program appears to have enabled affected client households to smooth their income flows through diversification of their income sources and to have invested in the education of its boys aged 6 to 16. Moreover, it had an impact on the way affected clients manage their finances. There also appears to have been a negative relationship between participation in the program and the number of hours worked in household enterprises. This relationship is most likely to be associated with more attention being devoted to non-enterprise income sources.

Effect of Illness and Death on MFI Operations and Participation. Zambuko has adopted a number of measures to reduce the risks to its financial portfolio. It does not, however, have any means for estimating the impact of illness and death, or HIV/AIDS in particular, on its operations. Members of loan groups normally assist members having difficulty making their loan installment, but expect to be repaid. During the next loan cycle, a person who had difficulties making their loan payments due to illness or death in the household is normally permitted to remain in the group. Until recently the groups have borne the responsibility of paying the outstanding loans of deceased members. Both loan officers and most clients tend to believe that a loan is an unwelcome burden when they are in the midst of a crisis.

Measures to Mitigate the Impact of HIV/AIDS on Households and MFIs. Zambuko staff and clients as well as other key stakeholders made a number of suggestions**.** They called for establishment a permanent network among MFIs and HIV/AIDS support organizations to share information and establish collaborative partnerships.

B. Policy and Program Recommendations

Consideration of the Macroeconomic Environment. Inflation has been extremely high in Zimbabwe since 1996, placing economic stress on households. At the same time, Zambuko's interest rates have not kept pace with inflation and the loan money repaid has had a lower real value than the money paid out. The macroeconomic conditions and political situation in Zimbabwe suggest that new microcredit programs and expansion of existing microcredit programs ought to proceed with caution or be put on hold until the economy is in a better state.

The findings imply that microfinance institutions operating in countries with high inflation rates need to ensure that their interest rates and fees keep pace with inflation, so that their capital base is not eroded. Moreover, development assistance organizations should focus more attention on assisting governments to strengthen policies that directly influence the ability of households to mitigate the negative economic impact of HIV/AIDS on their households.

Combating the Denial of HIV/AIDS. The denial of HIV/AIDS by leaders and the general population hinders progress in combating the pandemic. In countries where discussion of the incidence of HIV/AIDS is shrouded in silence, MFI managers and boards of directors ought to join with those in other sectors to take an active role in overcoming the silence and denial. This implies that the organizations discuss the topic in a compassionate manner and devise strategies for dealing with affected clients and working with other stakeholder groups.

Estimating HIV-affectedness and its Impact. MFIs and other organizations normally do not have a basis for estimating the extent or ways their clients or target group are affected by HIV/AIDS. Also, they often have no basis for estimating the impact of HIV/AIDS on their program. In the short term, this implies two things. First, organizations should not feel compelled to provide estimates of the impact of HIV/AIDS on their programs and clients, unless they have a sound basis for making such estimates. Second, when organizations report reaching and having an impact on HIV/AIDS-affected persons, they ought to be able to explain how they derived their estimates. A set of tools should be developed and tested that would permit MFIs and other programs to better estimate affectedness among their clients and ways their programs are negatively affected by HIV/AIDS.

Measures to Ameliorate the Impact of HIV/AIDS on MFIs. The study points to the importance of mandatory insurance to cover the outstanding loans of deceased clients. Transparency and accountability ought to govern fees charged for loan insurance against death of the borrower. The income and payouts should be accounted for separately from other funds both to monitor the feasibility of the fee charged and to account for the use of the funds. Mandatory savings to cover defaults also appear to be a prudent policy.

In countries with high inflation and high HIV prevalence rates, it is difficult for loan officers and microentrepreneurs to predict what will happen over a nine or twelve month period. The findings suggest that there may be scope for loan products of a six-month or shorter duration.

In addition, there appears to be merit in testing a new approach to loaning for microenterprise activities. Currently organizations tend to loan to an individual for a specific, existing enterprise rather than a set of household enterprises. MFIs might pilot test loans that would cover existing and new enterprises that would be assessed on the ability of the household to repay the loan, possibly with the contract co-signed by two adult household members. This approach could be combined with encouraging young adults in the household to learn skills in managing and operating an enterprise (see below).

MFI managers and boards of directors need to consider HIV/AIDS both from the standpoint of the organization, its outreach and its client base. This may require that MFI leaders and donors look beyond their current focus on financial sustainability to better understand the ways the epidemic affects this sustainability and achievement of the MFI's stated mission. Financial sustainability is crucial, but it may take longer than anticipated to achieve this state, and complementary activities either by the MFI or through partnerships with other organizations may be warranted.

MFIs should focus more on delinquency management and how to manage risks, in recognition of the hardships most current and potential clients face. They ought to be given the latitude to experiment with different strategies to determine their feasibility and impact.

Measures to Help HIV-affected Persons. MFIs might want to experiment with criteria and procedures associated with granting a grace period when clients are faced with hardships due to illness or death in their household. Also, they might experiment with criteria and procedures related to payment of group loan installments. It may be feasible and prudent to accept 80 percent of the amount due, rather than require that 100 percent be paid each time.

MFI loan officers often encounter situations related to HIV/AIDS. They ought to be trained on how to communicate in these situations and the importance of verbal and non-verbal behaviors. They might also be provided with basic counseling skills and be updated on a regular basis on HIV/AIDS-related services so that they may inform their clients and others in need.

The focus group discussions with past and present clients suggest that much more needs to be done to educate people about HIV/AIDS related topics. Since MFIs have links into communities, they might choose to among the following options: a) set up a separate, specialized unit, b) use their loan officers to provide education, or c) partner with another organization.[18] Other organizations with networks into communities, such as churches and cooperatives, might also be enlisted to help with education following one of these approaches. Related to this, there is a need for short, simple and clearly written educational materials on HIV/AIDS-related topics.

MFIs should encourage borrowers to train one of their teenage children to operate the enterprise. The objective would be twofold. First, if successful it would provide a fall-back position if the client has to take time away from the business due to illness or death. Second, it would help to

[18] See an outstanding paper by C. Dunford (2001) that provides examples of MFIs integrating education and a discussion of institutional issues.

install business knowledge and skills that could assist the child in future years, especially if economic hardships befall the household due to death of the adult income earners.

The findings suggest that there may be scope for other types of microfinance products. These include funeral insurance, limited access savings accounts, and short-term loans secured by wages. Funeral insurance can be provided directly by a commercial firm or non-profit organizations linked with a commercial provider. Also, well-managed burial societies operated by churches or closely knit communities can serve a similar function.

Under certain conditions, there may be scope for a special loan product for microentrepreneurs who are caring for orphans and helping those affected by HIV/AIDS. For example, loans might be extended to persons who are committed to caring for the abandoned, terminally ill in their rural community. In an unstable economic environment, this type of loan ought to be for enterprises that involve products or services that have a relatively stable market.

There are also a number of other possible measures to help individuals who are not microentrepreneurs, but these fall outside the scope of the study.

Regulatory Framework of MFIs. The legal status of an MFI sets the boundaries on the types of products and services it may offer. For example, Zambuko registered as a moneylender is prohibited from operating a funeral insurance fund and from offer voluntary savings services. Particularly in countries where HIV/AIDS is widespread and institutions with outreach into communities are relatively limited, attention should be given to changing the regulatory framework of MFIs to enable them to broaden their products and services to meet the demands of HIV/AIDS affected households and safeguard client deposits.

Linkages with Other Organizations. A formal network of organizations from the same 'sector' as well as networks that cross-cut sectors have potential in a) information sharing, knowledge generation, b) establishment of collaborative relationships, c) development of a common strategy or at least social pressure to help curb activities that would undermine strategies more commonly pursued, and d) greater focus of attention and resources on the problem.

Through this study a network was formed in Zimbabwe between HIV/AIDS support organizations and MFIs and donors. If the network proves to provide a valued service, it is likely to serve as an example to others who would gain from joining together to discuss and act on ways to address the impact of HIV/AIDS on their 'sector' or industry and clients. For example, medium and large-scale enterprises in a particular geographic area might form a network to address HIV/AIDS in the work place. Also, religious organizations might form a network to share information and strategies.

Additional Studies. The findings imply that studies similar to this one ought to be undertaken in a more stable economic environment. In such instances, the economic impacts of HIV/AIDS on households and of microfinance on affected clients may be more apparent since these will not be commingled with negative macroeconomic factors.

More studies should be undertaken to better understand the distribution of HIV affectedness among MFI clients. Participatory approaches should continue to be used to identify ways to

ameliorate the negative economic impact of HIV/AIDS on households and to simulate collaboration between organizations. In addition, operations research or a pilot test approach should be taken to test the feasibility of new services and products. In these cases, the feasibility of the products or services in terms of acceptability and impact, as well as costs should be determined.

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* These papers are available on the AIMS website (www.mip.org).

ANNEX 1

SUMMARY OF THE KEY FINDINGS OF THE AIMS ASSESSMENT OF ZAMBUKO

Microentrepreneurs and their Households

The profile of Zambuko clients shows that among those interviewed in 1997 approximately two-thirds of the new clients and half of the old clients were from households under the US$2 or less a day per person poverty line**.** The typical client in the survey is a married female about 41 years old, with seven to eight years of education. An important finding is that between 1997 and 1999 nearly half of the client sample had an increase in the proportion of household members who were not economically active. The tendency toward a higher economic dependency ratio partially reflected the dependency status of individuals who joined the respondents' households during the study period. Twelve percent of the households of the client respondents took in a sick person or a person from a household that had experienced illness or death.

In analyzing factors that were significantly associated with the 1999 respondent households movement out of poverty, the results indicted that this was primarily related to a reduced number of household members and lower dependency ratios. Since the definition of poverty was primarily based on per capita per day income, size of the household and economic dependency ratios influenced whether a household moved out of extreme poverty or moved into poverty.

Clients' Use of Credit

The cumulative sum of all loans borrowed from Zambuko was Z$10,052 for those respondents who had taken at least one loan since 1997, referred to as continuing clients. This amount was equivalent to less the US$650 at the time they borrowed. Sixty percent of the continuing clients had taken three or more loans from Zambuko. In contrast, those client respondents who had not taken a loan since the 1997 interview, referred to as departing clients, had taken loans that averaged Z$2,921, which was equivalent to US$295 in 1997. Approximately 60 percent of the departing clients had taken only one loan.

In 1997 the average size of the last loan was equivalent to 20 - 25 percent of the client's monthly net revenue from the enterprise that secured the loan, and approximately 12 percent of the client household's total monthly income. Thus, the loan size was relatively small in terms of total household income. This suggests that money from other sources might be drawn on to assist with repaying the loan.

Approximately half of the client respondents used their loans in 1997 exclusively for their enterprise. The other half used a portion for savings or household needs and the rest for their enterprise. The use of funds was not significantly related to the timely repayment of the loan.

In 1997, approximately 60 percent of the client respondents reported that if they had not received a loan from Zambuko they would not have made such expenditures. Among those who had taken a loan since then, half of them reported that they would not have made such expenditures if they had not received a loan from Zambuko.

There was little evidence that microentrepreneurs have access to other sources of credit for their enterprises and households. Other than microfinance organizations, the main source of credit was from businesses that sell furniture, appliances and other types of durable assets on a hire-purchase arrangement. The assessment found that the provision of credit by the formal sector is extremely limited, suggesting potential expansion, especially when the economy improves.

Program Impacts

The analyses of the survey data that controlled for specific initial differences make a strong case that Zambuko's program has a positive impact. The results further indicate that the impacts tend to vary among clients based on whether or not they had remained in the program. In some areas, the analysis suggests program impact only among continuing clients, departing clients or those who were continuing clients that had received more than one loan at the time of the 1997 interview, referred to as repeat continuing clients. In addition, the analysis suggests that Zambuko's program has a positive impact on extremely poor households, especially among clients who remained in the program. On a number of the impact variables tested, however, the data suggested neither a positive nor negative impact.

Household Level. Loans provide a lump sum of money that clients tend to use for their enterprise. The generation of profits from the use of the loans and better management of financial resources are likely to explain the ability of client's households to make lump sum expenditures. At the household level, the impact on education of boys aged 6-16 appears to be widely spread across continuing and departing clients, including those who were extremely poor. The data also suggest that participation in Zambuko increased the probability of continuing clients and departing clients acquiring a stove, and continuing clients acquiring a refrigerator. Participation was also found to be strongly related to the amount of money repeat continuing client households had spent on household durable assets. In addition, the data suggest that program participation positively affected the value of assistance continuing client households provided to non-household members for funeral related expenditures.

The results also suggest impacts at the household level on food consumption among the extremely poor and diversification of income sources among departing clients. Better management of financial resources is likely to explain the increase in the frequency that meat, chicken or fish, and milk were consumed in the households of extremely poor continuing clients. Also, the data on diversification of income sources among departing clients suggests that loans enabled these households to gain an additional income source.

The analysis did not suggest that participation in Zambuko's program had an impact on the level of monthly household income, the value of assistance given to non-household members, education of girls aged 6-16, education of girls and boys aged 6-21, expenditures on housing improvements, nor on acquisition of a television, electric fan or means of transport. Thus, the study reveals the areas where lump sum expenditures are most likely to occur and that total household income does not appear to be significantly influenced by program participation.

Enterprise Level. At the enterprise level, the data reveal that the net revenue of the enterprises often did not keep pace with inflation. No significant differences were found in the level of net revenue in all of the household's enterprises, nor in indicators of employment in the enterprises.

However, for the enterprise which secured the loan and against which the non-clients were matched, the results suggest that Zambuko had a positive impact on the 1999 net revenue of the matched enterprise of repeat continuing clients. Also, participation in Zambuko's program appears to be related to the 1999 value of all of the household's enterprise assets for repeat departing clients, that is those who had more than one loan in 1997 but did not take an additional loan since the 1997 interview.

The data on enterprise net revenue involved comparing the month prior to the interviews. Thus, they do not capture the variation in levels income 1997 until the month prior to the interview in 1999. This helps to explain why impacts might occur at the household level even though the enterprise net revenue did not increase in value when adjusted for inflation.

Individual Level. The analysis of the survey data suggest that participation in Zambuko's program had a positive impact on clients having an individual savings account and on the number of ways extreme poor continuing clients' saved. Both of these imply that participation in a program that does not contain a savings component nevertheless has an impact on the way people save.

The case study findings support the hypotheses that participation in a microfinance program can lead to greater self-esteem and self-confidence, and enhances a client's ability to plan for the future. The greater self-esteem and self-confidence appear to be associated with clients' increased ability to manage their enterprise, meet the financial demands of the household, and acquire assets.

Implications

The assessment findings and conclusions have implications for microfinance institutions (MFIs) in Zimbabwe. The implications may also have broader applicability.

Influence of the Macroenvironment. High inflation is likely to place economic stress on MFIs as well as households. For MFIs, the loan money repaid has a lower real value than the money borrowed. Also, interest rates may not keep pace with inflation. Therefore, a MFI is likely to suffer as the money received has less value than the money paid out. Over time, this may lead to an erosion of the MFI's capital base. The findings suggest that the fees charged in addition to the interest rate should be increased on a regular basis to keep pace with inflation. For clients, inflation is likely to put economic stress on their enterprise, which makes it difficult to increase the real value of their enterprise net revenue, which in turn may affect the household's allocation of income. The likely negative effect of high inflation on MFIs and clients suggests that caution should to be exercised in the establishment of new microfinance programs and expansion of existing programs. An inflationary environment also implies that MFIs may be faced with decisions related to the level of services that can and should provided.

Financial Products and Terms. The assessment results suggest that there may be a market for shorter-term loans. Many microentrepreneurs join an MFI program to test if a credit program is appropriate for them. The data reveal that 60 percent of the client respondents who did not seek another loan after 1997 had received only one loan. Also, nearly half of the clients are traders and even those in manufacturing did not tend to invest their loan funds in an enterprise asset.

Traders in particular have rather rapid turn-around times and loans of four to six month duration appear to be more suited to their needs.

The findings also suggest that there is a dearth of financial services accessible to microentrepreneurs' households for non-enterprise investments. There may be a niche market for loans specifically related to the building of rental units by those who own their homes. These loans would most likely require a repayment period longer than one year.

Given that repayment problems were not found to be associated with the use of some of the loan funds outside the enterprise, it is worth exploring the feasibility of offering loans secured by an enterprise or another source of income for educational or emergency needs. Also, there may be a demand for savings accounts that are designated for limited uses, such as educational expenses. While in general, there does not appear to be a lack of access to savings services in these key urban areas, restricted access accounts might help individuals set aside money for specific, lump sum needs.

Business Management Training. The case studies and survey data on business management training reveal that microentrepreneurs value and benefit from basic business management training. There appears to be an unmet demand for this type of training that is appropriate to low-income microentrepreneurs. MFIs in Zimbabwe may want to pilot a training product focused on this target group to determine if it can be a financially sustainable service. Or, there may be scope for MFIs in Zimbabwe to establish a partnership with an existing business management training organization that can offer training appropriate for microentrepreneurs.

Program Leavers. Clients have left the Zambuko program for a number of reasons. Clients leave due to difficulties repaying the loan and this departure may be either voluntary or coerced. Others leave because they move outside the program's catchment area. Especially during periods of instability in the economy and household, a microentrepreneur might be satisfied with the program but not have an obvious viable use for credit at a given time. He or she may want to 'rest' for a time before taking another loan. The value of an MFI program like Zambuko is that it proves access to credit otherwise not available to poor households in Zimbabwe.

Implications for Future Assessments. Some key lessons were learned in the conduct of this assessment. These lessons may be useful not only to the microfinance industry but also other types of programs concerned with measuring their results.

First, the experience highlighted that care ought to be used in setting increased household income as an indicator of program results. While many programs aimed at the disadvantaged and poor often seek to increase household income, a number of non-program factors can influence household income levels irrespective of the program. Therefore, it might be more reasonable to expect a program to increase a particular source of income, rather than total household income. As suggested by this study, income is difficult to measure precisely. Therefore, a multi-pronged approach that considers income and indicators of expenditure flows as well as asset accumulation help to overcome this weakness.

Second, results of the analyses of the survey data reinforce the importance of using a non-client control group. This group represents what occurred among non-program participants and enables the analysts to more convincingly identify the specific impacts of program participation.

Third, the data on changes in the household's poverty status indicate that the definition influences the results. This suggests the need for the microfinance industry to agree on some common approaches to defining and discussing poverty.

ANNEX 2

STUDY DESIGN AND METHODS

Understanding the study design, methods and sites provides a background for understanding of the results that follow. This annex summarizes the survey design, sampling, final database and the comparison groups used in the analyses. It also includes an explanation of the statistical tests used to suggest impacts. Then the annex explains the approaches used for the qualitative components of the study. [19] It concludes with a map and brief description of the study sites.

A. The Survey

The survey consisted of interviewing a randomly selected group of clients and non-client microentrepreneurs. The survey questionnaire was preceded by a qualitative study and pre-and pilot tests of the questionnaire. In 1999, preparations for the second round of data collection involved inclusion of key questions related to illness and death and location of the 1997 respondents. Prior to each survey round, the enumerators attended a one-week training session. During the data collection and entry phases, additional measures were taken to help ensure the quality of the data. The analysis of the data involved comparing clients and non-clients and categorizing households according to how they were affected by illness and death. This permitted statistical tests to indicate the impact of microfinance and of illness and death upon clients, their households and enterprises.

Sampling

When the sample design was developed in April 1997, Zambuko had a number of branches and satellite offices. Logistics and cost implications dictated limiting the number of geographic areas covered by the survey. After a discussion with the Executive Director of Zambuko, it was decided that the sample of clients should be from Bulawayo (excluding the new Gwanda office), Harare and Chitungwiza since these were established programs with some clients who had received more than one loan, and the majority of clients were from these geographic areas. In addition, Mutare was included as representing Zambuko's offices in the smaller cities.[20] Thereafter, from lists of current clients from the four offices, a sample of 244 new clients was randomly drawn from a list of 1,281 persons who had received their first loans between May 1 and June 30,1997. All 196 repeat borrowers who had received a loan between April 1 and June 30, 1997, were included in the sample.

Zambuko provides loans to individuals who have enterprises and the loans are supposed to be used for a designated enterprise. The design centered on inclusion of a sample of non-client microentrepreneurs as the quasi-experimental design control group to permit a comparison of differences in the impact variables between clients and non-clients, and thus facilitate the identification of the impacts of Zambuko's program. The non-clients were matched with clients

[19] More detailed information on the survey methods and procedures are in the AIMS report (Barnes 2001).
[20] A preliminary analysis of this sub-sample in 1999 indicated that they did not vary significantly from others in the client sample on assets, a key indicator of poverty level.

on the basis of gender, enterprise sector and geographic location (within walking distance of the client with whom they were matched). In addition, to be included in the study, non-client microentrepreneurs had to own an enterprise that was at least six months old, and not be employed elsewhere on a fulltime basis, mirroring basic criteria used by Zambuko. Thus, care was taken to help ensure that the client and non-client samples shared key characteristics. Also, non-client microentrepreneurs who had received loans for their enterprises from other formal institutions were excluded. This helped to ensure that those selected were an appropriate control group.

Respondents Included in the Final Analysis

Care was taken in relocation of the respondents in 1999, resulting in re-interviewing 88 percent of the clients and 86 percent of the non-clients from the 1997 sample. These rates include 36 (six percent) substitute respondents when the respondent was not available during the survey period. On certain questions, the responses of the substitutes are excluded from the analysis. When the body of the report refers to client and non-client respondents, the findings include information from the substitutes except on the questions on individual-level impacts.

The final analysis excluded those who were case study respondents, the 14 non-clients who had taken loans from Zambuko since 1997, and a few inappropriate substitute respondents. Thus out of the 599 persons interviewed in 1999, the final database used for the analysis was 579. Approximately 80 percent of the respondents were women since most of Zambuko's clients are women.

Comparative Groups

The analysis compares microentrepreneurs who were borrowers in 1997 with non-client microentrepreneurs. The client group consists of those who were on their first loan in 1997 and those who had taken more than one loan at the time of the first interview. By the time of the follow-on interview 54 percent of the clients had not taken any additional loans from Zambuko since the first interview.

The next major classification centered on categorizing households according to how they were affected by illness and death. A number of indicators of possible HIV/AIDS were used to classify the respondents into two comparison groups: *affected* and *other*. (The indicators are described in the text of the report.) This classification was combined with that on client status to yield four comparison groups: affected clients, affected non-clients, other clients and other non-clients. For ease of reading, the body of the report and tables often refer to the affected households as *affected,* when the context makes the reference group explicit.

Statistical Methods

The survey data were analyzed using a number of statistical methods. In particular, two statistical methods were used that take into account the possibility that the comparison groups differed initially on a particular impact variable. First, the ANOVA gain score analysis method centers on the change in each comparison group on a particular variable, rather than on the absolute values for each group. As such, it does not assume that the two groups were similar in 1997 on the variable analyzed. When the score involves a numerical value, it is based on the

1999 findings minus the 1997 for each respondent[21] The ANOVA gain score analysis includes determining whether the results differ significantly between any two of the comparison groups, taking into account the grand mean across all respondents. The gain score approach used in the analysis does not attempt to take into account the influences of other factors.

The second method used was ANCOVA. It includes the measure from the first survey in the model in the form of a linear regression. ANCOVA analysis controls for differences between the analytic groups in 1997 on specified variables, differences that might have influenced the relationship between program participation and the values found in 1999 on the impact variables. The ANCOVA statistically matches observations in the analytic groups on their 1997 measures and other covariates, and then uses the average difference between the matched groups on their 1999 values to estimate the treatment effect (Reichardt and Mark 1998). The ANCOVA test may introduce bias with random measurement error in the 1997 scores used in the analysis and when irrelevant covariates are used (Reichardt 1979). Hence, the results suggest areas of impact and make a strong plausible case for where impacts most likely occurred.

As discussed above, one reason for including covariates or independent variables is to explicitly control for specific values or factors that may affect change in the impact variable. A second reason for including multiple covariates is that the analysis will suggest whether a specific independent variable significantly influenced the differences found in 1999. The 1997 values were used for each covariate included in the ANCOVA analysis of the impact variables.

The selection of covariates was guided by the factors thought to be most closely associated with the impact variables. In addition to the 1997 values on the variable analyzed, the ANCOVA analyses used the following set of covariates:

- extremely poor compared to all others (i.e., moderately poor and non-poor),
- non-poor compared to the poor (i.e., extremely poor and moderately poor),
- household economic dependency ratio,
- loan status (repeat borrowers compared to all other respondents), and
- those affected by illness or death in 1997 compared to those not affected.

Other Considerations

Several of the impact variables are measured in terms of Zimbabwe dollar values. However, during the assessment period, inflation as indicated by the Consumer Price Index (CPI) was high and the Zimbabwe dollar decreased in value. Thus, on variables that measured last month's expenditures and income, the data provided in 1999 were deflated to 1997 constant values.[22]

[21] In a few instances, the gain score varies slightly from the value of 1999 minus 1997 for the comparison group due to rounding each of the values.

[22] The CPI was 488.5 in September 1997 and 1091.6 in September 1999. Using September 1997 as the base (September 1997 = 100), the CPI value in September 1999 was 223.47. The results show that the value had more than doubled since 1997. Thus, the formula used deflated the 1999 values by 2.235. For example, the monthly income of clients averaged Z$9,071 in September 1999; when deflated (9,071 divided by 2.235) to real income values or 1997 constant values, the average income was Z$4,059.

Data from questions that gathered information over a longer period, however, were not deflated. An example is the amount of money spent on household durable assets during the past 24 months. It was not feasible to deflate to 1997 constant value each of the monetary values since they covered a range of months and the inflation rates varied from month to month and often respondents could not recall the exact month the expenditure was made.

When an analysis is based on the mean value for a group, it might be influenced by a few responses that are either extremely high or extremely low. The initial data verification and cleaning process had already determined if the outliers represented data entry errors or special cases. The analyses of variables in dollar terms is normally given without outliers, values more than three standard deviations ("z-scores") from the mean were removed.

Another consideration was the treatment of missing data. In particular, respondents often could not provide an estimate in response to questions that center on monetary values, such as the amount of income earned by a household member last month. These cases are treated as missing values and are not included in the analysis. This leads to the N values, that is, the number of persons reporting, varying among the analyses of specific variables. For the ANCOVA analysis, in a few cases the data were missing on a covariate. Therefore, the household was dropped from the ANCOVA analysis and the respondent base for the t-tests and gain score analyses was adjusted to include only those respondents included in the ANCOVA.

B. Focus Groups and Key Interviews

Focus Groups with Borrowers

Two types of borrowers were invited to attend the focus groups: those who were clients in late 2000, and those who had participated in the survey and taken a loan between 1997 and 1999. It was anticipated that more than half of those invited would not attend the session due to conflicting demands on their time. Also, since most of Zambuko's clients are women and most of the clients in the survey were women, it was decided to invite women. For one session, however, both men and women were invited.

The lists of clients from Harare, Chitungwiza, Bulawayo and Mutare who had participated in the survey and who had received at least one loan between 1997 and 1999 were studied to identify the women. These women provided the population for the random selection of individuals to be invited to the focus group sessions. For each session, up to 30 persons were randomly selected and mailed an invitation. The invitation explained that participation was voluntary, and there would be no direct benefit from participation nor would it affect receipt of financial services. It also stated that the information collected would not be attributed to individuals, their name would not appear in any document, and they might withdraw from participation if they did not want to discuss a particular topic.

In order to reflect more recent events and circumstances, lists of individuals who had loans in late 2000 were obtained from Zambuko for the Kuwadzana Trust Bank, Chitungwiza, Highfield and Mbare branch offices under the Harare Regional Office, Mpopoma branch office in Bulawayo and the Mutare City branch office. With the exception of the Mbare list, the next step involved identification of the females. Then, a random sample was drawn to select 30

individuals from each branch to be invited to the focus group. They were sent letters of invitation similar to those sent to the survey clients.

The focus group sessions with current clients centered on the following key questions. The first two stimulated discussion of illness and death, and HIV/AIDS. The questions were devised to place illness and death in the broader context, and then to narrow the focus of the discussion. The key questions were as follows.

1) How are loan co-guarantee groups formed and reformed? What criteria are used by members of a loan group for selecting members?

2) What were the main reasons why clients had difficulty repaying their loans on time in 2000? (Then a ranking of those reasons).

3) Are there ideas and suggestions about services that might help those who support or take care of individuals with a long illness and those affected by death in their household?

The focus groups with former clients centered on the following key questions.

1) What were your main objectives when you joined Zambuko and were these achieved?

2) Why did you leave the program?

3) Are there ideas and suggestions about services that might help those who support or take care of individuals with a long illness and those affected by death in their household?

Key probe questions were also asked. These included the following. If a member had difficulty repaying a loan due to long illness and death in the family, how does the group respond? For the next loan cycle, does the affected individual usually remain in the group during the next loan cycle? If she leaves, is it voluntary or do group members encourage her to leave? Would there be a difference between a Zambuko client and a non-client microentrepreneur in their ability to cope with serious illness or death in their household? Participants were asked to provide concrete examples.

In order to stimulate contributions from all participants on the question related to the main reasons why clients had difficulty repaying their loans on time in 2000, participants were asked to think about their response and then jot it down on a piece of paper. Thereafter, they were asked to share their response with the group.

All focus group sessions with the randomly selected sample were held in a 'public' place and in a room that was conducive to a private, confidential discussion, without the presence of outsiders. Each session began by the facilitator reading the protocol, which repeated information that was in the invitation related to the purpose of the session and ethical issues.

Including the pilot tests, the focus group sessions included 155 current and former clients. Approximately 40 percent of the randomly selected invitees attended. Individuals from 26 loan co-guarantee groups participated. Their groups varied in size from five to 38 members and were formed between 1996 and 1998 with a total of 232 original members.

Table II-1. Focus Groups with Clients

Place	Number		Client Status	Loan Type
	Attended	Invited		
Harare - pilot test	21	NA	Current clients (women and men)	Group loans
Chitungwiza- pilot test	26	NA	Current clients (women)	Group loans
Harare	7	21	Survey clients (women) drop-outs/resting-6	Group loans
Harare-Highfield	10	30	Current clients (women)	Group loans
Harare-Mbare	22	30	Current clients(women and men)	Group loans
Harare- Trust Bank, Kuwadzana	9	30	Current clients (women) Drop-outs/resting –3 women	Group loans, special methodology
Chitungwiza	11	30	Survey clients (women) drop-outs-7 current clients-4	Group loans
Chitungwiza	9	30	Current clients (women)	Group loans
Mutare	7	21	Survey clients (women) drop-outs/resting-4 current clients -3	Individual and group loans
Mutare	10	30	Current clients (8 women and 2 men)	Individual and group loans
Bulawayo	7	19	Survey clients (women) drop-outs/resting-6 current clients-1	Individual and group loans
Bulawayo	16	30	Current clients (women)	Individual & group loans

Focus Groups with Branch Supervisors and Loan Officers

Four sessions were planned and successfully completed with Zambuko officers. Meetings were held with business development officers (loan officers) and branch supervisors from Harare, Bulawayo and Mutare regions, plus the Chitungwiza branch office. These sessions were held in Zambuko offices. A total of 33 business development officers and branch managers attended. The sessions began by explaining that their participation was voluntary and that the information provided would not be attributable to individuals or branch offices. Then the sessions opened with an exercise led by the facilitator with the objective of demonstrating that individuals may see the same thing differently.[23] A set of predetermined key questions stimulated the discussion on issues related to HIV/AIDS. The questions centered on criteria for joining and remaining in groups, and the reasons why clients had difficulty repaying their loans. The discussion was interspersed with probe questions related to HIV/AIDS. The sessions ended with a discussion of ideas and suggestions for services to help those who take care of the terminally ill or support people affected by HIV/AIDS. The principal researcher led the discussions, with the local team members assisting with note taking.

[23] This was not done in Mutare where the session was only facilitated by the principle investigator.

Interviews with Key Zambuko Managers

The principal researcher conducted a series of interviews with key Zambuko managers. In particular, she talked with the Executive Director, regional officers for Harare, Bulawayo and Mutare and the Coordinator of the Trust Bank program. These interviews centered on the following questions: a) what has been the impact of HIV/AIDS on their financial portfolio and operations, b) what current and possibly future policies mitigate the potential negative impact of HIV/AIDS on their financial portfolio, c) what measures has the program taken to mitigate the economic impact of HIV/AIDS on clients?

ANNEX 3

ADDITIONAL TABLES

Table 1. Types of Affectedness Among Respondents Possibly HIV-affected, 1995- 1999 (percentage)

	Clients N=134	**Non-Clients** N=94	**Total** N=228
1997-1999 illness or death of non-household member	38	32	36
1997-1999 illness of spouse, self, or other member 20 years or older	47	55	50
1997-1999 death of spouse or other member 20 years or older[1]	34	24	30
1999 chronically ill member	22	19	21
1999 new household member due to illness or death	30	27	29
1995-1997 illness in household[2]	35	23	30
1995-1997 illness and death in household[3]	53	41	45

[1] Significant difference between clients and non-clients (p=<.15).
[2] Significant difference between clients and non-clients (p=<.05).
[3] Significant difference between clients and non-clients (p=<.10)

Table 2. Data on Variables Related to Analysis of Impacts of Affectedness on Households

	Affected	**Other**	**Significance**
Average monthly household income (Z$)	N=162	N=275	
1997	3,040	3,552	<.10
1999 (1997 constant values)	3,343	4,142	<.05
Gain score change	304	590	
Average monthly net revenue of matched enterprise (Z$)*	N=160	N=265	
1997	1,912	1,976	
1999(1997 constant values)	1,441	2,058	<.01
Gain score change	-471	82	<.05
Average monthly net revenue of all enterprises (Z$)**	N=177	N=307	
1997	2,321	2,296	
1999(1997 constant values)	1,974	2,486	<.05
Gain score change	-347	190	<.10
Average number of person hours in matched enterprise*	N=180	288	
1997	58	63	
1999	65	70	<.05
Gain score change	-7	+7	<.05
% with individual savings account***	N=212	N=331	
1997	80	79	
1999	82	76	<.10
Gain score change	2	-3	

*Only for same matched enterprise 1997 and 1999.
**Only for households with enterprises.
***For same respondent 1997 and 1999.

Table 3 Additional Data on Affected Households and Other Households

	Affected	Other
Affectedness Index	N=228	N=351
Average number of ways affected by illness/death, 1995-1999	2.5	1.1
Respondent's Age, 1997	N=209	N=330
Average age	39	38
Marital Status of Respondent		
Proportion widowed[1]	N=210	N=331
Widow 1997 and 1999	11	11
Widow 1997, married 1999	3	3
Widowed since 1997	13	0
Other marital status	73	86
Household Size	N=228	N=351
1997	5.6	5.6
1999	5.8	5.6
Gain score change	.2	0
Per capita Household Monthly Income (w/o outliers)	N=165	N=273
1997[3]	692	825
1999 (deflated to 1997 constant values)	665	706
Gain score change	-27	-118
Education of Children in Household		
% of household's boys aged 6-16 enrolled in school	N=107	N=151
1997[4]	92	96
1999	98	96
Gain score change[2]	6	0
% of household's girls aged 6-16 enrolled in school	N=118	N=161
1997	94	94
1999	93	92
Gain score change	-1	-3
% of household's children aged 6-21 enrolled in school	N=179	N=267
1997	78	78
1999	78	77
Gain score change	0	-1
Average Number of Days in Last Week Consumed Specified Foods in Household		
Average number days meat/chicken/fish consumed	N=225	N=344
1997	4.1	4.2
1999	4.3	4.5
Gain score change	.2	.3
Average number of days milk consumed	N=224	N=343
1997	1.6	1.7
1999	1.1	1.2
Gain score change	-.4	-.5
Average number of days eggs consumed	N =224	N=344
1997	2.0	2.2
1999	1.7	1.9
Gain score change	-.3	-.4
Assistance to Non-Household Members		
Changes in Giving Assistance (percent)[2]	N=228	N=351
No assistance 1997 nor 1999	6	9
Assistance both 1997 and 1999	61	53
Assistance in 1997, not 1999	21	17
Assistance in 1999, not 1997	12	21

	Affected	Other
***Average Z$ value of assistance (all reasons*)**	N=221	N=343
1997	249	247
1999 (deflated to 1997 constant values)	318	360
Gain score change	69	113
Average Z$ value for funeral related assistance	N=222	N=344
1997	67	51
1999 (deflated to 1997 constant values)	70	55
Gain score	4	4
Average Hours Worked Last Week in Household Enterprises		
Average total person hours in matched enterprise	N=180	N=288
1997	58	63
1999[2]	65	70
Gain score[2]	-7	+7
Average total person hours. in up to three enterprises	N=198	N=330
1997	73	74
1999	81	87
Gain score	7	14
Average total hours of respondent in household enterprises*	N=191	N=315
1997 [4]	45	49
1999	41	44
Gain score	-4	-6
Average total hours worked by other household members in household enterprises	N=198	N=330
1997	12	12
1999	19	20
Gain score	6	8
% With Paid Employees in Household Enterprise(s)	N=198	N=330
1997	17	23
1999	23	28
Gain score	6	5

Outliers (values 3 standard deviations from the mean) were removed. Same respondent microentrepreneur in 1997 and 1999.

[1] p=<.01. 2 p=<.05. 3 p=<.10. 4 p=<.15.

Table 4. Distribution of Respondent Households by Poverty Level, 1997 and 1999 (percentage)

	Possibly HIV-affected		Others		
	Clients N=134	Non-clients N=94	Clients N=204	Non-clients N=147	**Total** N=579
1997[1]					
Extremely Poor	34	46	34	36	36
Moderately Poor	37	39	31	45	38
Non-poor	29	15	35	19	26
1999[2]					
Extremely Poor	24	39	23	29	28
Moderately Poor	45	34	35	28	35
Non-poor	31	27	42	43	37

[1] Statistically significant differences between the following:
affected clients and affected non-clients: extremely poor (p=<.10) and not poor (p=<.01).
affected clients and other non-clients: not poor (p=<.05)
other clients and other non-clients: moderately poor (p=<.01) and not poor (p=<.01).

[2] Statistically significant differences between the following:
affected clients and affected non-clients: extremely poor (p=<.05) and moderately poor (p=<.10).
affected clients and other non-clients: moderately poor (p=<.01**)** and not poor (p=<.05)
affected non-clients and other non-clients: extremely poor (p=<.15) and not poor (p=<.01)

Table 5. Changes in Poverty Status of Respondent Households, 1997 and 1999 (percentage)

	Possibly HIV-affected		Others		Total N=579
	Clients	Non-clients	Clients	Non-clients	
1997 Extremely Poor	N=45	N=43	N=69	N=53	N=210
% 1997 extremely poor moved upwards[1]	67	44	54	57	55
1997 Non-poor	N=39	N=14	N=71	N=28	N=152
% 1997 non-poor to moderate or extreme poverty in 1999[2]	59	50	38	21	41

[1] Significant difference between affected clients and affected non-clients (p=<.05).
[2] Significant difference between other clients and other non-clients (p=<.10).

Table 6. Average Per Capita Monthly Household Income, 1997 and 1999 (Zimbabwe dollars in 1997 adjusted values)*

	Possibly HIV-affected		Others	
	Clients N=92	Non-clients N=73	Clients N=161	Non-clients N=112
1997[1]	729	646	846	794
1999[2]	750	559	791	585
Gain Score[3]	21	-87	-54	-209

*Includes only those with complete income information for both years and without outliers (values 3 standard deviations from the means).
[1] Significant differences between: affected non-client and other clients (p=<.05); and between affected non-clients and other non-clients (p=<.15).
[2] Significant differences between: affected clients and affected non-clients (p=<.10); between affected clients and other non-clients (p=<.05); between other client and other non-clients (p=<.01); and between other clients and affected non-client (p=<.01).
[3] Significant differences between: other clients and other non-clients (p=<.15);affected clients and other non-clients (p=<.05); and affected clients and other clients (p=<.15).

Table 7. Average Ratio of Enterprise Net Revenue to Total Monthly Household Income

	Possibly HIV-affected		Others	
	Clients N=96	Non-clients N=73	Clients N=165	Non-clients N=117
1997[1]	75	74	67	66
1999	56	53	56	58
Gain Score[2]	-20	-21	-11	-8

Includes only those with complete income data.
[1] Significant differences between: affected client and other client (p=<.05); affected clients and other non-clients (p=<.05); affected non-clients and other clients (p=<.10); and affected non-clients and other non-clients (p=<.10).
[2] Significant differences between: affected client and other clients (p=<.05); affected clients and other non-clients (p=<.05); affect non-clients and other clients (p=<.05); and affected non-clients and other non-clients (p=<.05)

Table 8. Changes in Number of Household Enterprises, 1999 compared to 1997 (percentage)

	Possibly HIV-affected		Others	
	Clients N=134	Non-clients N=94	Clients N=204	Non-clients N=147
Less/none	23	20	17	18
Same	60	62	67	70
More	17	18	16	12

Table 9. Average Monthly Household Income 1997 and 1999 (Zimbabwe dollars in 1997 adjusted values)*

	Possibly HIV-affected		Others	
	Clients N=92	Non-clients N=70	Clients N=160	Non-clients N=115
1997[1]	3,708	2,159	3,958	2,987
1999[2]	3,943	2,553	4,125	4,165
Gain Score[3]	235	394	167	1,178

*Includes only those with complete income information for both years, and without the outliers (values 3 standard deviations from the mean).

[1] Significant differences between: affected clients and affected non-clients (p=<.01); affected clients and the other clients (p=<.10); other clients and other non-clients(p=<.01); and affected non-clients and other non-clients (p=<.03).

[2] Significant differences between: affected clients and affected non-clients (p=<.05); and affected non-clients and other non-clients (p=<.01).

[3] Significant differences between: affected clients affected and other non-clients (p=<.10); and other clients and other non-clients (p=<.05).

Table 10. Average Total Net Revenue from Matched Enterprise Last Month, 1997 and 1999 (Zimbabwe dollars in 1997 constant values)*

	Possibly HIV-affected		Others	
	Clients N=90	Non-clients N=70	Clients N=153	Non-clients N=112
1997[1]	2,194	1,549	2,189	1,686
1999[2]	1,591	1,248	2,099	2,003
Gain Score[3]	-603	-300	-90	317

*Analyzes only those with the same matched enterprise and with complete information for both years. Outliers (values 3 standard deviations from the mean) removed.

[1] Significant differences between: affected clients and affected non-clients (p=<.05); affected clients and other non-clients (p=<.10); other clients and other non-clients (p=<.05); and other clients and affected non-clients (p=<.05).

[2] Significant differences between: affected clients and other non-clients (p=<.15); affected clients and other clients (p=<.05); affected non-clients and other clients (p=<.01); and affected non-clients and other non-clients (p=<.01).

[3] Significant differences between: affected clients and other clients (p=<.10); affected clients and other non-clients (p=<.01); and affected non-clients and other non-clients (p=<.10).

Table 11. Proportion of Households with Paid Employees in their Household Enterprises

	Possibly HIV-affected		Others	
	Clients N=119	Non-clients N=79	Clients N=193	Non-clients N=137
1997 [1]	20	11	27	16
1999	26	18	28	28
Gain Score [2]	6	6	1	12

[1]Significant differences between affected clients and affected non-clients (p=<.10) and between other clients and other non-clients (p=<.05).

[2]Signficant difference between other clients and other non-clients (p=<.05).

Table 12. Average Household Size and Economic Dependency Ratios*

	Possibly HIV-affected		Others	
	Clients N=134	Non-clients N=94	Clients N=204	Non-clients N=147
Average Household Size				
1997[1]	5.9	5.2	5.7	5.4
1999[2]	6.2	5.4	5.8	5.4
Gain Score	.3	.2	.1	0
Economic Dependency Ratio*				
1997	31	30	30	28
1999[3]	43	37	32	33
Gain Score[4]	11	7	2	4

*Percentage household members not economically active.

[1] Significant differences between: affected client and affected non-clients (p=<.05); and affected clients and other non-clients (p=<.10).

[2] Significant differences between affected clients and the other groups: affected non-clients (p=<.05), other non-clients (p=<.01) and other client (p=<.15).

[3] Significant differences between the affected clients and the other groups: affected non-clients (p=<.10), other non-clients (p=<.01) and other clients (p=<.01). Also significant difference between affected non-clients and other clients (p=<.15).

[4] Significant differences between: affected clients and other clients (p=<.01);affected clients and other non-clients (p=<.01); and affected non-clients and other clients (p=<.10).

Table 13. Findings Related to the Analysis of Impacts of Microfinance on HIV-affected Clients' Households and Enterprises

	Possibly HIV-affected		Others	
	Clients	Non-clients	Clients	Non-clients
Average Number Income Sources	**N=133**	**N-94**	**N-203**	**N-147**
1997[2]	2.5	2.1	2.5	2.4
1999[2]	2.8	2.3	2.7	2.6
Gain Score	0.3	0.2	0.2	0.2
% Household's Boys aged 6-16 in School)	**N=72**	**N=35**	**N=89**	**N=62**
1997 [6]	91	93	95	98
1999 [5]	99	95	97	94
Gain Score [4, 10]	8	1	2	-4
Average Person Hours in Matched Enterprise Last Week **	**N=103**	**N=77**	**N=166**	**N=122**
1997 [10]	66	64	59	69
1999 [10]	55	62	64	77
Gain Score [5]	-11	-1	6	9
Av. Hours Worked by Respondent in All Household Enterprises Last Week ***	**N=114**	**N=79**	**N=193**	**N=137**
1997 [5]	46	44	46	54
1999 [2,4]	37	46	42	46
Gain Score [2]	-9	2	-4	-8
% that Insist on Deposit When Extending Customer Credit *****	**N=70**	**N=52**	**N=123**	**N=83**
1997	57	69	63	57
1999 [3,5]	75	60	68	58
Gain Score [1,6]	19	-10	4	1
% Respondents with Individual Savings Accounts***	**N=124**	**N=88**	**N=194**	**N=137**
1997 [2,4,7]	86	73	87	68
1999 [1,4,7]	91	69	83	66
Gain Score	6	-3	-4	-2
Average Number Ways Resp. Saves***	**N=124**	**N=188**	**N=194**	**N=137**
1997[1,4,7]	2.1	1.6	1.9	1.6
1999[1,4,7]	2.6	2.0	2.5	2.1
Gain Score	.4	.3	.4	.5

*Only covers households with boys aged 6-16 in both 1997 and 1999.

**Only covers matched enterprises operating in both 1997 and 1999.

***Only covers same respondent both years.

****Only covers households with enterprises both years.

The following notes indicate significant differences between affected clients and affected non-clients: [1]p=<.01; [2]p=<.05; and [3]p=<.10.

The following notes indicate significant differences between affected clients and other non-clients: [4]p=<.01; [5]p=<.05; and [6]p=<.10.

The following indicate significant differences between other clients and other non-clients: [7] p=<.01; [8]p=<.05; [9]p=<.10; and [10]p=<15.